OHIO DEPARTMENT OF INSURANCE

A

TARGETED

MARKET CONDUCT EXAMINATION

OF

FORTIS INSURANCE COMPANY

NAIC #69477

As Of

June 30, 2004

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The Honorable Mary Jo Hudson
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, OH 43215-1067

Dear Director Hudson:

Pursuant to your authority delegated under the provisions of R.C. 3901.011 and in accordance with your instructions, a target market conduct examination of the business practices and affairs has been conducted on:

Fortis Insurance Company
501 W. Michigan
P.O. Box 3050
Milwaukee, WI

The Company is a Wisconsin domiciled life, health and annuity insurance company hereinafter referred to as "FIC" or the "Company." The examination was performed as of June 30, 2004, at the Company's office located in Milwaukee, WI. As of September 6, 2005 the Company has changed its name, and currently operates as Time Insurance Company.

A report of the examination is enclosed.

Respectfully submitted,

_____ _____

Lynette A. Baker Date
Assistant Chief, Market Regulation Division

SCOPE OF EXAMINATION

This Target Market Conduct Examination was performed to determine Fortis Insurance Company's (hereinafter referred to as "Company" or "FIC") compliance with Ohio statute and rules. In addition, the Health Insurance Portability and Accountability Act ("HIPAA"), the Women's Health and Cancer Rights Act ("WHCRA"), and the Newborns' and Mothers' Health Protection Act ("NMHPA") were included in the compliance examination.

The examination process is governed by, and performed in accordance with, the procedures developed by the National Association of Insurance Commissioners, Centers for Medicare and Medicaid Services, the Ohio Department of Insurance (Department), and the Insurance Regulatory Examiners' Society. Examiners rely primarily on records and materials maintained and provided by the Company. The examination covers the period of July 1, 2002 through June 30, 2004.

The Ohio Department of Insurance regards the function of the Examiner-In-Charge to be a determining factor in the expeditious conduct of this examination. Your response to the examiners' requests will not only affect the quality of the final report, but will determine the time required completing the examination and, ultimately, the cost to your company.

The examination includes, but is not limited to, review of the following phases:

1. Company Operations and Management
2. Marketing and Sales
3. Complaints and Grievances
4. Contract/Policy Language
5. Underwriting: Polices Issued, Declined and Terminated, Certificates of Creditable Coverage
6. Claims Paid and Denied
7. Association Coverage

The Target Market Conduct Examination will consist of a review of information, materials, documents and files requested by the examiners and supplied by the Company. Upon review of the documents, any concerns, discrepancies or questions will be noted and the Company will be notified in writing with an "inquiry form." The inquiry form provides space for the Company to respond in writing, either in agreement with the findings or to explain or justify the Company's action regarding the issue raised by the examiners. After consideration of the Company's responses, any invalid or non-issue comments are eliminated from the final report findings.

The Report of Examination will contain an explanation of the procedures performed and the findings and conclusions reached in each phase of the examination. Examination report recommendations that do not reference specific insurance laws, rules and bulletins may be presented to encourage improvement of company practices and operations and to ensure consumer protection. Examination findings may result in administrative action by the Ohio Department of Insurance.

All unacceptable or non-complying practices may not be discovered during the course of the examination. Additionally, findings may not be material to all areas that would assist the Director of Insurance. Failure to identify specific Company practices does not constitute acceptance of such practices. Additionally, a report of examination should not be construed to endorse or discredit any insurance company or insurance product.

COMPANY OPERATIONS AND MANAGEMENT

Company History and Profile

The Company first organized in LaCrosse, Wisconsin, in 1892 as the LaCrosse Mutual Aid Association. The Company moved to Milwaukee during 1900 and in 1905 took the name of Time Indemnity. On February 11, 1910 the Company incorporated and changed its name to Time Insurance Company (TIC). TIC commenced business March 6, 1910.

During April, 1969, Time Holdings Inc., was formed to become the parent company of TIC. During January, 1978, control of Time Holdings Inc. was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. On April 1, 1998, TIC changed its name to Fortis Insurance Company (FIC).

FIC's direct parent is Interfinancial, Inc., which is controlled by Fortis, Inc., in New York, New York. The ultimate controlling entities are Fortis AG, located in Belgium, and Fortis AMEV. Effective January 1, 1999, Fortis AG was renamed Fortis (B), and Fortis AMEV was renamed Fortis (NL) N.V. On September 27, 2001, Fortis (B) was replaced by Fortis SA/NV, a Belgian company and Fortis (NL) N.V. was replaced by Fortis N.V., a Netherlands company. The U.S. operations were known as Fortis Inc., which was renamed Assurant, Inc. when it became a publicly traded company on the New York Stock Exchange through an Initial Public Offering (IPO) February 5, 2004. The Company is licensed in all states, except for Hawaii and New York. As of September 6, 2005, Fortis Insurance Company was renamed and now operates as Time Insurance Company (TIC).

The Company offers individual and group health insurance products in Ohio. The Company markets its individual products through an Association (Health Advocates Alliance Association) and a Trust (Health Advocates Insurance Trust). Both the Association and the Trust master policies were issued in the State of Illinois. The Company offers its group products through a Trust (Praesidium Trust). The Praesidium Trust master policy was issued in the State of Alabama.

In addition, the Company offers two specialty products, a short-term product offered through Short Term Trust, and a plan offered by Student Insurance Trust. The master policy for Short Term Trust was issued in the State of Alabama. The Student Insurance Trust master policy was issued in the State of Delaware.

Furthermore, the Company offers ancillary products to small employers for life insurance, short-term disability insurance and dental insurance.

Adequacy of Records

The Company provided files, records, and other data in a timely manner. The records were provided in an orderly fashion, which helped expedite the examination process.

Cooperation with Examiners

The Company personnel were cooperative throughout the examination. However, the examination was extended because of delays associated with responses to inquiries and memorandum requests. The Company averaged 23 calendar days to respond to memorandum requests and 54 calendar days to respond to inquiries.

Previous Market Conduct Examination Reports

The Company had five market conduct examinations completed during the period under examination. The states of Pennsylvania, Oklahoma, Arizona, Texas and Delaware completed market conduct examinations. Texas completed a targeted market conduct examination of claim practices and consumer complaints. Delaware completed a targeted market conduct examination. Oklahoma completed a target market conduct examination addressing complaints, underwriting and rating, producer licensing and claims. Pennsylvania examined forms, underwriting and claims. Arizona's examination targeted agent terminations, policy forms, claims and underwriting.

The following violations were noted during the Pennsylvania examination:

- The Company failed to provide evidence of the issuance of Certificates of Creditable Coverage to 85 terminated members.
- The Company failed to provide an underwriting file.
- The Company failed to provide two applications for issued files. Three applications were not legibly scanned.

The following violations were noted during the Arizona examination:

- The Company failed to issue coverage to one small group for the stated reason that the employer had not been in business for at least six months.
- The Company failed to provide declined applicants with a proper notice of adverse underwriting decisions.
- The Company failed to provide five sampled files.
- The Company participation agreement/application included a statement that only full-time employees and their dependents are eligible for coverage. Arizona law requires insurers to allow employers to establish eligibility criteria for the group.

- A Company form used a 30-day standard for imposing preexisting condition limitations on newborns and children adopted or placed for adoption if they were "late entrants," rather than 31 days as required by Arizona law.

The following violation was noted during the Delaware examination:

- The Company was unable to provide any documentation for certain files.

The Texas and Oklahoma market conduct examinations did not note failures that would be associated with this examination, or non-compliance with provisions of WHCRA, NMHPA or HIPAA.

MARKETING AND SALES

Marketing and Sales Standard #1 *– Test all sales (including producer materials) and advertising to determine compliance with HIPAA, NMHPA, WHCRA and Ohio Statutes and Rules.*

The Company was requested to provide all its marketing, sales, and agency training solicitation materials. The Company provided a total of 85 items. Of the 85 items provided, all were tested. The files could Pass, Fail, or be found to not have an issue related to WHCRA, NMHPA, HIPAA, or associated Ohio Law (N/A). The results of the testing are provided in the table below:

	HIPAA	WHCRA	NMHPA	Ohio Law
Pass	3	0	0	67
Fail	12	8	0	18
N/A	70	77	85	0
Percentage of items failed with an issue related to law	80%	100%	0%	21%
# of Items	85	85	85	85

Issue No. 1 – Individual Guide (maternity services)

The Individual Medical & Short Term Medical Form No. 24357, ("Individual Guide"), stated, "There must be no history of Caesarean section or current pregnancy." The underwriting guidelines contradict this statement as follows: "C-section delivery followed by: a normal vaginal delivery . . . All Cases Standard."

This contradiction would result in an agent (without reference to the Individual Guide, and for an applicant with a history of C-section delivery), submitting an application, and the Company accepting the application electing maternity coverage, while another agent, after referring to the same Individual Guide, advises the applicant (also with a previous

history of C-section delivery) that she cannot elect maternity coverage. If this occurred it would also be a violation of R.C. 3901.21(B).

The contradiction would result in discrimination between two individuals of essentially the same risk by enabling one to obtain coverage for maternity services while the other does not. Any such discrimination would contravene R.C. 3923.15, which provides, "No insurer doing the business of sickness and accident insurance in this state shall make or permit any unfair discrimination between individuals of substantially the same hazard . . . ."

COMPANY RESPONSE: The Company disagrees that there is a violation of R.C. §3923.15 . . . . The Agent Guide is not provided to the insured. Further, all agents are provided with the same Agent's Guide. Therefore, we note no violation of Ohio law. However, the Company has updated the Agent Guide to include specific information regarding maternity coverage per the Department's recommendation.

***EXAMINER RESPONSE*:** The information supplied to the Company's agents is misleading, would result in discrimination, and is in direct conflict with its underwriting guidelines.

Issue No. 2 – Individual Guide (notification to applicants)

The Individual Guide provides procedures when an applicant requests the reasons for an adverse underwriting decision, when that decision involves confidential information. The applicant is required to mail or fax a written request to the Home Office, asking that the information be sent to his or her medical practitioner and include the name and address of the medical practitioner.

The Guide is misleading in that it is in direct conflict with Ohio statutes, and which if supplied to an applicant, would be in contravention of R.C. 3901.21(B) as materially misleading or deceptive. Additionally, R.C. 3904.10(A) requires that in the event of an adverse underwriting decision, the insurer or agent shall provide the applicant with the specific reason(s) for the decision in writing or advise the applicant that (s)he may request and receive in writing, the specific reason(s) for the decision. During testing of files, it was determined that the Company's form letter to declined applicants follows this procedure and does not permit the applicant to receive the specific reason(s) for adverse underwriting decisions from the Company. The letter provides that the applicant may only receive this information from his or her physician. Each issuance of the form letter to a declined individual was a contravention of R.C. 3904.10(A), which provides in part, "In the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing, or advise such person that upon written request he may receive the specific reason or reasons in writing."

COMPANY RESPONSE: The Company agrees, however respectfully notes that the Company had modified its administrative practices such that both confidential and non-

confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice. Among the documentation planned for revision to comport with current company practice is the Agent's Guide. However, please note that the Agent Guide is not designed for or supplied to the applicant.

Issue No. 3 – Sales and Marketing Materials (Form No. 20426)
The initial "Information, Files and Data Request," requested the Company to provide all advertising and marketing materials. The Company failed to provide the Small Group Markets Rating and Renewal Provisions Brochure when it supplied its advertising and producer marketing materials for testing. The Company was asked to provide the form because it was referenced in other marketing materials. Additionally, the solicitation packet from an outside source did not include Form No. 20426 (Rev. 5/2000).

The Company was asked to provide the small group health plan packet to determine if the Company's solicitation of small group business was in compliance with Public Law 104-191, Part A - Group Market Reforms, Sec.2713, 45 CFR § 146.160, and R.C. 3924.033. These statutes and the regulation specify that each carrier shall disclose to the employer, as part of its solicitation and sales materials, the following:

- The carrier's right to change premium rates and the factors that may affect changes in premium rates;
- The provisions of the plan relating to renewability of coverage;
- The provisions of the plan relating to any pre-existing condition exclusion; and
- The benefits and premiums available under all health plans for which the employer is qualified.

The Company provided a copy of the Small Group Brochure Form No. 20426 in response to the request, and advised that it was in use to comply with the small group disclosure requirements cited above.

COMPANY RESPONSE: The Company agrees. We regret that Form 20426 (Rev 5/2000) was not provided with the original request for all advertising and producer marketing materials, and that the form was not provided in the solicitation packet requested from an outside source on Fortis Insurance Company individual and small group health plans. While Form 20426 (Rev. 5/2000) was available for use by the sales force in Ohio on the same basis as all other solicitation material, Form 20426 was not consistently utilized in the intended manner. Appointed agents may obtain copies by ordering directly from our Supply Department or download copies from a dedicated web-site. Please note, we will take the necessary steps to remind the sales force to include successor form [Form 20426 (Rev. 12/2004)] with any materials provided to interested employers during the solicitation process.

EXAMINER RESPONSE: The Company's solicitation process during the period under examination failed to provide employers with the following information that is required

to be provided for compliance with Public Law 104-191, Part A - Group Market Reforms, Sec. 2713, 45 CFR § 146.160, and R.C. 3924.033:

(1) The carrier's right to change premium rates and the factors that may affect changes in premium rates; and

(2) The provisions of the plan relating to renewability of coverage.

The Company *did* provide the required information concerning:

(3) pre-existing conditions; and

(4) benefits and premiums available.

Issue No. 4– Small Group Marketing Materials (termination provisions)
P.L. 104-191, Part A - Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and R.C. 3924.03(B)(1) and (2), all indicate that a health insurance issuer may nonrenew or discontinue health insurance coverage offered in connection with a group health plan in the small or large group market based only on one or more of following:

- Nonpayment of premium. The plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.
- Fraud. —The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- Violation of participation or contribution rules.
- Termination of coverage.
- Movement outside service area.
- Association membership ceases.

The Small Group Markets Rating and Renewal Provisions Brochure, Form 20426 (Rev. 5/2000) did not include the provisions relating to renewability of small group health plans that are required in order to comply with the laws and regulation noted above. The Brochure stated, "Your coverage will not be terminated for poor claims experience. Termination will only occur when one of the following conditions exist:

- non-payment of premium at the time it is due
- evidence of fraud or material misrepresentation . . .
- business ceases to operate on a full-time basis . . ."

COMPANY RESPONSE: The Company disagrees. We respectfully note that our administrative practices are in compliance with Section 3923.04 (C) of the Ohio Revised Code. We acknowledge that pursuant to § 3923.04 (C), a carrier cannot terminate coverage for non-payment of premium until the expiration of the grace period . . . In addition, the brochure provides summary information only. Moreover, the brochure also

contains the following statement: A description of the policy exclusions, reductions, exceptions can be found in the insurance policy, the Plan brochure and on the State Variation sheet. The certificate of insurance clearly establishes the rights pertaining to the grace period, in compliance with the referenced statute. However, **we will amend the language to clarify this termination provision**.

EXAMINER RESPONSE: It is agreed that the certificate of insurance language is correct. However, the Brochure (Form No. 20426 (Rev. 5/2000) is failed for providing misleading and inaccurate information to employers, which is a violation of Ohio Adm.Code 3901-1-16(E)(2) and R.C. 3923.16. The brochure did not correctly depict the requirements of Public Law 104-191, Part A - Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and R.C. 3924.03(B)(1)(2).

Issue No. 5 – Small Group Marketing Materials (termination provision)
Brochure Form 20426 (Rev. 5/2000) also indicated that the Company could terminate coverage for evidence of fraud or material misrepresentation. As indicated in Public Law 104-191, Part A - Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and R.C. 3924.03(B)(1)(2), a group health plan can be terminated for fraud or an intentional misrepresentation of material fact, not for a material misrepresentation. Therefore, the Brochure provided misleading and inaccurate information, which is a violation of Ohio Adm.Code 3901-1-16(E)(2) and R.C. 3923.16

COMPANY RESPONSE: The Company disagrees. We respectfully note that the brochure is a summary only and contains the disclaimer noted above. A description of the policy exclusions, reductions, exceptions can be found in the insurance policy, the Plan brochure and on the State Variation sheet. However, we will amend the language to include "an intentional misrepresentation of a material fact.

Issue No. 6 – Small Group Marketing Materials (termination provision)
The Company's Brochure (Form No. 20426 (Rev. 5/2000) indicated the Company could terminate coverage if the business ceased to operate on a full-time basis. A small group health plan cannot be terminated because the business ceases to operate on a full-time basis. This is not one of the reasons permitted by law for which health insurance issuers may nonrenew or discontinue health insurance coverage offered in connection with a group health plan. Therefore, the Brochure provided misleading and inaccurate information, which is a violation of Ohio Adm.Code 3901-1-16(E)(2) and R.C. 3923.16.

COMPANY RESPONSE: The Company disagrees. We note that our administrative practice is in compliance with state and federal law. We only terminate coverage if the business is no longer viable. However, in order to clarify this point, we are willing to modify the language and we will be taking the necessary corrective action to address this issue. We will amend this language to indicate that termination may occur when a business ceases to operate as a viable business.

EXAMINER RESPONSE: The Brochure is failed because it stated the Company could terminate a small group health plan if a business ceased to operate on a full-time basis.

To terminate a small group plan for this reason would be a violation of Public Law 104-191, Part A - Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and R.C. 3924.03(B)(1)(2). The Company's determination of the viability of an employer's business is irrelevant to continuation of the health plan. If the business is still operating and premiums are being paid, the plan must be continued in force.

Issue No. 7 – Small Group Marketing Materials (underwriting guidelines)
The Company's Underwriting Guidelines in the Small Group Guide, stated in part:

> "(1) A *business must be in existence for a minimum of six months* and be a viable business at the time of application.

For (1) above, a business does not have to be in existence for six months at the time of application to be guaranteed availability of a small group plan. The Company must issue a small group plan to all employers that apply and have 2-50 employees.

COMPANY RESPONSE: With respect to item 1, the Company agrees. The Company practice with regard to the 6-month durational requirement found on page 4 of the Agent's Guide has been discontinued and is no longer applied to small employer applicants. We will amend language in the Agent's Guide to reflect this change. We would note that the information provided in response to Memo Request #5 (Small Groups Declined) found that no groups were declined coverage for being in existence less than six months. Consequently, there were no violations of small group guarantee issue requirements resulting from this practice during the examination period.

EXAMINER RESPONSE: However, if an agent read the provision in the Small Group Guide and did not submit an application for a business that had been in existence for a period of less than six months, the Company would have avoided issuing a small group plan in violation of R.C. 3924.03(E)(1), Public Law 104-191, Part A - Group Market Reforms, Sec. 2711, and 45 CFR § 146.150.

Issue 8 – Small Group Marketing Materials (termination provisions)
The Small Group Guide stated that a group may be terminated for the following reasons:

1. The number of employees insured in a group is fewer than two persons.

1. An insurer may not terminate a group that has fallen to one participant until the first renewal date following the beginning of the new plan year. This is indicated in HCFA Bulletin, Transmittal No. 99-03. A group cannot be terminated at any time after it falls to one participant. The termination must be delayed until the first renewal date following the new Plan Year.

COMPANY RESPONSE: With respect to item 1, the Company disagrees. We note the Agent's Guide is a summary overview only and is not intended to replicate all requirements of the law. With respect to groups with fewer than two persons, we periodically conduct reviews to establish compliance with participation and contribution

requirements. When it is determined that a group may have fewer than 2 employees, an investigation is conducted to establish whether or not the employer group remains eligible for participation in the small employer health plan. Upon determination that a group no longer qualifies as a small employer because they have fewer than 2 employees, a notice is sent advising that the group is no longer eligible to participate in the health plan and that coverage will be terminated. Current practice provides for a 30 day notice with termination effective on the premium due date following the 30 day notice period. **In view of the information noted from the HCFA Bulletin Transmittal No 99-03, we will amend practices to provide termination at the end of the plan year (i.e., the group's renewal date following our determination that they no longer qualify as a small employer.**

EXAMINER RESPONSE: Termination practices should ensure that Small Employer groups that decline to one Employee are not terminated until *the first renewal date following the beginning of the new Plan Year*. The Company's response did not indicate that it would correct its termination practices to comply with the requirements of HCFA Bulletin Transmittal No. 99-03. The Plan Year and the renewal date do not necessarily coincide. The Plan Year is defined in HCFA Transmittal No. 99-03:

"The regulations at § 144.103 define plan year as . . . "the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is: (1) the deductible/limit year used under the plan; (2) if the plan does not impose deductibles or limits on a yearly basis, the *HCFA Bulletin Transmittal No 99-03* plan year is the policy year; (3) if the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year; or (4) in any other case, the plan year is the calendar year.""

The Company may only terminate the Plan on *the first renewal date following* the new Plan Year, not the group's renewal date following the Company's determination that the group no longer qualifies as a small employer.

Issue No. 9 – Small Group Marketing Materials (coverage guarantees)

The Small Group Guide failed to provide for guaranteed issue of a small group plan by stating (in part), "State/Federal COBRA Continuation – At the time of application, no more than 20% of the total employees in the business may be on State/Federal (COBRA) Continuation."

The Company may refuse an application based only upon the regulatory exceptions for small employer health insurance issuers set forth in R.C. 3924.03, R.C. 3924.031, R.C. 3924.032 or Public Law 104-191, Part A - Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. When the Company imposed this provision, it was a violation of the above noted statutes and regulation. Therefore, the Guide provided false and misleading information in violation of R.C. 3901.21(B).

R.C. 3924.03(E)(1), provides in part, "Except as provided in sections 3924.031 [3924.03.1] and 3924.032 [3924.03.2] of the Revised Code, and subject to such rules as may be adopted by the superintendent of insurance in accordance with Chapter 119 of the Revised Code, a carrier **shall offer** and **make available** every health benefit plan that it is actively marketing to **every small employer** that applies to the carrier for such coverage."

Both Public Law 104-191, Part A - Group Market Reforms, Sec. 2711, and 45 CFR § 146.150 indicate:

(a) Issuance of coverage in the small group market. Subject to paragraphs (c) through (f) of this section, each health insurance issuer that offers health insurance coverage in the small group market in a State must--

(1) Offer, to **any** small employer in the State, **all** products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept **any employer** that applies for any of those products; and

(2) Accept for enrollment under the coverage **every eligible individual** (as defined in paragraph (b) of this section) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan, or during a special enrollment period, and may not impose any restrictions on an eligible individual's being a participant or beneficiary, which is inconsistent with the nondiscrimination provisions of Sec. 146.121.

To deny coverage to small employers, who at the time of application have more than 20% of the total number of employees on State/Federal (COBRA) Continuation, would be a violation of the guaranteed availability of coverage requirements indicated above. Therefore, the Guide provided misleading information in violation of R.C. 3901.21(B).

COMPANY RESPONSE: The Company agrees and is taking the necessary corrective action to address this issue. Please note that the information provided in response to Memo Request #5 (Small Groups Declined) found that no groups were declined coverage based on the number of participants on State/Federal Continuation. Consequently, there were no violations of small group guarantee issue requirements resulting from this practice during the examination period.

EXAMINER RESPONSE: It is unknown if any small employers were deterred by the agent from applying for coverage with the Company, based on the statement in the Guide.

Issue No. 10 – Small Group Marketing Materials (continuation provision)

The Company's Small Group Ohio State Variations Form failed to provide the state continuation option in compliance with R.C. 3923.38, for certain terminated employees.

The form provided, "The covered person's employment is considered terminated when the covered person stops actively working for the participating employer, including layoff or leave of absence. However, a covered person's insurance may be continued for up to six months if employment terminates for any reason other than: (a) the covered person's total disability; (b) the participating employer's bankruptcy; or (c) discontinuance of the participating employer's business."

None of the three above (a, b, c) is a permissible reason for denying continuation coverage to terminated employees. The only reasons permitted by law are provided in R.C. 3923.38.

(a) A person can be totally disabled by the Company's standards and still be eligible for state continuation coverage.

(b) Filing for bankruptcy is not a valid reason to deny employees continuation coverage as long as the premium is being paid for the coverage to remain in effect.

(c) If the Employer is still running any business entity covered by the group health plan, the employees of the terminated entity of that Employer are entitled to state continuation coverage. Continuation coverage is unavailable only if the Employer's plan is discontinued in its entirety, i.e. there is no longer *any* entity of the Employer still in business that is covered by the plan. While discontinuance of the employer's businesses in their entirety would result in loss of continuation rights, discontinuance of fewer than all of the employer's businesses covered under the group health plan would not result in the same loss of continuation rights.

R.C. 3923.38, provides:

"(A)(2)'Eligible employee' includes only an employee to whom all of the following apply:

(a) The employee has been continuously insured under a group policy or under the policy and any prior similar group coverage replaced by the policy, during the entire three-month period preceding the termination of the employee's employment.

(b) The employee is entitled, at the time of the termination of the employee's employment, to unemployment compensation benefits under Chapter 4141 of the Revised Code.

(c) The employee is not, and does not become, covered by or eligible for coverage by Medicare under Title XVIII of the Social Security Act, as amended.

(d) The employee is not, and does not become, covered by or eligible for coverage by any other insured or uninsured arrangement that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not

covered immediately prior to such termination. A person, eligible for continuation of coverage under this section, who is also eligible for coverage under section 3923.123 [3923.12.3] of the Revised Code, may elect either coverage, but not both. A person who elects continuation of coverage may elect any coverage available under section 3923.123 [3923.12.3] of the Revised Code upon the termination of the continuation of coverage.

(B) A group policy shall provide that any eligible employee may continue the employee's hospital, surgical, and medical insurance under the policy, for the employee and the employee's eligible dependents, for a period of six months after the date that the insurance coverage would otherwise terminate by reason of the termination of the employee's employment . . ."

R.C. 3923.38 does not provide that the employee's privilege to obtain coverage, or to continue coverage, ceases if the covered person becomes totally disabled or if the employer is bankrupt or if there is a discontinuance of the employer's business. Therefore, the Company has acted in violation of R.C. 3923.38 every time it has applied any of the provisions indicated above. In addition, the Form provided inaccurate and misleading information in violation of R.C. 3901.21(B).

In addition, the Company's Small Group Guide stated, "Fortis Insurance Company's Small Group products also comply with state continuation mandates for medical coverage." The Company should adhere to the state continuation mandates as indicated in R.C. 3923.38.

COMPANY RESPONSE: The Company disagrees. We note that our administrative practice is in compliance with state and federal law. We may refuse continuation to a covered person if their termination occurs for total disability because 3923.38(A)(2)(b) states that an 'eligible employee' must be a person entitled at the time of termination of employment to unemployment compensation benefits. According to s. 4141.29(A)(4)(a)(i) of the Ohio Revised Code, a person is not eligible for unemployment compensation if the person is not able and available for work. A person who is totally disabled would not be able and available for work under the unemployment compensation standards.

With respect to bankruptcy and discontinuance of a business, we will only terminate coverage if the business is no longer viable. As a result, we feel our standards are in compliance with s. 3923.38(B) of the Ohio Revised Code. However, **we are willing to modify the language to reflect that an employer's coverage will be terminated if the employer is no longer a participating employer under the policy, and we will be taking the necessary corrective action to address this issue**.

EXAMINER RESPONSE: The Company's Small Group plan (Form No. C99.100.DEF.OH) defines "Total Disability or Totally Disabled" as follows:

"1. For you: you are unable, because of *illness* or *injury*, to perform all of the essential duties of your occupation at your customary place of work and are under the regular care of a *physician*."

Total Disability according to the Company's standards means that the person is not able to perform all of the *essential duties of that person's occupation at his or her customary place of work*. This does *not* mean that the individual is unable to work at all. The individual may have several different options for further employment and may be actively pursuing those alternatives. Such a person would be eligible for unemployment benefits and therefore be eligible for state continuation benefits.

The Company's wording is misleading, and therefore is a violation of R.C. 3901.21(B). An insured who is totally disabled by the Company's standards will incur medical expenses which could be substantial and for which the Company would be liable. It is unfair to deter an insured from making application for continuation coverage by making a blanket exclusion of coverage for a person who is "Totally Disabled" by the Company's standards. Further, if the Company deprives a person of continuation coverage, the Company would also be depriving the person of federal eligibility for an individual policy without the imposition of a preexisting conditions limitation if that person does not have eighteen months of creditable coverage under the group health plan and cannot achieve the eighteen months without continuation coverage. Total disability by the Company's standards should not be used to deprive an individual of continuation coverage. Only the Ohio Department of Job and Family Services may make the determination of an individual's total disability as it concerns eligibility for unemployment compensation and only ineligibility for unemployment compensation is a permitted reason for denial of continuation coverage.

Issue No. 11 – Small Group Marketing Materials (waiting period notification)

The Company's Small Group Ohio State Variations Form failed to provide the employer with the required choice of a waiting period from zero to 90 days. The Form stated in part:

"Waiting Period

The waiting period applies to new hires after the original effective date of the group. The employer will be required to select a ***30 or 60-day*** waiting period for all new employees."

The Waiting Period is *at the option of the Small Employer*, whether the waiting period applies at the time of initial group enrollment for existing employees, *or* after employment begins for a new employee. The Company may not force an employer to impose a waiting period on new employees. The decision concerning the imposition of a waiting period rests solely with the small employer. The Form provided inaccurate and misleading information in violation of R.C. 3901.21(B).

It was noted during the testing of Small Groups Issued files that the Company does not impose the 30 or 60 day requirement consistently but rather: (1) permits some Employers a waiting period in excess of the 60 days specified in the Small Group Ohio State Variations Form; and (2) has permitted one Employer a Waiting Period of 180 days.

R.C. 3924.01(M) provides, "'Service Waiting Period' means the period of time ***after employment begins*** before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer."

R.C. 3924.03, provides in part:

> "Except as otherwise provided in section 2721 of the 'Health Insurance Portability and Accountability Act of 1996,' Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, health benefit plans covering small employers are subject to the following conditions as applicable: . . .
>
> (E)(2) Each health benefit plan, at the time of initial group enrollment, shall make coverage available to all the eligible employees of a small employer without a service waiting period. ***The decision of whether to impose a service waiting period shall be made by the small employer. Such waiting period shall not be greater than ninety days."***

COMPANY RESPONSE: With respect to item (1), the Company agrees and will amend the 'Small Group Ohio State Variations' to reflect options for waiting periods of 0 and 90 days. With respect to item (2), the Company agree**s.** We have identified the application of a 180 day waiting period to this group as an underwriting error. We will require the group to amend its waiting period to those options not exceeding 90 days. A copy of the letter advising the employer of this change will be provided as soon as it becomes available.

Issue No. 12 – Small Group Marketing Materials (waiting periods)

The Small Group Guide failed to provide for non-discrimination between groups in the choice of a waiting period. The Guide stated:

> "Occupational Eligibility
>
> Some businesses are considered 'high risk' or have high turnaround and therefore are subject to coverage limitations (i.e. not eligible for disability, ***waiting period limitations***) and/or surcharges. Due to their nature, other businesses have no coverage limitations but may be either discounted or surcharged."

The Small Group Ohio State Variations page stated:

> "Waiting Periods
>
> At time of initial group enrollment, a waiting period is not allowed."

(1) The Company may not waive or permit a zero day waiting period for some groups but not others, e.g. it may not permit a zero day waiting period for low or standard risk groups, and impose a waiting period on "high risk" groups or groups that have a high turnaround. The Small Group Guide in conjunction with the Small Group Ohio State Variations pages indicated that "high risk" and high turnaround groups are not eligible for a zero days waiting period. Such discrimination avoids the guaranteed availability requirements of law by deterring "high risk" or high turnaround groups from seeking coverage with the Company because their employees will be subject to a gap in their coverage, which would be a violation of R.C. 3901.21. The statement in the Guide that some groups could be treated differently from other groups provided inaccurate and misleading information in violation of R.C. 3901.21(B).

(2) The Company may not refuse to permit a new group to impose a Waiting Period on existing employees, whether that group is a true new group or a group transferring its coverage from another carrier. The statement in the Ohio State Variations pages that at the time of initial group enrollment a waiting period is not allowed, provided inaccurate and misleading information in violation of R.C. 3901.21(B).

The decision concerning the imposition of a waiting period rests solely with the small employer. The Guide should not imply that the Company may restrict a high risk group's right to choose the waiting period if the waiting period chosen is in compliance with law. The Small Group Ohio State Variations pages should not state that a waiting period is not permitted at the time of initial group enrollment.
R.C. 3901.21, provides in part, "The following are hereby defined as unfair and deceptive acts or practices in the business of insurance: . . .

> (M) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of the premium . . . or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.
>
> (V) Using any program, scheme, device, or other unfair act or practice that, directly or indirectly, causes or results in the placing of coverage for adverse risks with another carrier, as defined in section 3924.01 of the Revised Code."

R.C. 3924.01, provides:

> "(M) 'Service Waiting Period' means the period of time after employment begins before an employee is eligible to be covered for benefits under the terms of any applicable health benefit plan offered by the small employer."

COMPANY RESPONSE: The Company agrees that § 3924.03 (E)(1)(2) permits the employer the option of imposing a waiting period. We also agree that this waiting period, by law, may not be greater than 90 days. However, the statute does not require the insurer to allow the employer the option of picking any waiting period, so long as it is

90 days or less. The law states that the decision of whether . . . to impose a service waiting period shall be made by the employer. The insurer merely must present the employer with a waiting period (or choice of waiting periods) that the employer may accept or reject. As a result, we maintain that we are in compliance with § 3924.03 (E)(1)(2) of the Ohio Revised Code.

In addition, please note that there were no instances during the exam period in which we have disallowed groups the option of electing a waiting period on the basis that they were considered a 'high risk' group. The only procedures in place during this time were to limit waiting periods for groups based on state mandates. We are currently in compliance with §§ 3924.03 and 3924.01 of the Ohio Revised Code. Please note, however, that we will amend the 'State Variation Guide' to reflect our practices.

EXAMINER RESPONSE: The Company stated that it would amend the "State Variation Guide" to reflect "our practices." However, the Company has ***not*** stated that it will correct *the "Agent's Guide"* to remove the statement that "high risk" and high turnaround groups are subject to coverage limitations (waiting period limitations) and therefore, the "Agent's Guide" would continue to provide information that is not in compliance with state and federal law. To state that limitations apply to "high risk" and high turnaround groups advises agents to direct potential applicants to other insurers that would comply with the law and that do not impose or suggest they will impose limitations on these groups. Further, despite the Company's statement that the underwriters are advised not to look to the "Agent's Guide" as their primary source, it was found during the testing of Small Groups Issued that the Company's underwriters do not always comply with these instructions. For instance, the Company's underwriters have permitted the denial of coverage to employees who work 25 or more hours, contrary to the instructions in the Ohio State Variations pages, and have implemented instead the instructions in the "Agent's Guide," which provides for a 30 hour work week for eligibility. Another example of reliance on the Agent's Guide rather than the State Variations pages was found in the sample of Small Groups Issued when waiting periods varying between 30 and 180 days were found. Of the sample of 50 Small Groups Issued files, 25 were found to have waiting periods of 90 days, despite the limitation to a maximum of 60 days in the State Variations pages.

The Company has not agreed to correct the Guide, which appears to be the document most relied upon by agents. However, the Company's practice and statement are not correct. An insurer must permit a group the option to choose any waiting period between zero and ninety days.

Issue No. 13 – Small Group Marketing Materials (coverage for married employees)

The Small Group Guide failed to comply with its own guidelines concerning coverage of married employees, thus permitting discrimination between groups in which both husband and wife are employees. The Guide stated:

"For new groups:

Husband and Wife Employment

If the husband and wife are both employees of the same business, they must be covered as separate employees for all lines of coverage issued.

For existing groups

Adding Dependents

If the husband and wife are both employees of the same business, they must be covered as separate employees for all lines of coverage."

It was noted during the testing of Small Groups Issued files that the Company permits one Employee to be covered as a Dependent while requiring another Employee to be covered as an Employee. Permitting one employee to be covered as a dependent, while requiring another employee to be covered as an employee, is unfairly discriminatory and not in compliance with the Company's own standards. In addition, it would be a violation of R.C. 3901.21. Therefore, the Guide provided misleading information in violation of R.C. 3901.21(B). The Company however, did not comply with the information in the Guide and permitted discrimination between groups.

COMPANY RESPONSE: The Company agrees and will amend our business practices to ensure consistent application of our treatment of married employees and compliance with § 3901.21 of the Ohio Revised Code. We propose doing the following:

- If a group may only qualify for small group insurance by listing both spouses as separate employees, then each person will be listed as an employee and issued a certificate.

- If a group may only qualify for small group insurance by listing both spouses as separate employees, but the group elects an HSA (Health Savings Account), each person will be listed as an employee, but only one certificate will be issued.

- If listing the spouses is not necessary for the group to qualify for small group insurance, one spouse will be listed as the employee and the other will be listed as the dependent. The decision of naming the 'primary' insured and the dependent will be at the discretion of the employer.

Please note that this proposal is subject to change before final implementation.

Issue No. 14 – Small Group Marketing Materials (purchase of Life and AD&D Insurance)

The Company failed to sell a small group health plan without the mandatory purchase of Life and AD&D Insurance. The Company stated on June 3, 2005, that the purchase of Life Insurance is mandatory. However, the Company's marketing materials mislead the Employer and contradict the Company's underwriting guidelines concerning the purchase

of Life Insurance, in that the former are either silent or imply that the product may be available, whereas the latter state that the purchase is mandatory. From the testing of Small Groups Issued, it was apparent that the purchase of Life Insurance is indeed mandatory, despite the statements made to the public in the marketing materials. Of the fifty small group files tested, all fifty were sold with Life Insurance, although ten contained application forms in which the Employer did not elect that coverage. A requirement for small employers to purchase Life Insurance avoids adverse risk by deterring the least viable small employers from buying its small group health plans, due to the added cost of compulsory Life Insurance, and violates the guaranteed availability of health insurance coverage in the small group market if a small employer is refused coverage due to its declination of Life Insurance that it does not want and/or cannot afford for its employees.

The Company acknowledges that small employers have difficulty paying the costs of health insurance. The Company's brochure "Small Employers – Pay Only for the Health Insurance You Need!" stated:

> "Many small employers try to match the benefit-rich plans of large employers or HMOs. With medical inflation and prescription prices increasing and health insurance premiums rising accordingly, ***that approach is one most small employers can no longer afford***."

Issuance of a small group health plan is guaranteed under both federal and state law to small employer groups. Issue cannot be restricted to those Employers who are prepared to purchase additional products. To force the sale of Life Insurance upon a small employer group is an unfair device that contravenes the guaranteed issue requirements of both state and federal law in that it may directly or indirectly, cause or result in the placing of coverage for adverse risks with another carrier.

The following marketing materials provided inaccurate and misleading information in violation of Ohio Adm.Code 3901-1-16(E) and R.C. 3923.16.

(A) Take Control of Health Care Costs," Form No. 28034.

> This brochure is silent concerning the requirement for the sale of Life Insurance. It also appears that the brochure has not subsequently included the requirement, as evidenced by Form Nos. 28211(Rev. 10/2004) and 28447 (2004), which are also silent concerning any requirement for the purchase of Life Insurance.

(B) Flexible Funding for Affordable Health Plans," Form No. 28211 (Rev. 10/2002).

> This brochure listed Life, Dental and Short Term Disability coverages as ***optional***, but also stated "Refer to State Variations for state specific plan information." Since the Ohio State Variation pages are silent, it appears that the wording of the brochure prevails and these coverages should be optional.

(C) "Sensible Coverage at a Sensible Price," Form 27366 (Rev. 6/2002).

This form stated that Life Insurance ***may be available***, again implying that the coverage is optional. The brochure stated:

"Plan ***Enhancements***

Additional Information

Ask your agent for assistance or additional information on the Employee Choice Program, as well as Dental, ***Life*** and Short Term Disability ***insurance plans that may be available*** to round out your employee benefit package."

(D) "Custom Coverage You Can Count On," Form No. 27979, stated that Life Insurance is an optional benefit. The form stated:

"You may also add life, dental and short term disability income ***insurance to round out your employee benefits package***."

However, the testing of Small Groups Issued files demonstrated administrative and underwriting practices that contradict the marketing materials, as follows:

(a) One file included a chart, which stated, "Requirements: ***Please note that Life coverage is not optional in Ohio***, so we need applications from all current Employees." The chart also stated, "Responses: They are ***all waiving*** coverage for Life on this group. We were told it is a one or none type thing and have actually done this before. We are getting an app for (employee name) for record purposes only has (sic) he is not taking coverage."

The group clearly attempted to buy a stand-alone small group health plan, but was forced to buy Life Insurance in order to get small group health insurance, despite the statements to the contrary in the Company's marketing materials. The Employer did not elect Life Insurance on the application form, and the Employees uniformly waived this coverage. A fax from the Agent stated, "My information indicates that Life coverage is required in Ohio. When you run the quote see if it allows you to run a quote without Life on it. Thanks!" The group was issued coverage with Life Insurance.

(b) One file provided a further example in the Benefit Design Plan page, which stated:

"Benefit Design Plan 1

Life Coverage ***Required***"

(c) The Company's "Agent's Guide," ambiguously stated in part:

"How to Submit a Case

3. Since ***life and AD&D coverages are often mandatory****, an Employee Enrollment Form is required even if the employee waives medical coverage.

* See State Variation Form."

"Life and AD&D

- ***100% participation is required* for all full-time employees***.

* See State Variations for exceptions."

"Short Term Disability/***Life Insurance***

- ***To add*** or increase disability or life insurance coverage, all employees must complete an Employee Enrollment Form, including answers to all health questions.

- ***Issuance*** *or increasing* ***of*** *disability or* ***life insurance requires under-writing approval. If approved****, it is effective on the first of the month following approval by Fortis Health.****"***

The "Agent's Guide" (all versions tested), also stated:

"State Variation Form

The State Variation Form briefly covers the underwriting guidelines, mandates and product variations for your state. The State Variation form overrides the guidelines set forth in this Agent's Guide. . . ."

The Ohio State Variation pages are silent concerning the tying of Life and AD&D Insurance coverage to Health Insurance coverage. Testing of Small Groups Issued files demonstrated that *the purchase of Life and AD&D insurance was required.*

As shown above, the "Agent's Guide" stated "100% participation is required for all full-time employees." However, a response from the Company stated it denies Life Insurance to an individual in a group, based on the health status of that individual, *"Only the individual who is uninsurable for Life and AD&D is declined"* and *"The group is never declined Life and AD&D on the basis of uninsurability of the group, only the individuals in the group who are uninsurable for Life and AD and D."* Therefore, the Company is not complying with the standards in its "Agent's Guide. Therefore, the Agent Guides provided inaccurate and misleading information in violation of R.C. 3901.21(B).

During testing of Small Groups Issued, it was found that all 50 groups were sold with Life Insurance, despite the fact that ten had attempted to decline the coverage.

COMPANY RESPONSE: The Company disagrees. We acknowledge the positions you have articulated concerning the Company's practices, but do not agree that these practices serve either to discourage the acceptance of adverse risks or to contravene Ohio and federal guaranteed issue requirements. Nonetheless, we would inform you that the Company has elected to change its business practice and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage.

Despite the Company's decision to change its practice moving forward, we disagree with the position that requiring life insurance to be taken by qualified enrollees serves to discourage adverse risks from seeking insurance with the Company. First, we would note that there appears to be no statutory prohibition under Ohio law against such a tying arrangement, should it exist. Nor have we been able to ascertain that the packaging of a life benefit under the same master policy with small group health coverage would subject the life benefit to guaranteed issue requirements. Finally, small group carriers would consistently be free throughout the market to accept or decline individual members of small employer groups for life coverage. It does not appear to follow that the fact that the denial of life coverage to an individual within such a group would result directly or indirectly in the carrier avoiding adverse risk. In fact, the addition of premium costs to low risk groups, while adverse risk groups tended to pay less life premium suggests that the opposite is true.

The Company would also submit that the added cost of life coverage does not deter issuance of guaranteed issue coverage. The added cost of the nominal amounts of life coverage in question is small. In dollar terms, depending on the age of the enrollee, life coverage generally runs between five and fourteen dollars per month, a small fraction of the cost associated with the health coverage. Therefore, though there is a slight added cost for the life coverage, we do not believe this has a material effect of discouraging groups from obtaining health coverage. **As indicated above, the Company plans to change its practices and materials in such a way as to comport with the examiner's recommendations on this issue.**

EXAMINER RESPONSE: During testing of Small Groups Issued files, sums considerably in excess of five to fourteen dollars per month were charged for Life Insurance. For example, one file reflected an Employer who attempted unsuccessfully to decline Life Insurance. In this group of seven eligible employees, the lowest rate proposed for an employee was $13.50 and the highest $344.50, resulting in a premium load of $604.00 per month for the Small Employer or an average of $86.29 per employee. It follows that the sicker the group, the higher the cost of Life Insurance, and therefore the higher the cost of the plan to the employer. Therefore, an employer with sick employees would probably look for health coverage that is available without the added cost of Life Insurance.

The Company indicated that the cost of Life Insurance is "nominal." If that were the case, 20% of employers would not have declined the coverage.

Issue No. 15 – Small Group Marketing Materials (part-time employees)

The Small Group Guide failed to correctly specify the number of hours an employee must work per week in order to be considered eligible for coverage. The Guide stated in part:

> "Employee Eligibility
>
> Any employee, including a proprietor or partner, who works for the participating employer at least ***30 hours per week*** on a regular basis is eligible."

The Small Group Ohio State Variations pages, Form 25140-OH (Rev. 09/2001), stated:

> "Eligible Employee
>
> Any person, who is actively working on a full-time basis defined as at least ***25 hours per week*** and receives monetary compensation in the form of wages from the employer and, except for partners and sole proprietors, is considered an employee for federal employment tax purposes."

The Ohio State Variation pages comply with R.C. 3924.01, which defines an "Eligible employee" as an employee who works a normal work week of twenty-five or more hours. However, testing of 50 Small Groups Issued and 50 Small Groups Terminated files demonstrated that:

(A) Employees in Two Issued Small Groups were denied coverage due to working "less than 30 hours" per week;

COMPANY RESPONSE: The Company agrees. In the cases of both groups, the noted employees were not initially recognized as full time due to oversight by the underwriters. Apparently, the underwriter did not notice that the employer's erroneous designation of the employee as 'part time' while each of the individuals noted worked more than the minimum 25 hours required for eligibility in Ohio. The errors were not discovered and none of the employees received coverage. Coverage has already terminated for both groups. Underwriting management has been alerted of these issues to communicate with supervisors and trainers to ensure that all underwriters reviewing Ohio applications are aware of and apply the proper hourly requirement.

(B) One Small Group in the Terminated files was terminated in part because one of the two Employees was not working 30 hours per week;

COMPANY RESPONSE: The Company disagrees. Both letters sent to the group (May 8, 2003 and May 27, 2003) inappropriately reference a 30 hour per week minimum. **The company acknowledges the error and will remind staff** of the importance of adhering to state-specific guidelines.

(C) An employee who worked 25 hours per week in another Issued Small Group was denied coverage.

COMPANY RESPONSE: The Company agrees. Please note that the employee in question was offered coverage and enrolled in the employer's plan effective 11/9/03. Upon review of the enrollment materials submitted when the group applied, the underwriter did not notice the employer's erroneous designation of the employee as 'part time' though the individual reportedly worked the minimum 25 hours required for eligibility in Ohio. Underwriting management has been alerted of this issue and has been instructed to communicate with supervisors and trainers to ensure that all underwriters reviewing Ohio applications are aware of and apply the proper hourly requirement."

EXAMINER RESPONSE: The Company should ensure that the requirements stipulated in the Ohio State Variations pages are enforced and that all employees who work 25 or more hours per week are recognized as eligible employees and are offered coverage under a small group health plan. Failure to do so results in non-compliance with R.C. 3901.21, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. Therefore, the Guide provided inaccurate and misleading information in violation of R.C. 3901.21(B).

Issue No. 16 – Small Group Marketing Materials (all products guarantee)

The Small Group Guide failed to meet the All Products Guarantee of state and federal law by forcing maternity coverage on some groups, while making it optional for others. The following versions of the Guide contained language restricting the employer's option to choose:

1. Form No. 20776 (Rev. 10/2001) stated in part:

"Maternity is optional* on groups of three to nine insured lives. For groups of two or ten or more, maternity is required at time of issue. After issue, if the group grows to 10 or more insured lives, maternity is optional."

2. Form 20776 (Revs 1/2003, 5/2003, and 12/2003), stated in part:

"Maternity coverage may be an optional benefit depending on your state, group size and contract . . .

- If maternity coverage was not elected at time of issue, the benefit may only be added when the business grows to 15 employees (full or part-time). The group has 30 days from the date the 15th employee is hired to add maternity coverage. Fortis Insurance Company reserves the right to request proof of group size at the time the request is made."

The Ohio State Variations pages are silent concerning maternity coverage; therefore the wording in the Small Group Guide prevails.

3. The "Clear Choice – Healthy Edge Benefits brochure" stated:

   - "Maternity

   OPTIONAL FOR GROUPS OF 3-9, INCLUDED FOR GROUPS OF 2 AND 10 OR MORE."

   In the small group market, all products that are approved for sale in that market and that the issuer is actively marketing, must be offered to all small employers applying for a small group product. An insurer must accept any employer that applies for any of those products, except where contrary to law. The Company offers and actively markets, one product with maternity coverage and another without such coverage. R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150 indicate that all small groups of fewer than fifteen eligible employees must be permitted a choice of either product. Therefore, the above-mentioned marketing materials provided inaccurate and misleading information in violation of R.C. 3901.21(B).

   The Company is not allowed to:

   1. Offer a choice of either product only to groups of 3 – 9 employees;
   2. Deny the same choice to a group of:
      A. Two employees; or
      B. Ten to fifteen employees;
   3. Discriminate between groups of fewer than fifteen eligible employees of essentially the same class and hazard in eligibility for maternity benefits.

   The Company's marketing materials indicate that its practice is also a violation of R.C. 3901.21, because that statute prohibits as an unfair and deceptive act or practice, making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in any of the terms or conditions of such contract, or in any other manner whatever. All small groups (2-50 employees) are of the same class, and each group must be offered all products (options) the Company markets.

   Example 2 of HCFA Transmittal No. 00-03, dated June 2000, provides, "A state permits issuers to offer certain products without exclusions for pre-existing conditions to employers with more than 35 employees. However, under the PHS Act's all products requirement, issuers that offer products without pre-existing condition exclusions to employers with more than 35 employees also must offer those same products to small employers with between 2 and 34 employees." Therefore, all options for all plans marketed in the small group market must be available to all small employers who apply with an issuer.

   COMPANY RESPONSE: The Company disagrees. The Company believes neither federal nor Ohio law clearly establishes that offering maternity benefits to one group on a mandatory basis and to another on an optional basis fails to meet the 'All Products Guarantee'. The Company regards the 'product' feature in question to be payment for

maternity benefits. This feature is available to groups of all sizes, though it is delivered in different manners to some groups. Because the Company specializes in servicing the smallest of employer groups, the benefit offering was tailored as optional to some of these groups to help preserve more affordable premiums.

However, the Company respects Ohio's position on this matter, and will change its practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group.

Issue No. 17 - Specialty Products Marketing Materials (maternity rider)
The Optional Maternity Rider Brochure for the Student Select Plan indicated "covered charges" included medically necessary postpartum care for the mother including Inpatient Hospital care, but restricted the number of visits following Hospital discharge to two visits.

The Maternity Rider (Rider 2343) stated in part:

> "Covered Charges include *only*: . . .
>
> 4. Medically Necessary postpartum care for the mother including Inpatient Hospital care and *two visits* following Hospital discharge."

R.C. 3923.63 does not provide for such a limit. The law simply provides for coverage of all follow-up care that is provided within seventy-two hours after an early discharge.

COMPANY RESPONSE: The Company disagrees. We respectfully note that the rider provides coverage for 'medically necessary postpartum care,' which includes at least two visits following hospital discharge. Please note that we have determined that no claims for postpartum office visits in excess of two have been denied in Ohio under the limits described in Covered Charges section 4 of Rider 2343. Therefore, no violations of § 3923.63 of the Ohio Revised Code have occurred. However, **we are willing to modify this language, and will be taking the necessary corrective action to address this issue.**

R.C. 3923.63, provides:

"When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to **all follow-up care** that is provided within seventy-two hours after discharge."

Issue No. 18 - Individual Market Marketing & Sales (agent commissions)
When issuing an Ohio Basic or Standard Plan, during the period under examination, the Company provided a first year commission of 2% for agencies/agents, and renewal commissions and fees of 2% for every year thereafter. Therefore, every commission paid to an agent for issuance and renewal of an Ohio Basic and Standard plan has been in

violation of R.C. 3923.58(K), which mandates a five percent at initial placement, and four percent at renewal commission.

R.C. 3923.58, provides in part:

"Acceptance of applicants for open enrollment via individual policy. . . .

(K) An insurer shall pay an agent a commission in the amount of *five percent of the premium charged for initial placement* or for otherwise securing the issuance of a policy or contract issued to an individual under this section, and *four percent of the premium charged for the renewal* of such a policy or contract."

In addition, reducing commissions is a violation of guaranteed availability of the State of Ohio's Alternative Mechanism for FEIs as indicated in HCFA Bulletin, Transmittal 98-01, dated March 1998. To set commissions so low that it discourages agents from selling the Ohio Basic and Standard Plans violates R.C. 3923.581(C) and (D), which indicates that the plans are guaranteed available to all FEIs. The Bulletin provides in part, ". . . insurance practices that are inconsistent with the guaranteed availability provisions of . . . (HIPAA) . . . Setting agent commissions for sales to HIPAA eligible individuals and/or small groups so low that agents are discouraged from marketing policies to, or enrolling, such individuals . . ."

COMPANY RESPONSE: The Company disagrees. Please note, the only place commissions on Basic and Standard plans are addressed is in Section 3923.58 (K) of the Ohio Revised Code. Section 3923.58 requires commission rates of 5% for initial placement and 4% for renewal of Basic and Standard Plans. Therefore, we believe that the Commission schedule set forth in Section 3923.58(K) is reasonable and have taken the necessary corrective action to address this issue, consistent with the provisions of Section 3923.58 (K) of the Ohio Revised Code.

EXAMINER RESPONSE: The Company appears to be responsible for retrospectively (1) calculating the commissions it should have paid to agents who sold Basic and Standard Plans and (2) reimbursing those agents in compliance with R.C. 3923.58(K). The Company's commissions paid during the period under examination were a violation of R.C. 3923.58(K), and as noted above, restricted the guaranteed availability provisions of HIPAA.

Issue No. 19 - Specialty Products Marketing Materials (FEI eligibility)

The application for the Student Medical Certificate, which provides major medical coverage, does not provide a format for the Company to determine who is an FEI. The application process involves five questions, none of which allows the Company to determine who is an FEI. Therefore, the Company is not acting in compliance with R.C. 3923.581(D), because it is not determining who is an FEI, and is not offering the Ohio Standard and Basic plans to every FEI.

The Company is targeting college students, who upon reaching the age of 23 are still students, have a high possibility of having been insured under their parent's group health plan, but who cannot remain insured under that plan due to their age. If the student has been insured for years under their parent's policy, and are coming out of group coverage, the student would be an FEI if COBRA or other continuation was not available, or if the student exhausted any continuation coverage that had been available.

On the brochure, which also contains the Student Medical application, the Company targets these potential FEIs by stating:

"Student Select is ideal if you find yourself in one of the following situations: Are you no longer eligible for coverage under your parents' health plan? Many health plans only cover you up to age 19-23, or they require you to have more college credit hours than Student Select."

Once the student/applicant is insured under the Student Medical Certificate, he/she loses federal eligibility.

R.C. 3923.581, provides in part:

"(B) . . . carriers in the business of issuing health benefits plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage . . .

(C) No carrier shall do either of the following: (1) Decline to offer such coverage to, or deny enrollment, of such individuals . . .

(D) A carrier shall offer to federally eligible individuals the basic and standard plan . . . ."

COMPANY RESPONSE: The Company agrees that it must offer a Basic and a Standard Plan to a Federally Eligible individual who applies for coverage under the Company's student medical plan. The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage with no pre-existing condition exclusions. We will provide a 'HIPAA Rights Notice' that advises of the potential availability of the Basic and Standard Plans and that also describes the HIPAA eligibility requirements and how to contact the Company to inquire further regarding this coverage option. As such, we propose to adopt the use of the following 'HIPAA Rights Notice' for each applicant:

IMPORTANT HIPAA RIGHTS NOTICE: You may also be eligible under federal and Ohio law for guarantee available coverage that does not impose a pre-existing condition limitation and/or rider excluding a specific condition.

To qualify as an Eligible Individual, you/your:

(1) Must have at least 18 months of prior health insurance coverage as of the date on which you seek coverage;

(2) Most recent prior health insurance coverage was under a group health plan, governmental plan, or church plan;
(3) Must not be eligible for coverage under a group health plan, Medicare, or Medicaid;
(4) Must not have other health insurance coverage;
(5) Most recent coverage was not terminated because of nonpayment of premiums or fraud; and
(6) Must have elected and exhausted continuation coverage under COBRA or a similar State program (if applicable).

Eligible Individuals are eligible for coverage under Ohio's Basic and/or Standard Health Benefit Plans. This coverage may significantly differ in plan design, cost-sharing obligations and premium charged from the coverage quoted in the accompanying offer letter that you have requested. For more information about these potential additional coverage options, please contact your agent or a Fortis customer service representative at _____.

EXAMINER RESPONSE: Although the Company's proposal adequately describes eligibility requirements, it does not indicate that the individual will lose federal eligibility if (s)he has more than a 62-day gap in coverage. In addition, the Company still fails to provide a method of determining eligibility at the time of application; instead it has placed that requirement with the applicant. Therefore, the Company's above method of correction is not in compliance with R.C. 3923.581(B), (C) and (D). The Company must provide an application in a format that allows it to determine who is an FEI at application, and offer the Ohio Standard and Basic plans to all who are eligible. Therefore, the proposed application method for the Student Select plan would also violate Ohio law.

COMPLAINTS AND GRIEVANCES

Complaints and Grievances Standard #1 *– Test all Ohio Department of Insurance complaints to determine if the Company actions, which developed the Complaint, and the resolution of the Complaint, were in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules.*

The Company initially provided 62 Department Complaint files. After the Company compared its listing to the Department's COSMOS listing, it provided 34 additional files. There were four outstanding files after the Company supplied the 34 additional files. The Company could not locate one, and the remaining three were provided after the Department indicated the files were listed under the insured's attorney's names on the Department's COSMOS listing. Two of the files related to Long Term Care policies, and therefore, were eliminated from testing. Therefore, a total of (62-2+34+4) = 98) 98 Department Complaint files were tested.

The results of testing the Department Complaints are indicated in the table below:

Total # of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	HIPAA % Failed	Ohio % Failed
98	2	0	0	12	2%	12%

Issue No. 1 – Complaints and Grievances (maintenance of complaint files)
One complaint file was not maintained in compliance with Ohio Adm. Code 3901-1-60(H)(3), which provides in part, "Every third party payer shall: . . . (3) Keep records of written complaints from and responses to beneficiaries and providers for three years."

COMPANY RESPONSE: The Company agreed it could not provide one file in its entirety.

Issue No. 2 – Complaints and Grievances (declined coverage)
One Complaint file was for an applicant that was declined coverage. The letter informing the applicant of the declination stated, "You may request disclosure of this information, but we will only furnish it to a physician of your choice rather than directly to you. If you want this information disclosed, please write and let us know the name and address of the physician to who you want it sent." The insured requested the information be sent to his physician, and the Company provided a letter to the physician.

R.C. 3904.10, "Duty to furnish specific reason for adverse underwriting decisions and provide summary of rights," provides in part, "In the advent of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing, or advise such person that upon written request he may receive the specific reason or reasons in writing."

The Company's adverse notice procedures did not allow applicants to be provided with the specific reason(s) for adverse underwriting decisions. The adverse underwriting notice should have been provided to the applicant, not to his/her doctor. Therefore, the Company actions and procedures were in violation of R.C. 3904.10. The Company violated the law for this insured, and for every other applicant treated in the same manner.

COMPANY RESPONSE: The Company respectfully notes that it modified its administrative practices such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice.

EXAMINER RESPONSE: None of the adverse underwriting letters tested for members declined and rescinded, provided the specific reason(s) for the Company's adverse

underwriting decision. Therefore, it appears the Company's corrections to its administrative practices began during the examination.

Issue No. 3 – Complaints and Grievances (eligibility determination)

For three Department Complaint files, testing indicated the Company was not determining an applicant's federal eligibility at the time of application. From testing of all files, it appeared the Company only determined who was an eligible individual when the insured requested the Ohio Basic or Standard plans.

A. One applicant provided information which indicated she was trying to apply for a plan without pre-existing conditions and that she was a federally eligible individual (FEI). The Company failed to offer the Ohio Standard and Basic plans to an FEI. Instead, the applicant was offered FIC Certificate 225 (Association Plan) with a medical rider for hyperthyroidism.

COMPANY RESPONSE: The Company agrees and will take the necessary steps to ensure that federally eligible individuals applying for coverage in the individual market will be offered the Basic and Standard Plans without a pre-existing condition limitation.

B. An applicant indicated that COBRA coverage was expiring, and the previous coverage was under a group health plan, which had been effective for more than 18 months with no gap in coverage. Therefore, the applicant was a FEI. The Company failed to determine if the *applicant* was eligible; and therefore failed to offer the Ohio Basic and Standard plans.

COMPANY RESPONSE: The Company agrees. As noted in our response to Inquiry #45, the Company acknowledges that we did not consistently determine the HIPAA eligibility status of all applicant (sic) during the examination period. Further, the Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product Certificate Forms 225 and 227 or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals.

C. The Company's applications did/do not request enough information to determine who is an eligible individual. The applications only ask if any of the proposed insureds have existing health coverage. For one file, the Company was asked if the applicants were FEIs at the time of application.

COMPANY RESPONSE: The Company disagrees. We respectfully note that the applicant was not a federally eligible individual because there was no prior coverage." However, there was prior coverage, because the complaint file included a certificate of creditable coverage, which the applicant had sent to the Department. The applicant had more than 18 months of creditable coverage, and coverage terminated October 31, 2002, which was 12 days prior to the date the application was signed. Therefore, there was no gap in coverage. Additionally, we will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals.

EXAMINER RESPONSE: All three of the files were failed because it is the Company's responsibility to determine the federal eligibility of every applicant at enrollment. Every eligible individual should be offered the Standard and Basic policies at the same time the Company offers its open market plan(s), or prior to declining an applicant. Therefore, the Company was not acting in compliance with R.C. 3923.581(D).

Issue No. 4 – Complaint and Grievances (Complications of Pregnancy provisions)

In one complaint file, the Company denied miscarriage claims after receiving a letter from the physician indicating that the insured went into premature labor and miscarried at 21 weeks. This certificate holder's medical event should have been defined as a "spontaneous miscarriage." The certificate provides coverage for a "spontaneous miscarriage."

This file was failed initially for denying the claims dated 12/2/02 and 12/10/02, then for denying the first appeal 1/22/03, and subsequently the first grievance, 4/3/03. The Company overturned the denied claims at the second appeal, 5/5/03. The claims associated with the miscarriage should never have been denied; neither should they have been denied at appeal or at first grievance. It is acknowledged that the insured was treated correctly in the end.

To deny a claim, which is a covered benefit in the contract/certificate, is a violation of Ohio Adm. Code 3901-1-07(C)(1), (7) and (10), which state in part, "It shall be deemed an unfair or deceptive practice to . . . (1) knowingly mispresenting to claimants pertinent facts or policy provisions relating to coverage at issue . . . . (10) attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application . . . ." The insured had knowledge of the certificate language, because she quoted it when she submitted her complaint to the DOI, and when she appealed and grieved the denial of the claim.

COMPANY RESPONSE: The Company disagrees. Reviews by our medical staff (physicians) found that this was not a "spontaneous miscarriage" as described in the Complications of Pregnancy provision of the contract. We were billed for procedure code 59400, routine obstetric care. The Merck Manual defines miscarriage under spontaneous abortion as delivery or loss of the products of conception before the 20th week of pregnancy. This insured was 21 weeks when she delivered a dead infant; therefore, she did not meet the medical definition of spontaneous miscarriage. She went through labor and we were billed for all of her prenatal, delivery and postnatal care. The diagnoses that were submitted were premature rupture of the membrane, cervical incompetent complicating antepartum care and mental disorders complicating post partum condition. While the insured may have had a difficult pregnancy, she did not meet the definition of coverage for limited conditions of pregnancy. The case was reviewed by our Health Management staff on two occasions and it was determined that services did not meet coverage under the contract. In addition, the appeal letters from the providers never mentions that the insured had a spontaneous miscarriage but rather premature rupture of the membranes. Based on these facts, the charges were processed

correctly. However, due to the specific circumstances in this case, the decision was overturned.

EXAMINER RESPONSE: The Company's response indicates it acted correctly, but it reversed its decision to deny the claims due to specific circumstances. All claims are paid or denied based on the specific circumstances of the claim(s). The certificate holder's claims should never have been denied.

Issue No. 5 – Complaints and Grievances (child health supervision services)

The Company was requested to provide the certificate holder's certificate in its entirety. The certificate did not include Rider 2669, which had been indicated at the beginning of the examination as provided with every certificate issued during the period under examination.

R.C. 3923.55, "Benefits for child health supervision services from birth to age nine," provides in part, ". . . each policy of individual or group sickness and accident insurance delivered, issued for delivery, or renewed in this state . . . that provides coverage for family members of the insured shall provide, with respect to that coverage, that any benefits applicable for children shall include benefits for child health supervision services from the moment of birth until age nine. . . . (E) . . . from birth to age one shall not exceed a maximum limit of five hundred dollars . . . services that are provided to a child during any year thereafter shall not exceed a maximum limit of one hundred fifty dollars per year."

Without Rider 2669 attached to the Certificate Form 225 and 227, coverage is not in compliance with the Ohio mandated benefits for child health supervision services for children from birth through age nine. Therefore, the certificate holder's certificate was issued in violation of R.C. 3923.55. In addition, the Company was requested to indicate the effective date of use for the Rider. The Company indicated it had not been filed or approved. Therefore, a date of approval was not available.

COMPANY RESPONSE: The Company agrees. Please note that the benefits delineated in R.C. 3923.55 have been added to Certificate of Insurance Forms 225 and 227 in the pending filing with the Ohio Department of Insurance. Rider 2669 is issued with policy form 517 only. Policy Form 517 is a short term major medical policy. In contrast, the complainant in this instance was issued Certificate of Insurance form 225, which provides coverage under a master policy issued to the Health Advocates Alliance association in the State of Illinois. Rider 2669 is not issued with Certificate of Insurance form 225. Furthermore, we would note that we have been administratively complying with the requirements of § 3923.55 of the Ohio Revised Code since 8/15/98.

EXAMINER RESPONSE: Claims were excluded from the scope of the examination except for potential WHCRA sampled claims. Therefore, the Company reference to administratively complying with the statute could not be confirmed.

Issue No. 6 – Complaints and Grievances (maternity benefits)
The Company issued two letters to the insured which stated, "Conception that takes place within the 270 day waiting period is not listed as a covered medical service; therefore, no benefits are available." In response to the insured's grievance the Company stated in part, "Our records indicate the effective date of the Maternity Rider attached to your policy is July 7, 2002. The 270 day waiting period was not met at the time . . . pregnancy began. Therefore, no maternity benefits are available for this pregnancy."

The Company's maternity rider (endorsement 2804 for Certificates 225 and 227) provides in part, "Maternity benefits will be paid for Covered Charges incurred due to an Insured's pregnancy which: A health care Practitioner determines began more than 270 days after the effective date of this rider; and . . ."

The applicable service waiting period under the provision noted in the law allows for a service waiting period of 270 days, it does not allow a 270 day look forward provision for maternity benefits. Under the Company's Maternity Rider, the insured would have to pay for maternity benefits for 270 days before maternity coverage becomes available, and then pay premiums again for 9 months (normal delivery) if the individual conceives on the 271st day. The certificate holder was denied maternity benefits in violation of R.C. 3901.21(O).

COMPANY RESPONSE: The Company disagrees. We note no violation of Section 3901.21 (O) of the Ohio Revised Code. Our position has been that the 270 waiting period for maternity coverage was specifically authorized by Section 3901.21 (O) of the Ohio Revised Code. Our interpretation has been that the authorized waiting period applied to manifestation of the condition to be covered. We respectfully note that the position posed in the Inquiry would render the authorized waiting period meaningless because such benefits are a global charge. To illustrate, if an insured was issued coverage and became pregnant one month into the waiting period we would have to cover the childbirth but not the majority of the pregnancy. This would be contrary to the intent of the provision that allows the waiting period for "maternity benefits." Under § 3901.19(C) "maternity benefits" means those benefits calculated to indemnify the insured for hospital and medical expenses fairly and reasonably associated with a pregnancy and childbirth. To read the code in any other way would make it meaningless and would take away the protection of the 270 waiting period under the law. Please note that Rider 2804 was filed with the Ohio Department of Insurance with the March, 2004 filing of Certificate forms 225 and 227 and is pending the Department's approval.

EXAMINER RESPONSE: How providers bill an insurance company (global maternity billing) is not a determining factor for how laws are governed in the State of Ohio. As noted above, R.C. 3901.21(O) has a waiting period, not a look forward provision. The 270 day (9 month) waiting period is designed to ensure that coverage is not provided for a pregnancy that began before the effective date of coverage. It is not a waiting period before a pregnancy can begin.
[The Company disagreed in their response to Inquiry 39, but accepted the Department's position with their filing of Certificate Forms 225 & 227, approved 2/17/06]

Complaints and Grievances Standard #2 – Sample internal files by complaint reason, to determine if Company actions, which developed the complaint and the resolution, were in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules.

Due to the number of DOI Complaints (62) and Grievances (33), the Internal Complaints/Appeals were not sampled or requested for testing. It was determined that the testing of DOI Complaints and Grievances would provide a sufficient population for determining if the Company's complaint and grievance procedures and practices resulted in compliance with HIPAA, WHCRA, NMHPA, and Ohio Statutes and Regulations.

Complaints and Grievances Standard #3 – *Sample grievance/appeal files by complaint reason for testing, to determine if Company actions, which developed the complaint and the resolution, were in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules.*

The Company provided a listing of 33 policy/certificate holders with a grievance during the period under examination. All the files were sampled, and all were tested.

The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	% Failed
33	0	0	0	3	9%

Issue No. 1 – Complaints and Grievances (maintenance of records)
The Company stated it could not locate its Grievance response letters for two files, and the second page of a Grievance response for another file. Therefore, the Company failed to maintain records in compliance with Ohio Adm. Code 3901-1-60(H)(3) for three files. Ohio Adm. Code 3901-1-60(H)(3), provides in part, "Every third-party payer shall: . . . Keep records of written complaints from and responses to beneficiaries and providers for three years."

COMPANY RESPONSE: The Company agrees. Please note that company procedures require that all correspondence relating to grievances or written complaints from and responses to insureds or providers be filmed and retained for electronic retrieval. Appropriate staff will be reminded of the importance of compliance with all record retention requirements. We would also note that the two instances cited by the examiner comprise 6% of the Grievance Sample files reviewed.

CONTRACT/POLICY LANGUAGE

Contract/Policy Language Standard #1 *– Test all contracts/policies, applications, riders and endorsements to determine if the contractual language is in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules.*

The Company provided all its Association, Trust, Conversion, Student Select and Small Group certificates in force for the period under examination. The Company also provided its Ohio Basic and Standard policies, and all other policies and certificates which were in force during the period under examination. All the in force plans were tested and the results of the testing indicated the issues described below:

Issue No. 1 – Form of policy filed with superintendent

R.C. 3923.02 provides in part, "No certificate shall be furnished by any insurer in connection with, or pursuant to any provision of, any group sickness and accident insurance policy delivered, issued for delivery, or used in this state, and no policy of sickness and accident insurance shall be delivered, issued for delivery, or used in this state, nor shall any indorsement, rider, or application which becomes or which is designed to become a part of any such policy or certificate be delivered, issued for delivery, or used in this state, until a copy of the form of such policy, certificate, indorsement, rider, or application . . . has been filed with the superintendent of insurance."

The Company has issued (during the entire period under examination), Certificates 225, 227, 554 and J-1110 (JALIC conversion plan used by FIC, not Department approved for use by FIC) without prior Department approval. Therefore, the Company has been, and remains in violation of R.C. 3923.02 every time it issued, or issues one of those certificates in Ohio.

COMPANY RESPONSE:
The company notes that under 3923.02 the general filing requirement broadly outlines the filing procedure for policies and certificates delivered and issued within the state. However, the Department's position does not properly take into account the second paragraph of 3923.02, which directly addresses the form of certificate the Company used in Ohio. The second paragraph of 3923.02 provides in relevant part: "The form of any certificate furnished by any insurer to a resident of this state in connection with, or pursuant to any provisions of, any group sickness and accident insurance policy which policy is not delivered, issued for delivery, or used in this state but which insures residents of this state shall, upon request of the superintendent, be filed with the superintendent." The master group policies, pursuant to which certificates are issued to Ohio residents, are not delivered, issued for delivery or used in this state. The Superintendent has not requested that the Company file the form of certificates which insures residents of Ohio. Bulletin 14, Section 6 fully supports this reading of 3923.02.

Bulletin 14, Section 6 state: "The certificates referred to in the last sentence of the second paragraph of Section 3923.02 are those which are used in the State of Ohio in connection with or pursuant to the provisions of any group sickness and accident insurance policy which is not delivered or issued in the State of Ohio but which insures residents of Ohio. The purpose of such sentence is to provide a method whereby the Superintendent of Insurance may request the filing of a particular form of certificate for informational purposes. When the Superintendent desires such information he will request it."

Since the company acknowledges that certain benefit mandates applicable to policies (defined to include certificates) delivered in the state do impact certificate forms under out-of-state master policies, the company of its own accord now files all certificate forms for review by the Office of the Superintendent as a way of ensuring benefit mandates are in compliance with state interpretation. However, we respectfully note this is not required under Ohio law under the specific provisions of 3923.02.

1. Individual market group certificates 225 and 227 were accepted as "FILED" by the Ohio Department of Insurance on February 17, 2006.

2. "Certificate Form 554, the Student Select Product, was filed and approved in Delaware, the state in which the master policy was issued, 5/17/94. The Student Select Certificate Form 554 was accepted as "FILED" by the Ohio Department of Insurance on November 8, 2006.

3. Certificate Form J-1110, used by FIC as a conversion plan, was filed by John Alden Life Insurance Company in Tennessee, the state in which the master policy was issued, and approved on 1/4/89." John Alden Life Insurance Company offered conversion coverage on behalf of FIC. Form J-1110 is no longer offered in Ohio. Time Insurance Company Basic and Standard plans were accepted as "FILED" on 1/16/1998. Time Insurance Company has filed updated Basic plan (form 185-OH Rev. 2/2008) and updated Standard plan (form 186-OH Rev. 2/2008) for use as conversion plans and as Basic and Standard required offers. Time Insurance Company updated Basic and Standard plans were accepted as "FILED" on 5/2/2008.

4. The Company provided the stamped acceptance letter from the Ohio Department of Insurance for Small Employer Certificate Form C99.100.SIG.OH et al., stamped as "Filed" on 9/17/99.

Furthermore, we are providing the following information regarding Rider #'s 2343, 2801 and 2485. These riders are issued in connection with Student Select Certificate Form 554. The riders were accepted as "FILED" by the Ohio Department of Insurance on November 8, 2006.

The Company also stated in part, "some of the forms provided were never issued in the state of OH (e.g. Form 150.001.TX, issued in Texas). These forms were included in the source documents as forms being discontinued in OH, even though they were only in OH

by virtue of the insured moving there." However, R.C. 3923.02 includes all certificates and policies "used" in the state of Ohio. Therefore, each of the six files noted as move-ins were failed (Form 110 TX, 125 GA, 150 TX, 182 "multiple states," 192 "multiple states," 195 GA), because the Company "used and renewed" the policies or certificates in Ohio without prior Department approval, which is a violation of R.C. 3923.02. All forms were discontinued/replaced with Certificate Form 227 before the examination commenced.

Issue No. 2 – Coordination of benefits

The following individual market certificates and policies allow for carve out of Medicare benefits, which is a violation of HIPAA, as indicated in the Federal Register Preamble.

Supplementary Information:

II. Provisions of This Interim Final Rule,

C. Guaranteed Renewability (page 16989)

Becoming eligible for Medicare by reason of age or otherwise is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market, because it is not included in the statute's specifically defined list of permissible reasons for nonrenewal. If permitted by State law, however, *policies that are sold to individuals before they attain Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that* ***Medicare pays***.

Exclusions within Certificates 225 and 227 stated, "Charges that are payable or reimbursable by: Medicare Part A or Part B (where permitted by law). *If you do not enroll in Medicare we will estimate benefits."*

Exclusions within Certificate 554 stated, "If the covered person is eligible for Medicare, that part of any charge for *which a benefit would be paid under Medicare* to a person enrolled under Parts A and B of Medicare, regardless of whether such person actually was enrolled. This does not apply when the benefits of this plan are, by law, primary to those of Medicare."

The Ohio Basic (185) and Standard Plans (186), both stated, "Exclusions . . . For covered persons who are eligible for Medicare, that part of any charge for *which a benefit would be paid under Medicare* to a person enrolled under Parts A and B of Medicare, regardless of whether such person actually was enrolled. This does not apply when the benefits of this plan are, by law, primary to those of Medicare." This provision is not in the Department's current version of the Standard and Basic plans.

The Company cannot carve out Medicare benefits if the individual does not enroll in Medicare when eligible. As indicated in the HIPAA preamble above, to do so is a violation of HIPAA.

COMPANY RESPONSE: The Company disagrees. The coordination of benefits that takes place when an insured becomes eligible for Medicare relates to the payment of

claims under the health insurance plan. As such, it is outside the scope of the regulatory grant of authority bestowed under the provisions of the HIPAA. Further, when this very question was raised at a session co-hosted by the Centers for Medicare and Medicaid (CMS) at a meeting of the National Association of Insurance Commissioners (NAIC), the CMS representative informed the audience that it was CMS' position this practice was not inconsistent nor violative of HIPAA's guaranteed renewability requirements. Since this statement was made in a public forum by a government representative, we respectfully note that it was reasonable for Fortis Insurance Company, and others in the industry, to rely upon this statement. In addition, we find no evidence that CMS has enforced this interpretation against other carriers and are therefore concerned about the competitive disadvantage that this would impose against the Company in relation to other insurance companies in the market.

Furthermore, it remains the Company's position that coordination of benefits provisions do not violate the guaranteed renewability provisions of either Ohio or federal law. However, this addendum is provided to advise that the Company has determined to amend COB practices such that, with respect to all guaranteed renewable coverages in the individual and small employer markets, we will coordinate benefits with Medicare only to the extent that benefits are payable or paid by Medicare. The necessary steps to implement this change are in process and contract language and marketing materials will be amended to reflect this change as soon as practicable.

EXAMINER RESPONSE: The contractual clause is a violation of HIPAA. When the Company applied the provision in practice it would have been a violation of HIPAA. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B). In addition, the examinations performed by CMS have addressed the non-compliance of Medicare carve-out (there is a published report). The Company's statement was not accurate.

Issue No. 3 – Termination provisions

Rider B021 (Policy/Certificate Amendment Rider) is provided with Certificates 227 and 225. It provides in part, "This certificate will terminate . . . on the date: . . . (1) there is fraud or *material misrepresentation* made by or with the knowledge of any Insured applying for this coverage or filing a claim for benefits; . . . *(2) You become eligible for Medicare, if allowed by federal law . . .*"

Certificate 554 (Student Medical) provides the certificate *may be terminated* by the Company "on the first day of the calendar month following the date You *become eligible for Medicare.*"

The Company can only terminate coverage when an applicant commits fraud or makes an intentional misrepresentation of a material fact (other than exceptions noted in the law). Certificates 225 and 227 allow the Company to terminate for a material misrepresentation without intent, which would be a violation of R.C. 3923.57, Public Law 104-191, Part B—Individual Market Rules, Section 2742, and 45 CFR § 148.122. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

COMPANY RESPONSE: The Company has eliminated provisions permitting termination upon Medicare eligibility in the filings of Certificate forms 225, 227 and 554 that were approved by the Ohio Department of Insurance on February 17, 2006 (225, 227) and November 8, 2006 (554).

Issue No. 4 – Renewal policy

The Company's Ohio Basic and Standard plans stated in part, "Nonrenewal . . . . Time can nonrenew the policy only on the renewal date occurring on, or after and nearest, each anniversary. The anniversary will be based on the Effective Date or last reinstatement date." Time, and/or FIC are not allowed to terminate either of these plans. If the policyholder continues to pay the premium the Company has to provide coverage. The plans are guaranteed renewable at the option of the policyholder.

COMPANY RESPONSE: The Company disagrees. The Company's Basic and Standard plans (form 185 and 186) were filed and approved for use by the Ohio Department of Insurance on January 16, 1998. As noted in prior responses, we plan to re-file these forms upon receipt of approval of the John Alden variants of these forms.

EXAMINER RESPONSE: However, the language in the policy provides the Company "can" nonrenew coverage for a reason, which is not allowed under R.C. 3923.57, P.L. 104-191, Part B - Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 5 – Rescission provision

The Student Medical Certificate (554), "Omissions or misstatements in the application can cause an otherwise valid claim to be denied or coverage to be rescinded." This notice provides that omissions or misstatements *can* cause rescission of coverage. The Company may not rescind a policy in the State of Ohio unless it meets the standards indicated at R.C. 3923.14, which indicates an insurer must establish the applicant made a willfully false statement, or committed fraud, and it affected the issuance of the certificate. The clause was not in compliance with R.C. 3923.14. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

COMPANY RESPONSE: The Company has filed amended language with the Ohio Department of Insurance and certificate form 554 was approved on November 8, 2006.

Issue No. 6 – Maternity benefits

Neither Certificate 225 nor Certificate 227 had maternity coverage without Rider 2804 (Maternity Rider). The Rider does not address the mandated 48 hours for a vaginal delivery, or 96 hours for a cesarean delivery. The benefits provided by the rider, for both the Association and Trust plan certificates, were not in compliance with R.C. 3923.63. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The Rider also did not indicate it would provide the physician directed follow-up care indicated in R.C. 3923.63(A)(2). Without the mandated requirement for a length of stay of 48/96 hours in the rider, the Company has not guaranteed the provisions of R.C. 3923.63(B), which indicate the only way the length of stay is to be shortened is if the physician or midwife agree to a reduction of the 48/96 hours, and provide for the follow-up care in the event of early discharge requirements of R.C. 3923.63(A)(2).

Furthermore, neither the Ohio Basic (185) and Standard Plans (186), nor the Student Medical (554) Rider (2343) addressed the required physician directed source of follow-up care. Therefore, none were in compliance with R.C. 3923.63(A)(2).

R.C. 3923.63 provides in part, "(A) . . . each individual and group policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:
(1) The policy shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. . . .
(2) The policy shall cover a physician-directed source of follow-up care. . . . "

COMPANY RESPONSE: The Company has filed Rider 2804 at the same time we filed Certificate forms 225 and 227. Rider 2804 was approved for use on February 17, 2006.

The Company's Basic and Standard plans (form 185 and 186) were filed and approved for use by the Ohio Department of Insurance on January 16, 1998. We plan to refile these forms upon receipt of approval of the John Alden variants of these forms.

The Student Select Certificate form 554 and associated Riders were filed and approved by the Ohio Department of Insurance on November 8, 2006.

Issue No. 7 – Maternity benefits

Rider 2343 (Optional Maternity Rider for Student Select Plans) provides Medically Necessary postpartum care for the mother but restricts the number of visits following Hospital charges to two visits. In addition, the Maternity Rider (Form 2804) for the 225 and 227 plans did not indicate that postpartum care is a covered benefit. Thus, it would not be in compliance with R.C. 3923.63. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

R.C. 3923.63, "Maternity benefits to include inpatient and follow-up care minimums; early discharge decisions; prohibitions," provides in part:

(A) Notwithstanding section 3901.71 of the Revised Code, each individual or group policy of sickness and accident insurance delivered, issued for delivery, or renewed in this state that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1) The policy shall cover a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery….

(2) The policy shall cover a physician-directed source of follow-up care …provided in a medical setting or through home health care visits.

When a decision is made in accordance with division (B) of this section to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn.

To not provide, or limit follow-up (postpartum) care to two visits is a violation of R.C. 3923.63.

COMPANY RESPONSE: The Company has filed Rider 2343 at the same time we filed Certificate forms 554. Rider 2343 was approved for use on November 8, 2006.

Issue No. 8 – Maternity benefits

The Company's maternity rider (Rider 2804 for Certificates 225 and 227) provides in part, "Maternity benefits will be paid for Covered Charges incurred due to an Insured's pregnancy which: *A health care Practitioner determines began more than 270 days after the effective date of this rider; and . . ."*

R.C. 3901.21(O), provides, "Nothing in this division shall be construed to prohibit an insurer from imposing a reasonable waiting period for such benefits under an individual sickness and accident insurance policy to an individual who is not a federally eligible individual or a nonemployer-related group sickness and accident insurance policy, but in no event shall such waiting period exceed two hundred seventy days."

The applicable waiting period under the provision noted in the law allows for a waiting period of 270 days, it does not allow a 270 day look forward provision for maternity benefits. Under the Company's Maternity Rider, an insured had to pay maternity coverage premiums for 270 days before maternity coverage became available, and then pay premiums again for 9 months (normal delivery) if the individual conceives on the 271st day. Therefore, the Company Maternity Rider did not provide maternity coverage in compliance with R.C. 3901.21(O).

During the testing of complaints, a certificate holder was denied maternity benefits for a pregnancy that was conceived during the initial 270 days of coverage. The file indicated the Company's interpretation and practice was to delay maternity benefits as noted above.

COMPANY RESPONSE: The Company has filed Rider 2804 at the same time we filed Certificate forms 225 and 227. Rider 2804 was approved for use on February 17, 2006.

Issue No. 9 – Termination of benefits

The only employer group certificate (Form No. C99.100.SIG.OH) issued in the State of Ohio during the period under examination provides in part, "Employee's Termination Date, Your insurance and all benefits will terminate at 12:01 a.m. at the main office of the participating employer on the earliest of the following dates:

3. The date you or your covered dependent knowingly file a claim containing any misrepresentation or any false, incomplete or misleading information; (The Company may not cancel a participant's group coverage for incomplete or misleading information. There must be a fraudulent claim submitted. R.C. 3999.21 indicates an insurer must provide a fraud warning on applications and claim forms, which provides, "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.")

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

6. The date you join, on a full-time basis, the military forces of any country for the service of any governmental agency involving employment outside the United States; (As long as the employee meets the definition of an employee, his/her coverage cannot be terminated for the stated reason, as noted below in R.C. 3924.03(B)(2).

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

10. The date your life coverage terminates. (This is not a valid reason for termination as noted below in R.C. 3924.03(B)(2).

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

The Company was also requested to provide a valid reason for Provision (5). The Company was asked why the 5th clause for employee termination is in the certificate. The 5th clause provides in part, "the date you no longer meet the definition of employee." Employee is defined in part as, "Any person who is actively working . . ." And actively at work defines the hours an employee must be working." The 5th clause is not necessarily provided in violation of a statute or regulation. However, it appears to be confusing, and the situation it attempts to define as a reason for termination is already defined in the fourth clause. Therefore, to avoid confusion it was recommended the clause be removed.

COMPANY RESPONSE: The Company disagrees. As noted by the examiner, we maintain that there is no underlying violation of a law or regulation. **However, we are**

willing to modify the language, and we will be taking the necessary corrective action to address this issue."

Issue No. 10 – Termination provisions

The Group contract also stated, Termination of Employer's Participation Under the Policy

3. The date there is fraud or misrepresentation by the participating employer. The Company cannot terminate a group for a misrepresentation, only for an intentional misrepresentation of a material fact as indicated at R.C. 3924.03.

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

4. The date the participating employer's business ceases to operate on a full-time basis or loses its identity by means of liquidation, merger or otherwise*; (To cancel the group if it ceases to operate on a full-time basis is not a valid reason for termination as indicated in the laws below. The Company could terminate a Group who decided to shut down for a week, or had a fire and is rebuilding.)*

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

5. The date the participating employer is placed in bankruptcy or receivership; (To terminate coverage because of bankruptcy or receivership is not a valid reason for termination as indicated in the laws below. Many groups operate in re-organization under bankruptcy protection. The group is only required to make premium payments.)

COMPANY RESPONSE: Certificate Form 99.100.SIG.OH et al was amended by Rider 28902, which was approved for use by the Department on October 12, 2006.

Issue No. 11 – WHCRA benefits

None of the Company's certificates or policies, which were offered in the individual market or group market, during the period under examination, contained language for providing the mandated benefits of WHCRA or Bulletin 2001-1 in compliance with WHCRA. Therefore, the certificate's provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The Group certificate indicated it covers surgery for illness or injury. To have breast biopsies, or other types of partial mastectomies is not necessarily for an illness or injury (it may not be malignant, and to achieve symmetry on the other breast is cosmetic surgery), and therefore, there are times when WHCRA guarantees benefits when there is no illness or injury. Once a woman or man indicates she/he wants breast reconstruction, and she/he has a history of a mastectomy covered under his/her current coverage, the Company is to allow the procedure to be completed "in the manner determined by the patient and his/her physician."

In addition, the Company did not indicate that it covers breast prostheses or physical complications of all stages of mastectomy, including lymphedemas. The certificates also stated that other cosmetic services are not provided. Therefore, the certificates would allow for denial of the mandated benefits of WHCRA, which was/is not in compliance with WHCRA.

COMPANY RESPONSE: The Company disagrees. The "Covered Medical Services" section of the certificate referenced above reads:

Reconstructive Surgery required because of an *illness*, *injury* or congenital disease or anomaly resulting in a functional defect; and surgery which is incidental to or follows surgery resulting from *illness* or *injury* of the involved part including ***but not limited to*** reconstructive surgery following *medically necessary* removal of all or part of the diseased breast and surgical reconstruction of the non-diseased breast to achieve symmetry. *Cosmetic services* and services for complications from cosmetic services are not covered regardless of whether the initial surgery occurred while the *covered person* was covered under this plan or any previous coverage. [emphasis added]

Please note, the Company is administratively complying with the requirements of WHCRA. The above language does not restrict reconstruction to procedures subsequent to treatment for cancer, but rather to "reconstructive surgery following medically necessary removal of *all or* part of the diseased breast and surgical reconstruction of the non-diseased breast to achieve symmetry." Breast biopsies and other diagnostic procedures that may result in "partial mastectomy" result from symptoms, whether completely diagnosed or not, and are therefore treatment of an "illness" that would be covered, under the above language, and would be eligible for "reconstructive surgery following medically necessary removal of all or part of the diseased breast"

Issue No. 12 – Prosthetic device coverage

Certificates 225 and 227 contained identical language relating to prosthetic devices, reconstructive surgery, and the exclusion of cosmetic services. The certificates state there is coverage for basic prosthetic devices, and that repairs, replacements, or duplicates are not covered. The certificate reference to prosthetic devices included breast prostheses. The Company is not allowed to determine the best prosthetic device for the patient, and it may have to replace and/or repair breast prostheses to comply with the mandated benefits of WHCRA. In addition, the certificates state they cover the initial reconstructive surgery after mastectomy for cancer including surgery on the unaffected breast to achieve symmetry. An insurer cannot restrict itself to the initial surgery. The policy excludes all other cosmetic services. Therefore, none of the mandated benefits of WHCRA are provided by these certificates.

COMPANY RESPONSE: The Company disagrees. The company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy. The plan is currently administered such that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred. This benefit was addressed in the revision filing of forms 225 and 227 (originally submitted on March 10, 2004). Once the revised contracts are approved

by the Department, the forms will also reflect the properly administered benefit. Other recent form filings have addressed this language properly, such as form 244, approved April 8, 2004 which reads in part:

Reconstructive surgery after a mastectomy includes:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.

EXAMINER RESPONSE: The certificate language used during the period under examination is failed as indicated above. In addition, the language indicated above, which the Company states has been approved for form 244, and is attempting to have approved for Certificates 225 and 227 does not provide the mandated benefits of breast reconstruction being **"completed in the manner determined in consultation with the attending physician and the patient."** Therefore, the Company's suggested correction for its filing of Certificates 225 and 227 would not be in compliance with WHCRA or Bulletin 2001-1. The provisions provided in the certificates were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 13 – WHCRA benefits

The only language in the Student Medical Certificate which addressed the mandated benefits of WHCRA is incorrect. The certificate stated, "The initial external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast provided the surgical removal was done while the Covered Person was covered under the plan." The patient has to have a history of a mastectomy, (1) she/he does not have to have tissue removed from the breast while covered under the plan, (2) more than the initial prosthesis may be required, and is guaranteed by WHCRA (there is no limitation on breast prosthesis, as long as the patient and the provider agree it is necessary). The reconstructive surgery benefit provides the surgery must be due to illness or injury, which occurred while the covered Person was insured under this plan. She/he only has to have a history of a mastectomy. It does not matter when it was performed, or who paid for it, and it is not limited to the cause of the injury or illness. All other cosmetic services are excluded. Therefore, none of the mandated benefits of WHCRA are provided by the Student Select certificate.

COMPANY RESPONSE: **We respectfully note that these forms were written and approved (not approved in Ohio) prior to the passage of WHCRA**. The company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy. The plan is currently administered so that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred. Please note, this provision will be amended in the new contract filing to reflect our properly administered benefit.

EXAMINER RESPONSE: The certificates were provided without the mandated benefits of WHCRA during the period under examination. Therefore, the provisions provided in the certificate were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 14 – WHCRA benefits

The Ohio Basic (185) and Standard (186) plans have identical policy language, and it is similar to the language indicated for the Student Medical Certificate. Therefore, the mandated benefits of WHCRA and Bulletin 2001-1 were not provided by these policies. Therefore, the provisions provided in the policies were untrue, misleading and deceptive in violation of R.C. 3901.21(B). In addition, the suggested WHCRA language in the Department's version of the Ohio Basic and Standard plans is not provided in the FIC policy language.

COMPANY RESPONSE: **We respectfully note that these forms were approved prior to the passage of WHCRA.** The company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy. The plan is currently administered so that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred. Forms 185 and 186 will be filed following approval of the 225/227 revision filings. This provision will be amended in the new contract filing to reflect our properly administered benefit.

EXAMINER RESPONSE: As noted above, the Company's suggested correction to Certificates 225 and 227 would not be in compliance with WHCRA and Bulletin 2001-1, and therefore, should not be allowed for plans 185, 186 and 554.

Issue No. 15 – WHCRA benefits

The individual market certificates/policies (Forms #225, 227, 554, 185 & 186), under Rental and Purchase of Durable Medical Equipment and Supplies, or Supplies and durable medical equipment, all contain similar contractual language. The certificate language stated that the *initial* external breast prosthesis needed because of the Medically Necessary surgical removal of all or part of the breast was covered, provided the surgical removal was done while the Covered Person was covered under this plan. Charges for repairs to, or replacement of, maintenance or enhancement of the whole parts of such items are NOT covered. The Company is required to cover breast prostheses (plural), not just the initial breast prosthesis and it must cover replacement of doctor recommended breast prostheses.

The group certificate (Form #C99.100.CMS.OH) provides, "Supplies and Equipment include only the following:

a. prosthetic devices; . . . Charges for maintenance, repair, modification, enhancement, or replacement of durable medical equipment and supplies of any of the above are not covered, regardless of when the item was originally purchased. Charges for duplicate durable medical equipment and supplies are not covered."

The Company's individual market certificates and policies and group certificates, issued during the period under examination, and currently issued, were not provided in compliance with WHCRA and Bulletin 2001-1. The policies and certificates limit mandated breast prostheses benefits in a manner less favorable than the law allows. The Company's certificates do not allow for maintenance, repair, modification, enhancement, replacements or duplicate breast prosthesis, which is a violation of WHCRA. People lose and gain weight, and therefore, the breast prostheses may no longer fit properly. People may wear out breast prostheses and/or mastectomy bras. WHCRA does not limit these benefits. WHCRA does not allow for a monetary restriction, or a limited number of breast prosthetic devices if the individual has a history of a mastectomy, which would have been covered under their current plan. Therefore, it is essential for the Company to include the verbiage *"in consultation with the attending physician and the patient"* in its certificates and policies, because the doctor's prescription should be the restricting factor in determining if the patient's request for an additional breast prosthesis is warranted, not the Company.

The Department's versions of the Standard and Basic plans provide the complete language of WHCRA (Section 2753 and 2701 of the PHS Act). Therefore, if the Company had incorporated the language indicated by the Department, it would not have limited breast prostheses in a manner less favorable than allowed by WHCRA and Bulletin 2001-1.

Section 2753 of the PHS Act provides, "The provisions of section 2706 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market." Therefore, if any insured had a history of a mastectomy, and it would have been covered under its current plan, then an insurer "shall provide coverage" for all stages of breast reconstruction, reconstruction of the other breast for symmetry, and prostheses and complications of all stages of mastectomy. Prostheses is the plural of prosthesis. Therefore, the law anticipated multiple breast prosthetic devices, and replacement of breast prostheses. WHCRA limits the benefits provided under the law to a doctor's prescription and annual deductibles and coinsurance provisions. Therefore, there is no dollar limit, or limit for the number of prescribed prosthetic breast devices guaranteed by WHCRA to be covered, except for the individual's deductible and co-pay amounts.

COMPANY RESPONSE: The Company disagrees. The company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy (emphasis added). Forms 225, 227, 554, 185, 186, and CC2K (C99.100.CMS.OH) are currently administered such that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred. We have amended the forms referenced, consistent with the above.

EXAMINER RESPONSE: As indicated above, the Company proposed language does not provide the mandated benefits of WHCRA. It still excludes the mandatory language

"coverage provided in consultation with the attending physician and the patient," and FIC did not indicate it will eliminate the restrictions noted above for breast prosthetic devices (breast prostheses), and mastectomy bras. The suggested WHCRA language in the Department's version of the Ohio Basic and Standard plans is not provided in the FIC policy language. Therefore, the certificates and policies are provided with misleading and deceptive information in violation of R.C. 3901.21(B).

Ohio Bulletin 2001-1, "The mental health parity act of 1996 and the women's health and cancer rights act of 1998," provides:

Summary of WHCRA requirements: For benefit plans and/or health insurance that provides benefits with respect to mastectomy, coverage must include benefits for all stages of reconstruction of the breast upon which the mastectomy was performed, surgery and reconstruction of the unaffected breast to produce a symmetrical appearance, and *prostheses* [emphasis added] and treatment of physical complications at all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. . . .

Title IX – Women's Health and Cancer Rights Act of 1998, Sec. 713. Required Coverage for Reconstructive Surgery Following Mastectomies provides:

> "a. In General. – A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for –
>
> (1) all stages of reconstruction of the breast on which the mastectomy has been performed;
> (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
> (3) *prostheses* [emphasis added] and physical complications all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter."

Amendment to Part A of Title XXVII of the Public Health Service Act, adds Sec. 2706, which provides:

"The provisions of section 713 of the Employee Retirement Income Security Act of 1974 shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart."

Issue No. 16 – Adding Newborn and Adopted Children

The Company's Certificate 227 and Rider B021 (used with Certificate 225) are not in compliance with R.C. 3923.26, and R.C. 3923.40. These laws indicate a certificate or policy may require notification of the birth of a newly born child and payment of the required premium *within thirty-one days after the date of birth* in order to have coverage continue beyond such period. Therefore, the certificates were provided with untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

Certificate 227, and Rider B021 stated in part, ". . . Adding Newborn and Adopted children . . . we receive any required premium within "30 days" of birth or adoption. This is one day less than is allowed.

COMPANY RESPONSE: The Company disagrees. We note no violation of § 3923.26 or § 3923.40 of the Ohio Revised Code. Company practices with respect to Newborns are reflected in the attached Compliance Memorandum, which was effective May 1, 1996. The procedures noted therein comply with § 3923.26 of the Ohio Revised Code. Furthermore, company practice with respect to adding dependents applies equally to newborns and adoptees and we therefore administratively comply with § 3923.40 of the Ohio Revised Code. Please note that the Certificate Forms 225 and 227 have been revised to reflect the requirements of § 3923.26 of the Ohio Revised Code, including the 31-day period in which to add and pay premium for a Newborn or Adopted Child, in our filing of these forms with the Ohio Department of Insurance that was approved on February 17, 2006.

Issue No. 17 – FEI determination

The application process for the Student Medical Certificate (major medical coverage) does not provide a means for the Company to determine who is a federally eligible individual (FEI). The application process involves 5 Questions, none of which allows the Company to determine who is an FEI. Therefore, the Company is not acting in compliance with R.C. 3923.581(D), because it is not determining who is federally eligible, and therefore, is not offering the Ohio Standard and Basic plans to federally eligible individuals that apply for the Student Select plan.

The age group targeted by the Company for this product has a relatively high possibility of the applicants being FEIs. On the Student Select brochure, which also contains the application, the Company targets the potential FEI by stating, "Student Select is ideal if you find yourself in one of the following situations: Are you no longer eligible for coverage under your parents' health plan? Many health plans only cover you up to age 19-23, or they require you to have more college credit hours than Student select." However, once the student/applicant is insured under the Student Medical Certificate, he/she loses federal eligibility.

R.C. 3923.581(B, C & D) provides in part,

"(B) . . . carriers in the business of issuing health benefit plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage . . .

(C) No carrier shall do either of the following: (1) Decline to offer such coverage to, or deny enrollment of, such individuals . . .

(D) A carrier shall offer to federally eligible individuals the basic and standard plan . . ."

COMPANY RESPONSE: The Company agrees that it must offer a Basic and a Standard Plan to a Federally Eligible individual who applies for coverage under the Company's student medical plan. The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage with no pre-existing condition exclusions. We will provide a "HIPAA Rights Notice" that advises of the potential availability of the Basic and Standard Plans and that also describes the HIPAA eligibility requirements and how to contact the Company to inquire further regarding this coverage option. As such, we propose to adopt the use of the following "HIPAA Rights Notice" for each applicant:

IMPORTANT HIPAA RIGHTS NOTICE: You may also be eligible under federal and Ohio law for guarantee available coverage that does not impose a pre-existing condition limitation and/or rider excluding a specific condition.

To qualify as an Eligible Individual, you/your:

(1) Must have at least 18 months of prior health insurance coverage as of the date on which you seek coverage;
(2) Most recent prior health insurance coverage was under a group health plan, governmental plan, or church plan;
(3) Must not be eligible for coverage under a group health plan, Medicare, or Medicaid;
(4) Must not have other health insurance coverage;
(5) Most recent coverage was not terminated because of nonpayment of premiums or fraud; and
(6) Must have elected and exhausted continuation coverage under COBRA or a similar State program (if applicable).

Eligible Individuals are eligible for coverage under Ohio's Basic and/or Standard Health Benefit Plans. This coverage may significantly differ in plan design, cost-sharing obligations and premium charged from the coverage quoted in the accompanying offer letter that you have requested. For more information about these potential additional coverage options, please contact your agent or a Fortis customer service representative at _____.

EXAMINER RESPONSE: The Company proposal did not indicate that an applicant may have up to a 63 day gap in coverage and still be considered an FEI. In addition, the

Company still failed to provide a method of determining federal eligibility at the time of application; instead it has placed that determination with the applicant. The Company's method of correction would not be in compliance with R.C. 3923.581(B, C & D). Therefore, the application language would still be misleading and deceptive in violation of R.C. 3901.21(B). The Company must provide an application in a format that allows "FIC" to determine who is an FEI at the time of application, and offer the Ohio Standard and Basic plans to all who are federally eligible, at the same time it offers the Student Select plan.

Issue No. 18 – FEI determination

The Company's practices and procedures for Certificate 225 and 227 did not allow FIC to determine who is an FEI at the time of application. The application can be filled out correctly by the applicant, but the information requested will not allow the Company to determine if the applicant is an eligible individual in some situations. The FIC application does not request enough information to determine who is an FEI. The application only asks if (or requests information concerning whether) any of the proposed insureds have existing health coverage. If the applicant answers "no," then the Company interprets this to mean the applicant cannot be an eligible individual (evidenced during testing of complaint files). In addition, even when the insured provided adequate information (e.g., is an FEI), the Company did not offer the Ohio Standard and Basic plans. During testing of underwriting and complaint files, it appeared that all FEIs that received an Ohio Standard or Basic plan; had to specifically request those plans.

The Company was asked six questions:

1. Will the Company agree that it does not determine who is an eligible individual in Ohio at the time of application and this has been true for the entire period under examination and has continued to date?
2. If so, it is anticipated that several of the 50 files, which were issued during the period under examination and have been sampled, will have similar situations to this file, and therefore, an Inquiry will be written for each if the Company does not agree to #1 above.
3. The review of these files will be withheld until the Company makes such a determination.
4. Would the Company agree that Form 25238 should be provided to every applicant?
5. Would the Company agree Form 25238 should be filed, and become a document incorporated into the application process in the State of Ohio?
6. The Company, if it agrees to #1 above, should provide a written summation of the underwriting process it intends to implement to indicate it will determine who is a federally eligible individual, and indicate how it will guarantee that every federally eligible individual is offered the Ohio Standard and Basic plans.

COMPANY RESPONSE:

1. The Company agrees and acknowledges that it did not consistently determine the HIPAA eligibility status of all applicants during the examination period.
2. See #1, above.
3. No response called required.
4. The Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product Certificate Forms 225 and 227 or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals.
5. The Company will either file HIPAA Eligibility Form 25238, or an updated version of the form, with the Ohio Department of Insurance as part of the applications for the forms or will develop processes that will otherwise provide for the offer of the Basic and Standard plans to HIPAA eligibles. As previously noted, a filing for Certificate Form 225 and 227 is currently pending with the Department.
6. As noted in #4, above, the Company will ensure that an offer of the Basic and Standard plan is made to each HIPAA eligible applicant, regardless of whether or not an offer of fully-underwritten coverage may be made. A corrective action plan is not available at this time as the Company needs to ensure all areas impacted by these workflows are involved in the corrective action process. We will update the Department of Insurance when a corrective action plan is implemented.

EXAMINER RESPONSE: The Company response indicated that the Company did not consistently determine the federal eligibility status of all applicants during the examination period. However, during testing of all files, the Company never determined an individual's FEI status unless the individual was declined and requested an Ohio Basic or Standard plan.

Issue No. 19 – Policies and certificates not currently marketed

The Company provided the policies and certificates that were in force but were not marketed during the period under examination. These certificates were tested. The Company was provided an Excel listing of the contracts, which indicated the violations noted during testing of those contracts.

The Company had indicated that 150-TX, 110-TX and 195-GA are not applicable because the certificates were originally issued outside the State of Ohio. However, all certificates issued, used or renewed in the State of Ohio must comply with Ohio statutes and regulations. Therefore, those in force certificates issued outside Ohio were failed, as were the other in force certificates as noted below.

COMPANY RESPONSE: We would like to emphasize that, as noted by the examiner in the Inquiry, each of the referenced forms was discontinued and replaced with current forms (specifically, Certificate form 227) during the exam time frame. Therefore, any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. No coverage under these forms remains in-force in the state of Ohio.

A. Twenty-two of the 29 policies/certificates were failed because each policy/certificate provided maternity coverage via a rider. None of the riders, or contractual language within the policies/certificates was provided in compliance with R.C. 3923.63.

COMPANY RESPONSE: The Company agrees.

B. Twenty-three of the 29 policies/certificates were failed because each policy/certificate provided for termination due to Medicare eligibility. This type of provision is a violation of R.C. 3923.57(C), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and the Federal Register Preamble, II. "Provisions of This Interim Final Rule, Section C. (page 16989), which provides in part, "Becoming eligible for Medicare by reason of age or otherwise is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market . . . ."

COMPANY RESPONSE: The Company agrees.

C. Twenty four of the 29 policies/certificates were failed because each policy/certificate allowed for a "carve-out" of Medicare benefits. This provision is a violation of the Federal Register Preamble: II. Provisions of This Interim Final Rule, Section C (page 16989), which provides in part, ". . . policies that are sold to individuals before they attain *Medicare eligibility may contain coordination of benefit clauses that exclude payment under the policy to the extent that Medicare pays.*

COMPANY RESPONSE: The Company agrees. The coordination of benefits that takes place when an insured becomes eligible for Medicare relates to the payment of claims under the health insurance plan. As such, it is outside the scope of the regulatory grant of authority bestowed under the provisions of the HIPAA. Further, when this very question was raised at a session co-hosted by the Centers for Medicare and Medicaid (CMS) at a meeting of the National Association of Insurance Commissioners (NAIC), the CMS representative informed the audience that it was CMS' position this practice was not inconsistent nor violative of HIPAA's guaranteed renewability requirements. Since this statement was made in a public forum by a government representative, we respectfully note that it was reasonable for Fortis Insurance Company, and others in the industry, to rely upon this statement. In addition, we find no evidence that CMS has enforced this interpretation against other carriers and are therefore concerned about the competitive disadvantage that this would impose against the Company in relation to other insurance companies in the market.

EXAMINER RESPONSE: The Company's response was not in compliance with HIPAA. In addition, the provision has been enforced during examinations completed by CMS. Therefore, it would be a disadvantage to other insurers if the Company was allowed to include its provision.

D. Eight of the 29 policies/certificates were failed for providing a provision permitting the Company to cancel the policies/certificates, which is a violation of R.C. 3923.57(C), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742.

COMPANY RESPONSE: The Company agrees.

E. Ten of the 29 policies/certificates were failed because each policy/certificate allowed for termination of coverage, and or rescission for material misrepresentation. HIPAA and Ohio law indicate a policy can only be rescinded for fraud or a willfully false statement, or terminated when the applicant/insured makes an intentional misrepresentation of a material fact. Therefore, the ten policies/certificates violated R.C. 3923.14, R.C. 3923.57(C), 45 CFR § 148.122, and Public Law 104-191, Part B – Individual Market Rules, Sec. 2742.

COMPANY RESPONSE: The Company agrees.

F. Twenty-two of the 29 policies/certificates were failed because the policies/certificates indicated they could be discontinued without the proper notice of 90 days (and without an option to replace with any other policy issued), or 180 days notice for an individual market withdrawal. The lack of the provisions indicated a violation of R.C. 3923.57(D), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742.

COMPANY RESPONSE: The Company agrees.

G. Thirteen of the 29 policies/certificates were failed because they indicated that coverage could be terminated for having other coverage in force. This provision was a violation of R.C. 3923.57(C), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742.

COMPANY RESPONSE: The Company agrees.

H. None of the 29 policies/certificates had contractual language that provided coverage for the mandated benefits of WHCRA. Therefore, all were in violation of WHCRA and Ohio Bulletin 2001-1.

COMPANY RESPONSE: The Company agrees.

I. All of the 29 policies/certificates were failed because they indicated cosmetic services are excluded and they each had limitations on the coverage of prosthetic devices, which included breast prostheses. Therefore, all were in violation of WHCRA and Ohio Bulletin 2001-1.

COMPANY RESPONSE: The Company agrees.

J. Twenty five of the 29 policies/certificates were failed because they did not provide the mandated benefits for mammograms and Pap screening. Therefore, the 25 were in violation of R.C. 3923.52.

COMPANY RESPONSE: The Company agrees.

K. Eight of the 29 policies/certificates were failed because they did not provide for an eligible covered family member to exercise continuation or conversion rights within 31 days. Each of the eight policies limited the family member to 30 days in violation of R.C. 3923.32(D).

COMPANY RESPONSE: The Company agrees.

L. Twenty four of the 29 policies/certificates were failed because each contained a provision which indicated there were no benefits if the insured had other individual coverage in force. Without a coordination of benefits provision the Company's plan should have been primary and paid in compliance with the benefits of the plan. This was a violation of R.C. 3902.11, R.C. 3902.12 and R.C. 3902.13.

COMPANY RESPONSE: The Company agrees.

M. All 29 of the in force policies/certificates were failed because they did not provide the mandated benefits for child wellness services for compliance with R.C. 3923.55.

COMPANY RESPONSE: The Company agrees.

N. Twenty five of the 29 policies/certificates were failed because they provided a waiting period of 15 days for sickness or illness. This waiting period for a sickness or illness would provide for a pre-existing conditions exclusionary period for all sickness and illnesses, which would be a violation of the definition for pre-existing conditions cited at R.C. 3923.58.

COMPANY RESPONSE: The Company agrees.

Issue No. 20 – Child health supervision services

For testing, the Company provided Rider 2669 (Policy Amendment Rider-Ohio) with Certificates 225 and 227, and indicated the Rider was attached to these certificates during the period under examination. The Rider provides benefits for Child Health Supervision Services. However, during testing of complaints the Company stated in part, "*Please note that Rider 2669 is issued with policy form 517 only. Policy Form 517 is a short term major medical policy. . . . Rider 2669 is not issued with Certificate of Insurance form 225.*

COMPANY RESPONSE: We would note that we have been administratively complying with the requirements of § 3923.55 of the Ohio Revised Code since 8/15/98. We have attached a compliance memorandum used as source documentation by claims staff. In

addition, please note that Certificate Forms 225 and 227 were subsequently filed and approved by the Ohio Department of Insurance on February 17, 2006. The approved forms contain provisions that comply with R.C. 3923.55.

EXAMINER RESPONSE: Therefore, the Certificates failed to provide the mandated benefits of R.C. 3923.55 to all certificate holders issued Certificate 225 & 227. Therefore, the certificates were provided with untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

Issue No. 21 - Group Certificate and COBRA Coverage

The Company's Group Certificate (C99.100.SIG.OH) provides, "A covered person *who is entitled to Medicare is not eligible* for continuation of insurance provided under this provision. For this provision, a person becomes *entitled to Medicare when he/she applies* for hospital insurance benefits under Part A of Medicare."

2nd Sentence: No one is ever entitled to something just because they apply. The person has to be eligible for Medicare and then apply for coverage under Part A of Medicare in order to become entitled. Therefore, this statement is not in compliance with Medicare language and should be corrected.

1st Sentence: While the statement in the certificate is true as it concerns State Continuation Rights, it is untrue concerning COBRA rights. A person who is *entitled* to Medicare *prior to* eligibility for COBRA Continuation may elect COBRA Continuation. This was confirmed by the U.S. Supreme Court in Geissal v. Moore on June 8, 1998. The Company should not refuse COBRA Continuation rights to any individual on the grounds that he or she is entitled to Medicare when first eligible for COBRA Continuation. Therefore, the Company's language is not in compliance with an individual's continuation rights.

COMPANY RESPONSE: The Company agrees. We have amended the certificate language to comply with federal guidelines regarding COBRA eligibility. The amended language was approved by the Ohio Department of Insurance in Rider 28902 on October 12, 2006.

Issue No. 22 – Coverage Certificate (Medically Necessary/Medical Necessity)

Certificate 554 stated, "Medically Necessary/Medical Necessity: A covered Medical Service which, as determined by us: . . . any guidelines of the Health Care Financing Administration (HCFA);" HCFA was renamed Centers for Medicare and Medicaid Services (CMS) approximately three years ago. Therefore, the clause of medical necessity should be changed to reflect this change.

COMPANY RESPONSE: The Company agrees. We will be taking the necessary corrective action to address this issue. However, we respectfully note that we administer all provisions that reference HCFA as referencing its successor organization, CMS.

UNDERWRITING

Underwriting Standard #1 *– Test a sample of small group policies issued to determine if the Company actions are in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules.*

The Company supplied a listing of 81 Small Group Certificates Issued during the period under examination. Fifty files were sampled by use of the Excel Random Number Generator. One file was a Dental Only plan, and therefore that file was omitted from testing. The remaining 49 files were tested and the results of the testing are indicated in the table below.

# of Files	Failed HIPAA	Failed Ohio	HIPAA % Failed	OHIO % Failed
49	47	46	96%	94%

Issue No. 1 – Waiting periods

The Company failed to permit a small employer its choice of a 90 day waiting period.

The application indicated the employer had chosen a 90 day waiting period. This was crossed out and the box for a 60 day period was checked with the notation "Ohio," which indicated a 90 day waiting period was not permitted in Ohio.

COMPANY RESPONSE: The Company disagrees. Although the Company believes that the employer voluntarily elected a 60-day waiting period, we will offer the employer the option of electing a 90-day waiting period.

EXAMINER RESPONSE: However, the Company's Ohio Agents Guide (as indicated in Marketing and Sales) indicated that only a choice of a 30 or 60 days waiting period was allowed in Ohio. Therefore, the employer was denied the choice of a 90 day waiting period in violation of R.C. 3924.03(E)(2).

Issue No. 2 – Waiting periods

The Company failed to deny one group a waiting period of 180 days. A waiting period in excess of 90 days is a contravention of R.C. 3924.03, which provides *". . . . Such waiting periods shall not be greater than ninety days."* R.C. 3924.03(E)(2).

COMPANY RESPONSE: The Company agrees**.** We have identified the application of a 180 day waiting period to this group as an underwriting error. We will require the group to amend its waiting period to those options not exceeding 90 days. A copy of the letter advising the employer of this change will be provided as soon as it becomes available.

Issue No. 3 – Employee enrollment forms (evidence of insurability)

The "Employee Enrollment Forms" and "Employer Participation Agreement/ Applications" failed to eliminate health status as a condition of eligibility under its small group certificates.

The "Employee Enrollment Forms" stated, "Important Notice: I understand that (5) If I, my spouse or dependent children waive coverage and decide to apply for coverage at a later date, *evidence of insurability* may be required and benefits may be deferred for a specified period of time; . . ." The "Employer Participation Agreement/Applications" stated, "It is further understood and agreed that: (3) those subject to *evidence of insurability* must receive prior approval by the Company at its home office before coverage becomes effective."

The wording in the forms would deter a small group with poor health status, or an individual in such a group, from applying for coverage with the Company and would thus contravene R.C. 3901.21(V). Any use by the Company of such health information to deny health coverage to a group or individual in a group would contravene R.C. 3901.21(T)(1), 3924.03(C) and (D), Public Law 104-191, Part A – Group Market Reforms, Secs. 2702(a)(1)(G) and 2711(a)(1)(B), respectively, and 45 CFR §§ 146.121(a) (1)(vii) and 146.150(a)(2).

COMPANY RESPONSE: The Company agrees. The noted representations in the contract are being revised to remove these references. Please note that the Company has not required "Evidence of Insurability" (proof of medical fitness) for enrollment purposes and has treated the noted references as if they referred to permitted requirements for evidence to substantiate an employee or dependent's eligibility for coverage. This would cover items such as employment and dependent status, as well as other non-health related issues.

Issue No. 4 – Employer contribution percentage requirements

One file reflected failure by the Company to impose its employer contribution percentage requirements uniformly on all groups, thereby discriminating between small groups at the time of group enrollment.

The Agent's Guide provides, "*The employer must pay at least 50% of the employee's portion of the premium on all coverages selected*." One file reflected an employer contribution percentage of 40%. Failure to apply the Company's standards non-discriminately, contravenes R.C. 3901.21(M), which prohibits "permitting any unfair discrimination between individuals of the same class and of essentially the same hazard . . . in any of the terms or conditions of such contract, or in any other manner whatever."

COMPANY RESPONSE: The Company agrees**.** A review of the file and follow-up questions to the underwriter that processed this application found that this was underwriter error. The Company will reinforce with appropriate staff the importance of adhering to the Company's employer contribution rules.

Issue No. 5 – Additional coverages

Nine files reflected the Company's failure to guarantee issue a small group health plan unless the employer purchased other coverages in addition to the health plan. The employers had attempted to purchase a plan without Life Insurance and Accidental Death and Dismemberment Insurance (AD&D) but were forced to purchase a plan with those additional coverages.

(1) To force the sale of Life and AD&D insurance upon a small employer that wishes to purchase a small group health plan violates the guaranteed availability requirements of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a), and 45 CFR § 146.150(a).

(2) To force the sale of Life and AD&D Insurance upon an unhealthy group that seeks health coverage, considerably increases the cost to the group so that it may no longer be affordable, or competitive in price with other insurers. This would result in the transfer of adverse risks to other insurers, thus contravening R.C. 3901.21(V).

For one of the nine files, the Company responded to an internal memorandum: "Question asking if Life and AD&D is mandatory – *The answer is yes, it is mandatory*." *All* eligible employees in the group had waived Life and AD&D coverage. The coverage was issued with Life and A&D insurance for all employees.

Apart from the nine small employers that did not elect the additional coverages, it could not be ascertained whether other employers would not have elected this coverage but were advised that such coverage was compulsory prior to completing the application, or sought coverage with another insurer, rather than be forced to purchase the additional coverages.

COMPANY RESPONSE: The Company disagrees. We acknowledge the positions you have articulated concerning the Company's practices, but do not agree that these practices serve either to discourage the acceptance of adverse risks or to contravene Ohio and federal guaranteed issue requirements. Nonetheless, we would inform you that the Company has elected to change its business practice and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage.

Issue No. 6 – Life insurance coverage requirement

Two files reflected the Company's failure to comply with its own requirement of 100% employee participation for Life Insurance, by declining some individuals.

The Company packages the sale of a small group health plan with the sale of Life and AD&D insurance and provides in the Agent's Guide (Form No. 20776):

Life and AD&D

- *100% participation is required* for all full-time employees.*

However, the Company underwrites the Life and AD&D portion of the package and denies Life and AD&D coverage to poor risks, leaving only the better risks to be compulsorily insured. Employees listed in two files were denied Life and AD&D insurance when the Company assessed these employees' health status. The Company should have complied with its own rules and should not have discriminated among participants.

COMPANY RESPONSE: The Company disagrees. We acknowledge the positions you have articulated concerning the Company's practices, but do not agree that these practices serve either to discourage the acceptance of adverse risks or to contravene Ohio and federal guaranteed issue requirements. Nonetheless, we would inform you that the Company has elected to change its business practice and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage.

Issue No. 7 – Treatment of married employees

One file (in the Small Groups Terminated files) and two files (in the Small Groups Issued files) reflected the Company's failure to treat all groups non-discriminately when both husband and wife were employed by the same employer. To permit a husband and wife in one employer group to be covered as an employee and a dependent, and in another employer group require both to be covered as employees is unfairly discriminatory, in violation of both R.C. 3901.21(M), and the Company's own standards.

The Company's "Agent's Small Group Underwriting and Administration Guide," (the Guide) stated "If the husband and wife are both employees of the same business, they must be covered as separate employees for all lines of coverage issued."

COMPANY RESPONSE: The Company agrees. We will amend our business practices to ensure consistent application of our treatment of married employees and compliance with § 3901.21 of the Ohio Revised Code. We propose doing the following:

- If a group may only qualify for small group insurance by listing both spouses as separate employees, then each person will be listed as an employee and issued a certificate.

- If a group may only qualify for small group insurance by listing both spouses as separate employees, but the group elects an HSA (Health Savings Account), each person will be listed as an employee, but only one certificate will be issued.

- If listing the spouses is not necessary for the group to qualify for small group insurance, one spouse will be listed as the employee and the other will be listed as the dependent. The decision of naming the "primary" insured and the dependent will be at the discretion of the employer.

Please note that this proposal is subject to change before final implementation.

EXAMINER RESPONSE: The Company's proposed action is unfairly discriminatory in the third example above, in that the employer almost always contributes more to the employees' coverage than it does to the dependents' coverage and sometimes does not contribute at all to the dependents' coverage. Therefore, the Company's actions for one group could result in one of the two employees (the one listed as the dependent), having to contribute substantially more to his or her coverage than his or her spouse is required to contribute. In another group, the Employer would contribute equally to the coverage for both husband and wife. Further, there may be a difference in the premium charged to the small employer, which if different from that charged for two employees versus one employee with a dependent, would be discriminatory and would contravene R.C. 3901.21(M).

Issue No. 8 – Eligibility of part-time employees

The Company failed in three cases to provide for eligibility of employees who worked 25 or more hours. In two files, it was found that the Company failed to enroll eligible employees (who worked 28 hours per week. The third file (failed because it denied eligibility to employees who worked *fewer than 30* hours per week.

R.C. 3924.01(G) specifies a work week of twenty-five or more hours as the qualification for employee eligibility. The Company's State Variations pages correctly state the 25 hour requirement. By denying eligibility to employees on the basis of a 28 or 30 hour work requirement, the Company did not comply with its own rules and violated R.C. 3924.01(G). Additionally, when the Company permits eligibility of some employees who work 25 or more hours but denies the same to other employees, it is also a violation of R.C. 3901.21(M).

COMPANY RESPONSE: Concerning the two files that included the refusal to enroll the employees who worked 28 hours, the Company agrees. In the cases of both groups . . . the noted employees were not initially recognized as full time due to **oversight by the underwriters**. Apparently, the underwriter did not notice that the employer's erroneous designation of the employee as 'part time' while each of the individuals noted worked more than the minimum 25 hours required for eligibility in Ohio. The errors were not discovered and none of the employees received coverage. Coverage has already terminated for both groups. Underwriting management has been alerted of these issues to communicate with supervisors and trainers to ensure that all underwriters reviewing Ohio applications are aware of and apply the proper hourly requirement.

Concerning the third file, the Company agrees. Please note that the employee in question was offered coverage and enrolled in the employer's plan effective 11/9/03. Her coverage terminated 1/1/05 and the groups' plan terminated effective 5/1/05. Please see the attached screen print.

Upon review of the enrollment materials submitted when the group applied, the underwriter did not notice the employer's erroneous designation of the employee as "part

time" though the individual reportedly worked the minimum 25 hours required for eligibility in Ohio. Underwriting management has been alerted of this issue and has been instructed to communicate with supervisors and trainers to ensure that all underwriters reviewing Ohio applications are aware of and apply the proper hourly requirement.

This group was effective 10/15/02. The employee in the third group was therefore without coverage under the plan from 10/15/02 until 11/9/03, although she was an eligible employee.

Issue No. 9 – Maternity benefits

The Company's underwriting procedures failed to provide the same options for coverage to all groups of fewer than 15 employees with respect to maternity coverage, by ***offering*** such coverage to groups with three though nine employees, but ***requiring*** it for groups of two or ten or more eligible employees.

In the small group market, all products that are approved for sale and that the issuer is actively marketing, must be offered to all small employers applying for a small group product. The Company must accept any employer that applies for any of those products, except when contrary to law. The Company offers, and actively markets its small group plan both with maternity coverage and without such coverage. Therefore, all small groups of fewer than fifteen eligible employees must be permitted a choice of maternity coverage. The Company cannot deny the choice to groups of two employees or ten to fifteen employees. To discriminate according to small group size, e.g. offer a product to a group of three while forcing the product on a group of two, contravenes R.C. 3901.21(M), 3924.03(E), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A), and 45 CFR § 146.150. Of the three Small Groups Issued with only two employees, all had maternity coverage. Of these groups, one file reflected a group with one employee aged 61 (with a dependent wife aged 57) and another employee aged 57. Another file reflected a husband and wife group aged 46 and 44. It is unlikely that either of these groups would voluntarily have chosen to pay for maternity coverage.

COMPANY RESPONSE: The Company disagrees. The Company believes neither federal nor Ohio law clearly establishes that offering maternity benefits to one group on a mandatory basis and to another on an optional basis fails to meet the 'All Products Guarantee'. The Company regards the 'product' feature in question to be payment for maternity benefits. This feature is available to groups of all sizes, though it is delivered in different manners to some groups. Because the Company specializes in servicing the smallest of employer groups, the benefit offering was tailored as optional to some of these groups to help preserve more affordable premiums.

However, the Company respects Ohio's position on this matter, and **will change its practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group.**

HCFA Transmittal No. 00-03, dated June 2000, provides in part, "Regulations at 45 CFR § 146.150 clarify the requirements of section 2711 with respect to the marketing of

products to small employers. One of those requirements, the guaranteed availability requirement (also known as the 'all products' requirement)." The Bulletin indicates, that as required under Section 146.150 (unless an exception applies), "an issuer must offer to all small employers all the State-approved products the issuer is actively marketing in the small group market.

Underwriting Standard #2 *- Test a sample of small group policies discontinued/terminated to determine if discontinued in compliance with HIPAA, and Ohio Statutes, Rules and Regulations. Determine if Certificates of Creditable Coverage were issued to terminated members in compliance with HIPAA and Ohio Statutes and Rules.*

The Company stated there were 19 small groups terminated during the period under examination because the groups' participation fell below two participants. The entire population was tested. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
19	100%	100%	100%

Issue No. 1 - Small Groups Terminated for Fewer than Two Participants

All nineteen files were failed because the Company failed to terminate groups that fell from two to one participant in a manner that complied with HIPAA.

The Company terminated the plans prior to the first renewal date following the new plan year and ascertained the number of eligible employees employed *at the time of review*, rather than the number of participating employees employed on the first day of the plan year. Federal Bulletin No. 99-03 specifies that "coverage cannot be terminated until the first renewal date following the beginning of a new plan year, even if the issuer knows as of the beginning of the plan year that the employer no longer has at least two participants who are current employees."

COMPANY RESPONSE: The Company agrees**.** As we noted in our response to Inquiry #24A (and as cited by the examiner in this Inquiry), we have referred for implementation the amendments to current processes for termination of groups with fewer than two employees. Revised processes will comply with the requirements outlined in HCFA Bulletin 99-03.

EXAMINER RESPONSE: The Company's termination of coverage for the 19 small groups was in violation of R.C. 3924.03(B)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and HCFA Transmittal No. 99-03, dated March 1999.

Issue No. 2 - Small Groups Terminated for Fewer than Two Participants

One of the 19 files was failed because a small group plan was terminated on July 1, 2003, for failure to meet participation standards, inadvertently reinstated (with premium paid and accepted), and then terminated again on August 5, 2003, retrospective to the original termination date of July 1.

At the time of reinstatement, all individuals covered under the plan were entitled to file claims and believe they had health coverage. Once reinstatement has been made and premium accepted, the Company has accepted the risk. It may not retrospectively cancel the coverage by returning the premium.

By accepting premium and then retrospectively terminating the coverage of this small group as of the original termination date, the Company contravened R.C. 3923.04(D).

COMPANY RESPONSE: The Company agrees. Staff will be reminded that acceptance of premium results in reinstatement of coverage in cases where coverage has otherwise been terminated.

Issue No. 3 - Small Groups Terminated for Fewer than Two Participants

Another of the 19 files (failed because the small group's coverage was terminated due to one Employee neither: (1) working 30 hours per week; nor (2) receiving monetary compensation.

(1) The Company may not impose a 30 hour per week standard. An employee who is working 25 or more hours is eligible for coverage under a small employer plan. To impose a 30 hour per week standard violates R.C. 3924.01(G).

(2) The Company may not require the employee to be receiving monetary compensation in order for the employee to be considered eligible. For example, a small group in which a husband and wife are struggling to maintain a small business may not be in a position to pay wages to either the husband or wife although both are working 25 or more hours to maintain the business. In this group, the wife was performing the function of Secretary. To deny eligibility based on monetary compensation violates Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and R.C. 3924.01(G).

COMPANY RESPONSE: The Company disagrees. Both letters inappropriately reference a 30 hour per week minimum. The company acknowledges the error and will remind staff of the importance of adhering to state-specific guidelines. However, the error does not impact the ultimate determination that the person referenced was not an eligible employee. As noted by the examiner, the file includes correspondence from the employer disclosing that no wages had been paid to this employee for 'some time'. Uncompensated 'employees' are actually 'volunteers' and the law does not contemplate extending to volunteers the obligations imposed on insurers with respect to employees. The Company, however, acknowledges that termination of the group was not otherwise consistent with the requirements outlined in HCFA Bulletin 99-03.

EXAMINER RESPONSE: Nothing in either state or federal law requires that an employee be compensated for his or her services. Neither does it refer to an uncompensated employee as a "volunteer." If an employee is working 25 or more hours in the service of the employer, that employee is an eligible employee.

R.C. 3924.01(G), provides:

"'Eligible employee' means an employee who works a normal work week of twenty-five or more hours. 'Eligible employee' does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances."

All Small Groups Terminated

The Company provided a listing of 274 Small Group Certificates Terminated during the period under examination. The listing was sorted to eliminate the reason codes which indicated termination was for non-payment of premium, which left a total of 154 files for sampling. The Excel Random Number Generator was used to obtain a sample of 25 small group certificates terminated. An additional sample of 25 files was sampled by use of the Excel Random Number Generator. The second sample included all the files from the original listing (terminated files for non-payment were included) except for the 25 files already sampled. Therefore, a sample of 50 files was selected for testing. One plan was a dental only plan; therefore, it was not tested, leaving a total of 49 files tested. The results of the testing are indicated in the table below.

# of Files	Failed HIPAA	Failed Ohio	HIPAA % Failed	Ohio % Failed
49	17	17	35%	35%

Issue No. 4 – Small group termination

Three files (reflected small groups whose coverage was terminated when participation fell from two employees to one. These three files were also tested as part of "Small Groups Terminated for Fewer than Two Employees" and were failed because:

(1) All three groups were terminated after the Company discovered the decline in employee numbers, rather than at the renewal following the new plan year. To ascertain the number of employees currently employed *at the time of review* rather than on the first day of the plan year, and then terminate a small group health plan that has only one employee *at the time of review*, contravenes Public Law 104-191, Part A – Group Market Reforms, Sec. 2712(a), 45 CFR § 146.152(a), R.C. 3924.01(N)(1) and 3924.03(B)(1), and Federal Bulletin No. 99-03(V).

(2) One of the three files contained a letter stating that the termination was based on the number of employees currently employed and that attempting to add employees to the

plan would not exempt the group from termination of coverage. Such a statement contravenes the guaranteed renewability of coverage provided for in Public Law 104-191, Part A – Group Market Reforms, Sec. 2712(a), 45 CFR § 146.152, and R.C. 3924.03(B)(1) and 3924.01(N)(1).

COMPANY RESPONSE: The Company agrees. As we noted in our response to Inquiry #24A (and as cited by the examiner in this Inquiry), we have referred for implementation the amendments to current processes for termination of groups with fewer than two employees. Revised processes will comply with the requirements outlined in HCFA Bulletin 99-03.

R.C. 3924.01 provides in part: . . .

> "(N)(1) 'Small Employer' means, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year . . . ."

Issue No. 5 – Coverage of married employees

One file reflected a group with only two employees, one of whom was covered as the dependent of another. The Company stated verbally that an employee could be covered as a dependent only in groups with *more than* two employees. The "Agent's Guides" stated that husbands and wives must both be covered as employees regardless of group size. To permit one group to cover employees as dependents, but deny such coverage to another group contravenes the Company's own rules and discriminates between small groups of the same class. Such discrimination contravenes R.C. 3901.21(M), which is recited above.

COMPANY RESPONSE: The Company agrees. We will amend our business practices to ensure consistent application of our treatment of married employees and compliance with § 3901.21 of the Ohio Revised Code. We propose doing the following:

- If a group may only qualify for small group insurance by listing both spouses as separate employees, then each person will be listed as an employee and issued a certificate.

- If a group may only qualify for small group insurance by listing both spouses as separate employees, but the group elects an HSA (Health Savings Account), each person will be listed as an employee, but only one certificate will be issued.

- If listing the spouses is not necessary for the group to qualify for small group insurance, one spouse will be listed as the employee and the other will be listed as the dependent. The decision of naming the 'primary' insured and the dependent will be at the discretion of the employer.

Please note that this proposal is subject to change before final implementation.

EXAMINER RESPONSE: The Company's proposed action is unfairly discriminatory in the third example stated above, in that the employer almost always contributes more to the Employees' coverage than it does to the Dependents' coverage and sometimes does not contribute at all to the Dependents' coverage. The Company's actions would result in the "dependent" employee having to contribute substantially more to his or her coverage than employees who are not listed as dependents. Furthermore, there may be a difference in the premium charged to the small employer for an employee versus a dependent, which would thus also be discriminatory and contravene R.C. 3901.21(M).

Issue No. 6 – Termination of coverage letters

Nine files did not contain any Certificates of Creditable Coverage (CCCs) for terminated employees. A note in each of the nine files stated, "*No agent or group's request for termination and Certificate of Creditable Coverage letters exist due to policy lapsed (effective date). No Certificate of Creditable Coverage letters generated for policies prior to 10/1/03.*"

Therefore, all nine files failed because none of the employees or dependents in these nine groups received a CCC when the plan terminated.

Failure to provide terminated employees and dependents with CCCs is a violation of R.C. 3924.03(A)(3), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701(e)(1)(A), and 45 CFR § 146.115(a)(1)(i).

The Company failed to provide CCCs to employees of all groups with lapsed coverage for the period of July 1, 2002 through October 1, 2003. The Company procedure had the potential to adversely affect hundreds of employees and dependents insured under FIC group plans.

COMPANY RESPONSE: The Company agrees. Our systems were not programmed to automatically generate a CCC letter if a group lapsed for non payment of premium prior to that date (10/1/03). The system had been programmed to automatically generate a Certificate (sic) of Creditable Coverage if a group terminated for other reasons (e.g., group requests termination). Such a request would have prompted a different system code and resulting letter. The automation of CCC issuance upon lapse of a small employer plan was implemented on 10/1/03." Incorrect data reflected on the Certificate of Creditable Coverage resulted from an input error in a system field for 'Waiting Period.' The entry read '000' and should have read '090'. We have corrected the identified problem. Current processes provide for the administration system to automatically populate the 'Waiting Period' field with the correct waiting period selected by the employer for all enrollees and the possibility of a recurrence of the above scenario is not possible with these system enhancements.

Issue No. 7 – Waiting periods

One file failed to correctly state the waiting period that applied to the group. The file contained a CCC that indicated a waiting period of zero days for an employee. The waiting period for this group was 90 days.

This error resulted in the employee being provided with a CCC that showed an eligibility date of 12/13/1999 with no waiting period. However, coverage was not effective until 4/1/2000. This resulted in an apparent gap in coverage of more than 62 days. Such a gap may deprive an enrollee of credit for any prior coverage and subject him or her to a pre-existing conditions limitation under a subsequent plan.

Furthermore, if the insured's coverage had terminated before she achieved 18 months' coverage under the Company's plan, and if she was not eligible for other group health insurance, the incorrect information on the CCC would have deprived her of federal eligibility status and access to *individual* coverage without a preexisting conditions limitation.

Failure to accurately reflect an insured's coverage on a CCC contravenes R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, and 45 CFR § 146.115.

COMPANY RESPONSE: The Company agrees. However, as indicated in our response to Memo Request #97, incorrect data reflected on the Certificate of Creditable Coverage resulted from an input error in a system field for 'Waiting Period.' The entry read '000' and should have read '090'.

We have corrected the identified problem. Current processes provide for the administration system to automatically populate the 'Waiting Period' field with the correct waiting period selected by the employer for all enrollees and the possibility of a recurrence of the above scenario is not possible with these system enhancements.

Underwriting Standard #3 *– Test a sample of small group declinations to determine if declined in compliance with HIPAA, and Ohio Statutes and Rules.*

The Company provided a listing of the entire population of five declined applications. Of these, one was an application for a Life only policy. It was therefore omitted from testing, reducing the population to four files. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	HIPAA % Failed	Ohio % Failed
4	2	4	50%	100%

Issue No. 1 – Denial of small group health plan

(A) One file was failed because an eligible small employer group was denied a Small Group health plan on the basis of failure to provide a copy of the State Unemployment Withholding form and a business check.

The Company stated in the letter of denial to the Agent, "Based on the information provided, we are unable to consider The Crusade under Fortis' Group insurance plan. They are unable to provide us with the documentation necessary to determine business eligibility. They can reapply after they are able to provide us with a copy of their 2nd State Quarterly Unemployment Withholding form and a business check."

The Company's marketing materials also included both requirements in the "Agent's Small Group Underwriting Administration Guide."

COMPANY RESPONSE: The Company disagrees. The complete sentence out of the file referenced reads: "I don't think the following attachment will make any difference, because if I understand you correctly, there is no way of getting around the needed tax form, but the agent is really trying to keep this group."

The Company further state in part, " . . . in which the discussion involved the 1099 (contractor) status of one of the two persons applying as 'employees.' Subsequent documentation was obtained establishing the 1099 status of the applicant in question, as noted in the e-mail exchange. Because they were unable to establish that the applicant was an employee, our letter indicating 'They are unable to provide us with the documentation necessary to determine business eligibility' is a factually accurate representation of the results of the underwriter's assessment of the employer's eligibility. The e-mail exchange does not establish that the 'needed tax form' was the only documentation the Company would have accepted to determine the groups' eligibility; rather, it was part of an electronic conversation involving efforts to do so.' The e-mail continued 'the group was declined because we do not offer coverage to one life groups. This is why pay check stubs were not requested.'"

EXAMINER RESPONSE: The file indicated there was confusion about the 1099 status of the second person in the group. However, the letter of denial and the statement concerning the State Quarterly Unemployment Withholding Form, indicated the form was necessary for acceptance of the application and the wording in the "Agent's Guide" confirms this.

A small employer group is guaranteed availability of health coverage. If the small employer provides proof, in whatever form, that it is a legitimate small employer, then the Company must offer and make available all of its small group health plans. When the Company declines a legitimate small group it violates R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150.

(B) The same file was also failed because it contained an e-mail statement and a notation that the Company would not allow more than 25% of individuals in a small group to be 1099 subcontractors.

The e-mail statement and notation stated "We do not allow more than 25% in a group to be 1099. Since this constitutes 50%, it would not be eligible. 1099? Yes. More than 25%. Not eligible."

It is an unfair practice to exclude any group from coverage based on the percentage of 1099 subcontractors. The statement contravenes the unfair practices act of state law and the guaranteed issue requirements at R.C. 3901.21, R.C. 3924.01, R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150.

COMPANY RESPONSE: The Company disagrees. When considering the eligibility of a group from the perspective size (2-50), 1099 subcontractors are excluded from the count of employees. In the case of group #392110, the group was not eligible because there was only one eligible employee. There was, therefore, no discrimination between small groups with the equivalent number of eligible employees since all group sizes of one would be considered ineligible. Further, we note no violation of federal and state laws by declining small groups that meet the definition of 'small employer' because the group never did meet the definition.

EXAMINER RESPONSE: The Company did not address the issue concerning the statements made by Company personnel concerning disqualification of a small group due to the percentage of 1099 subcontractors. It is a contravention of law to deny coverage to a small group just because subcontractors comprise more than 25% of the individuals in the group. The percentage of subcontractors is irrelevant. Only the number of eligible employees in the group may be taken into account.

Issue No. 2 – Explanation for denial of application

Three of the four files were failed because the small employer had not been provided a reason for the declination of the application other than the group's "ineligibility." No further explanation as to why these groups were ineligible was provided in the letter to the employer. Therefore, the Company acted in violation of R.C. 3904.10.

COMPANY RESPONSE: The Company disagrees. In each case, eligibility as a small employer is specified for the reason for declining the request for coverage. We maintain that this satisfies the requirements of Section 3904.10 of the Ohio Revised Code. However, we will implement procedures to provide more detail regarding the eligibility determination in declination letters to employers that apply for small group coverage."

EXAMINER RESPONSE: A small employer group is guaranteed availability of health coverage. If declined, R.C. 3904.10 requires the Company to provide the applicant with the *specific* reason(s) for the declination. If the Small Group does not know the specific reason for the declination, it is unable to contest the declination or pursue a remedy with the Company.

Issue No. 3 – Reason for denial of an application

One file contained a letter to the employer, which stated *"Based on the group's ineligibility, we are unable to consider coverage under Fortis' group insurance plan."* The file was failed because none of the potential reasons for declination of the group was a valid reason for declination.

One reason appeared to be that the group had not been in business for six months. The agent wrote to the Company stating in part, "I cite the following background to allay any anxiety about insuring a new business . . . ."

COMPANY RESPONSE: The Company agrees. As we noted in our response to Inquiry #23: 'Company practice with regard to the 6 month durational requirement . . . has been discontinued and is no longer applied to small employer applicants.'

EXAMINER RESPONSE: The Company appears to have denied health coverage to this small group based in part on the length of time the employer had been in business. If this was the reason for the declination, it was a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and R.C. 3924.03(E)(1).

The Company's response also stated, "We would note that the information provided in response to memo Request #5 (Small Groups Declined) found that no groups were declined coverage for being in existence less than six months. Consequently, there were no violations of small group guarantee issue requirements resulting from this practice during the examination period."

The Company may have denied coverage to this group for its failure to provide a tax and wage report. The Business Census, which the employer completed on April 12, 2003, stated:

"Important Note: This form must be accompanied by your State Quarterly Wage & Tax Report (or applicable tax documentation based on type of business arrangement noted below)."

The "Small Group Critical Omission Check List" listed the "State Quarterly Unemployment Withholding Form (most recent quarter)" as one item stalling the application. The form stated:

"We are unable to forward this case to the Small Group Underwriting Department until the below critical omissions are received . . . ."

Additionally, the "Group Notes" in the file, dated 4/29/03, stated "Ineligible Group – 3 med certs all full-time employment date 4/21/03 all signed enrollment forms prior, *no business check or tax and wage report . . . .*"

The premium was paid on 4/22/03. The employer's application was signed on April 22, 2003, requesting an effective date of May 1, 2003, and indicated three full-time employees. The application was declined on May 5, 2003. At the time of application,

there would not have been a State Quarterly Wage and Tax Report filing for the employer.

It is irrelevant whether the employer was declined due to being in business less than six months, not providing a business check, or not providing a quarterly wage report, because none of these reasons invalidates the employer's status as a small employer, and therefore the employer should have been guaranteed availability of small group health coverage. While these items are valid underwriting tools for established businesses, they are not essential. There is no requirement in law for an employer to be in business for six months, provide a State Quarterly Wage and Tax Report, or pay with a business check. Therefore, for this employer, the Company violated Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and R.C. 3924.03(E)(1) by refusing guaranteed issuance of a small group health plan.

Issue No. 4 - Rescissions

The Company was asked if any group policies/certificates were rescinded during the period under examination.

COMPANY RESPONSE: Pursuant to our discussions regarding this question, we have confirmed that no small group or employer-sponsored plans were rescinded in Ohio during the exam period.

Underwriting Standard #4 *– Test a sample of conversion policies issued to determine if the policies are issued in compliance with HIPAA, NMHPA, WHCRA and Ohio Statutes and Rules.*

The Company first indicated that one conversion certificate was issued during the period under examination. However, the Company later stated, *"We have reviewed our records and found that we have not issued, declined, or terminated any individuals from a conversion policy in Ohio during the examination period."* Because no conversion certificates were issued during the period under examination a request was made for the Company to supply for testing, any five files reflecting individuals who were offered FIC conversion coverage during the period under examination, to determine if an offer was made in compliance with HIPAA and Ohio statutes and laws. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
5	5	5	100%

Issue No. 1 – Conversion coverage

The Company did not offer any FIC plans sold in the individual market to a conversion eligible individual. FIC only offered the John Alden Life Insurance Company (JALIC) plan J-1110.

The Company procedure of offering a JALIC product instead of the choice of "any" FIC policy (Ohio statute indicates "policy" includes certificates) issued in the State of Ohio is a violation of R.C. 3923.122(A), which provides in part, "Every policy of group sickness and accident insurance providing hospital, surgical, or medical expense coverage . . . shall include a provision giving each insured the option to convert to the following:

(1) In the case of an individual who is not a federally eligible individual, any of the individual policies of hospital, surgical, or medical expense insurance then being issued by the insurer with benefit limits not to exceed those in effect under the group policy;
(2) In the case of a federally eligible individual, a basic or standard plan . . ."

When an eligible individual requests conversion coverage, the Company must offer to such individual, all the plans it is currently marketing in the individual market. Therefore, during the period under examination, the Company should have offered all versions of Plan Forms 225, 227, 185, 186 and 554 to every conversion eligible individual, and for every federally eligible individual (FEI) it should have offered Policy Forms 185 and 186. Therefore, the Company's conversion practices and procedures for offering conversion were failed for not complying with R.C. 3923.122. This was true for every offer of a conversion plan during the period under examination.

COMPANY RESPONSE: The Company disagrees. *Please note that we do not regard the requirement to read that we offer "all" coverage issued in the individual market, but rather that the use of the term "any of the individual policies" provides the latitude to select from among individual market offerings.*

EXAMINER RESPONSE: R.C. 3923.122 indicates an insurer must offer any (meaning all) of the policies then being issued by the insurer. In addition, the Company was not offering "any" of its then issued individual plans in the State of Ohio, because JALIC's Plan J-1110 was not the Company's plan and was not an individual plan being "issued" (marketed) in the State of Ohio, other than as a conversion plan.

Issue No. 2 - Determination of FEI eligibility

The Company indicated that conversion eligible individuals were not evaluated to determine if they were federally eligible individuals (FEIs). Three of the five conversion applicants were confirmed as FEIs during testing (45 CFR § 148.103, noted in R.C. 3923.581(A)(2)). The certificates of creditable coverage indicated the three applicants each had more than 18 months of continuous creditable coverage. The other two may have been eligible, but there was not enough evidence within the file to make this determination. Therefore, all five of the files were failed because the Company did not determine if the applicants were federally eligible, and three of the five files were failed because the FEIs were not offered the Ohio Basic and Standard plans in compliance with R.C. 3923.122.

A Company response during the examination stated, *"Annual payment mode is the only payment mode offered in all states where Form J-1110 is issued, except where not permitted by state laws or regulations."* FIC offers Forms 225, 227, 185, 186 and 554 with monthly or quarterly modes for payment of premium but offers its conversion plan only with an annual mode of payment, which is a violation of R.C. 3923.122(B), which indicates that a conversion policy will be issued upon receipt of a written application and upon payment of at least the first quarterly premium. Therefore, the Company must allow a minimum of a quarterly payment. In addition, the annual mode of payment also appears to be a violation of R.C. 3901.21(M), which provides in part, "Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in . . . practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever." In addition, because the Company has to accept the conversion eligible individual, the Company policy also appears to be a violation of R.C. 3901.21(V), which provides in part, "Using any program, scheme, device or other unfair act or practice that, directly or indirectly, *causes or results in the placing of coverage for adverse risks with another carrier . . ."*

Policy Forms 225, 227, and 554 all have optional maternity coverage. Policy Form 186 (Ohio Standard Plan) has maternity coverage with no preexisting conditions limitation. Maternity coverage is not offered in Policy Form 185 (Ohio Basic Plan). The JALIC Conversion Form J-1110, did not allow maternity coverage if the group plan (insured's prior group coverage) did not have maternity coverage. If the insured's group plan had maternity coverage, JALIC Plan J-1110 only allowed maternity coverage for individuals who were already pregnant on the inception date of the conversion policy. R.C. 3923.122 (A) (1), requires an offer to individuals who are not FEIs, of "any of the individual policies . . . then being issued by the insurer with benefit limits not to exceed those in effect under the group policy," which includes optional benefits (maternity coverage). R.C. 3923.122(A)(2), provides in part for FEIs, "a basic or standard plan . . . or plan substantially similar to the basic and standard plan in benefit design and scope of covered services."

The Company has to offer "any" (all) of its then issued individual plans, and offer each of the plans as offered in the open market (as marketed) in Ohio. Therefore, it should offer Plan Forms 225, 227 and 554 to all non-federally eligible individuals with optional maternity coverage. In addition, FIC cannot restrict the maternity benefit to conversion eligible individuals who are currently pregnant. If the maternity benefit is chosen by the conversion applicant, then the maternity coverage has to be the same coverage that is issued in the open market, and it must be an ongoing benefit. The Company practice to only offer maternity coverage if the applicant is pregnant is a violation of R.C. 3901.21(V), which appears to attempt to avoid future maternity claims.

COMPANY RESPONSE: Although the Company believes that offering of the substantially similar JALIC form J-1110 meets the statute's requirements, the Company would also be willing to offer these FIC forms 185 and 186 to all conversion eligible individuals. As all five of the individuals noted above were offered the J-1110 without imposition of preexisting condition exclusions, the Company believes it has met the

requirements of Sections 3923.581 and 3923.122 as to plan offering (plan substantially similar to the Basic and Standard Plan).

With regard to Section 3901.21(M) referencing unfair discrimination for annual premium payments, the Company believes that conversion members represent both a separate class of insureds and a hazard of a different nature than other enrollees. Though we have been unable to find any other specific authority in Ohio law prohibiting annual premium payments, the Company will agree to extend monthly and quarterly premium payment options to convertees.

The Company acknowledges and agrees to offer maternity coverage to all individuals eligible for conversion and will immediately implement measures to ensure that all enrollees are provided with maternity services as an ongoing, covered benefit under JALIC form J-1110. The Company believed its practice of issuing the J-1110 form (a substantial equivalent to the Basic and Standard Plans) without requiring evidence of insurability and without preexisting condition limitations without requiring conversion applicants to produce evidence of prior coverage exceeds the requirements of Group Conversion Section 3923.122. However, as noted above, the Company is also willing to offer the additional FIC forms 185 and 186 to all eligible conversion individuals.

EXAMINER RESPONSE: The Company's response and its procedures are not in compliance with the mandates of R.C. 3923.122 and R.C. 3923.581. The Company would only be offering another company's plan for its conversion plan (other than where the Company has stated it is willing to offer the Ohio Standard and Basic plans). Furthermore, it does not appear that the J-1110 is substantially similar in benefits when compared to the Ohio Standard and Basic plans.

Underwriting Standard #5 *– When Conversion policies are discontinued/terminated, determine if discontinued in compliance with HIPAA, and Ohio Statutes and Regulations. Determine if Certificates of Creditable Coverage were issued to terminated members in compliance with HIPAA and Ohio Statutes and Rules.*

COMPANY RESPONSE: We have reviewed our records and found that we have not issued, declined, or terminated any individuals from a conversion policy in Ohio during the examination period.

EXAMINER RESPONSE: Therefore, there was no testing of terminated conversion certificates.

Underwriting Standard #6 *– Determine if Conversion policies declined are declined in compliance with HIPAA, and Ohio Statutes and Rules.*

COMPANY RESPONSE: We have reviewed our records and found that we have not issued, declined, or terminated any individuals from a conversion policy in Ohio during the examination period.

EXAMINER RESPONSE: Therefore, there was no testing of declined conversion applications.

Underwriting Standard #7 *- Test a sample of individual plans issued to determine if the Company actions are in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Regulations.*

The Company provided a listing of Individual Policies/Certificates Issued during the period under examination. The listing did not include short-term certificates issued during the period under examination. The Department indicated that the short-term certificates would not be tested with the issued certificate files. There were 8,677 individual market policies/certificates issued during the period under examination. The Excel Random Number Generator was used to obtain a sample of 50 individual policies/certificates issued for testing. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
50	0	50	100%

Issue No. 1 – Determination of FEI eligibility

(A) The application, and the Company's underwriting practices and procedures did not provide FIC with the ability to determine which applicants were FEIs. In addition, even when the insured had provided adequate information at application (was an FEI), the Company did not offer the Ohio Standard and Basic plans.

All of the files tested were failed, because the Company did not determine if the applicants were FEIs. For 15 files tested, the applicants indicated their last coverage was under an individual policy/certificate, which would indicate the applicants were not FEIs. There was one exception; one of the 35 files was for an individual who indicated their last coverage was under a State Farm individual plan. The Company knew that State Farm does not offer such plans, because the only plans offered in the individual market by State Farm agents are offered through Assurant (FIC). Therefore, all the files were failed because the Company did not determine the federal eligibility status of the applicants, and 35 files were failed for failure to offer the Ohio Standard and Basic plans for those individuals who may have been FEIs.

COMPANY RESPONSE: The Company disagrees with the assessment regarding State Farm coverage. In response to the question reading: "Are any of the proposed insureds covered by, or has application been made for any type of medical insurance." The application indicates "yes" and lists "State Farm" under company name, "I" (for Individual coverage) . . . Therefore, the answers provided are consistent and we have no reason to question the accuracy of the attested statements.

EXAMINER RESPONSE: However, the only individual plans offered by State Farm agents are the Assurant health plans. Therefore, the Company underwriters should have known the information on the application was not correct.

(B) The Company was asked:

1. Will the Company agree that it does not determine who is an eligible individual in Ohio at the time of application and this has been true for the entire period under examination and has continued to date?
2. If so, it is anticipated that several of the 50 files, which were issued during the period under examination and have been sampled, will have similar situations to this file, and therefore, an Inquiry will be written for each if the Company does not agree to #1 above.
3. The review of these files will be withheld until the Company makes such a determination.
4. Would the Company agree that Form 25238 should be provided to every applicant?
5. Would the Company agree From 25238 should be filed, and become a document incorporated into the application process in the State of Ohio?
6. The Company, if it agrees to #1 above, should provide a written summation of the underwriting process it intends to implement to indicate it will determine who is a federally eligible individual, and indicate how it will guarantee that every federally eligible individual is offered the Ohio Standard and Basic plans.

COMPANY RESPONSE: The Company's responses to six questions about its underwriting procedures for FEIs are stated below:

1. Agree: The Company acknowledges that we did not consistently determine the HIPAA eligibility status of all applicants during the examination period.
2. See #1, above.
3. (No response called for).
4. The Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product Certificate Forms 225 and 227 or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals.
5. The Company will either file HIPAA Eligibility Form 25238, or an updated version of the form, with the Ohio Department of Insurance as part of the applications for the forms or will develop processes that will otherwise provide for the offer of the Basic and Standard plans to HIPAA eligibles. As previously noted, a filing for Certificate Form 225 and 227 is currently pending with the Department.
6. As noted in #4, above, the Company will ensure that an offer of the Basic and Standard plan is made to each HIPAA eligible applicant, regardless of whether or not an offer of fully-underwritten coverage may be made. A corrective action plan is not available at this time as the Company needs to ensure all areas impacted by these

workflows are involved in the corrective action process. We will update the Department of Insurance when a corrective action plan is implemented.

Issue No. 2 – Determination of FEI eligibility

The application process for the Student Medical Certificate (major medical coverage) did not provide the Company with a method to determine which applicants were FEIs. The application process involved 5 Questions, none of which enabled the Company to determine if the applicant was an FEI. Therefore, each of the Student Medical (554) application files were failed, and were part of the 35 failed files above. The Company was not acting in compliance with R.C. 3923.581(D), because it was not determining who was federally eligible, and therefore, was not offering the Ohio Standard and Basic plans to FEIs that applied for the Student Select plan. The law requires the offer of the Basic and Standard plans to FEIs.

R.C. 3923.581(B, C and D) provides in part:

"(B) . . . carriers in the business of issuing health benefits plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage . . .

(C) No carrier shall do either of the following: (1) Decline to offer such coverage to, or deny enrollment, of such individuals . . .

(D) A carrier shall offer to federally eligible individuals the basic and standard plan . . ."

COMPANY RESPONSE: The Company agrees that it must offer a Basic and a Standard Plan to a Federally Eligible individual who applies for coverage under the Company's student medical plan. The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage with no pre-existing condition exclusions. We will provide a "HIPAA Rights Notice" that advises of the potential availability of the Basic and Standard Plans and that also describes the HIPAA eligibility requirements and how to contact the Company to inquire further regarding this coverage option. As such, we propose to adopt the use of the following "HIPAA Rights Notice" for each applicant:

IMPORTANT HIPAA RIGHTS NOTICE: You may also be eligible under federal and Ohio law for guarantee available coverage that does not impose a pre-existing condition limitation and/or rider excluding a specific condition.

To qualify as an Eligible Individual, you/your:

(1) Must have at least 18 months of prior health insurance coverage as of the date on which you seek coverage;
(2) Most recent prior health insurance coverage was under a group health plan, governmental plan, or church plan;
(3) Must not be eligible for coverage under a group health plan, Medicare, or Medicaid;

(4) Must not have other health insurance coverage;
(5) Most recent coverage was not terminated because of nonpayment of premiums or fraud; and
(6) Must have elected and exhausted continuation coverage under COBRA or a similar State program (if applicable).

Eligible Individuals are eligible for coverage under Ohio's Basic and/or Standard Health Benefit Plans. This coverage may significantly differ in plan design, cost-sharing obligations and premium charged from the coverage quoted in the accompanying offer letter that you have requested. For more information about these potential additional coverage options, please contact your agent or a Fortis customer service representative at _____"

EXAMINER RESPONSE: The Company proposal did not indicate that an applicant may have no more than a 63 day gap in coverage and still retain FEI status. In addition, the Company still failed to provide a method of determining federal eligibility at the time of application; instead it has placed that onus on the applicant. Therefore, the Company's method of correction is not in compliance with R.C. 3923.581(B, C and D). The Company must provide an application in a format that allows FIC to determine who is an FEI at the time of application, and must offer the Ohio Standard and Basic plans to all who are federally eligible, at the same time it offers a marketed plan.

Underwriting Standard #8 *- Test a sample of individual plans discontinued/terminated to determine if discontinued in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Regulations. Determine if Certificates of Creditable Coverage were issued to terminated members in compliance with HIPAA and Ohio Statutes and Regulations.*

The Company provided a listing of Individual Policies/Certificates Terminated during the period under examination. There were 7,212 individual policies/certificates terminated during the period under examination. The listing was sorted to eliminate the reason codes which indicated termination was for non-payment of premium, which left 4,610 files for sampling. The Excel Random Number Generator was used to obtain a sample of 50 individual policies/certificates terminated. However, during testing of the 50 files, three were noted to be policy/certificate holders that were rolled from a discontinued product into Form 227. Those three files were replaced with the first three files on the original listing with a non-payment termination reason code. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
50	28	28	56%

Issue No. 1 – Issuance of a certificate of creditable coverage

The Company failed to provide four individuals with an automatic issue certificate of creditable coverage (CCC) at the time their coverage was terminated.

COMPANY RESPONSE: The Company agrees that a certificate had not been issued to these policy/certificate holders.

EXAMINER RESPONSE: Therefore, the Company was in violation of R.C. 3923.57(F), which indicates that certificates/policies are subject to Sec. 2743 of the Health Insurance Portability and Accountability Act of 1996. The Company was also in violation of 45 CFR § 148.124.

Issue No. 2 – Issuance of a certificate of creditable coverage

For 24 files, the Company failed to provide an automatic issue CCC within a reasonable period of time in violation of Public Law 104-191, Part A - Group Market Reforms, Sec. 2701(e), which is referenced by R.C. 3923.57(F) and R.C. 3924.03(A)(3), Public Law 104-191, Part B - Individual Market Rules, Sec. 2743, and 45 CFR § 148.124.

Public Law 104-191, Part A - Group Market Reforms, Sec. 2701(e), which is referenced by Ohio State law at R.C. 3923.57(F) and R.C. 3924.03(A)(3), provides that the time period recognized by COBRA for notice to an employee of his or her COBRA eligibility is the time period within which a CCC should be issued. A U. S. Dept. of Labor COBRA brochure indicates that from the time an employer becomes aware that an individual is COBRA eligible, the employer has 14 days to notify that individual ("qualified beneficiary") of the availability of COBRA coverage. Therefore, 14 days is the standard for issuance of CCCs. This applies to both the individual and group markets. The 14 days starts at the time an insurer becomes aware of termination of coverage. The 14 days may extend to 45 days in the event non-payment of premium is the cause of the termination. The 45 days includes a grace period of 31 days, followed by the 14 day period. Non-compliance with the 14 day time frame is a violation of Public Law 104-191, Part A - Group Market Reforms, Sec. 2701(e), R.C. 3923.57(F) and R.C. 3924.03(A)(3), Public Law 104-191, Part B - Individual Market Rules, Sec. 2743, and 45 CFR § 148.124.

COMPANY RESPONSE: The Company disagrees. The examiner notes: "The federal law states, that the time period recognized by COBRA, for notice of COBRA eligibility, from the employer, to the eligible employee is the time period within which a CCC should be issued." However, as noted above, the codicil in the section of the U.S. Code cited reads: **"**The certification under clause (i) may be provided**, to the extent practicable,** at a time consistent with notices required under any applicable COBRA continuation provision." [emphasis added] Further, as noted by the examiner, 45 CFR 148.124 specifically states **"within a reasonable time period".** We respectfully note no violation of any Ohio or federal law requiring a CCC to be issued within 14 days of notification of termination. We submit again that it is reasonable for a CCC to be issued within 45 days of notification of termination.

EXAMINER RESPONSE: Testing of individual plans terminated, indicated that 50% of the CCCs were issued within 7 calendar days. Therefore, it is not reasonable for FIC to argue that the standard of 14 days is unreasonable. If an insurer was allowed 45 days to issue a CCC, it could issue a CCC for non-pay policy/certificate holders 76 days after termination (Grace Period 31 days + 45 days). An individual has a gap in creditable coverage if the gap is greater than 63 days. Therefore, HIPAA does not permit a CCC to be issued 76 days after termination.

Underwriting Standard #9 - *Test a sample of individual plans declined to determine if declined in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Regulations.*

The Company provided a listing of Individual Policies/Certificates Declined during the period under examination. There were 1,275 individual policies/certificates declined during the period under examination. The Excel Random Number Generator was used to obtain a sample of 50 individual policies/certificates declined for testing.

Due to the number of failures concerning how the Company issued its adverse notice letters, those failed files were separated out during testing. The results of the testing are indicated in the table below:

# of Files	Failed Ohio	Failed Notice	Ohio % Failed	Notice % Failed
50	50	38	100%	76%

Issue No. 1 – Determination of FEI eligibility

All 50 FIC individual market declined applicants' files tested were failed. All the files were failed because the Company did not determine the FEI status of the applicants at the time of application, in violation of R.C. 3923.581. In addition, the 37 applicants that indicated their last health coverage was under a group plan, or did not indicate current coverage, were also failed. The 37 applicants had the potential to be an FEI, and none were offered the Ohio Basic and Standard plans at the time of application. The other 13 applicants stated their last health coverage was under an individual product. In addition, 38 of the 50 files were failed for failure to issue an adequate adverse underwriting notice to the declined applicants. Therefore, some files were failed for as many as three reasons.

R.C. 3923.581provides in part:

"(B) . . . carriers in the business of issuing health benefits plans to individuals or nonemployer groups shall accept federally eligible individuals for open enrollment coverage . . .

(C) No carrier shall do either of the following: (1) Decline to offer such coverage to, or deny enrollment, of such individuals . . .

(D) A carrier shall offer to federally eligible individuals the basic and standard plan . . . ."

FIC failed to determine if applicants were federally eligible and therefore, failed to offer the Ohio Basic and Standard plans. FIC required the *applicants* to initiate the request for a Basic or Standard Plan. Failure of the Company to offer these plans to FEIs violates R.C. 3923.581. FIC stated that the applicants had to be declined an FIC open market plan before they were considered for the Ohio Basic and Standard plans, which is a violation of R.C. 3923.581. The Company must determine federal eligibility at the time of application, not after declination. If federally eligible, the applicant should have been offered the Ohio Basic and Standard plans simultaneously with its marketed plans. Only in this manner can an applicant compare the offers and determine which plan best suits their needs. In the case of a declined applicant, the Company should have already determined federal eligibility and offered the Ohio Basic and Standard plans at the time of underwriting.

COMPANY RESPONSE: The Company agrees that its underwriting procedures for determining federal eligibility were not in compliance with R.C.3923.581.

Issue No. 2 – Determination of FEI eligibility

One file was not failed for not recognizing the applicant as a federally eligible individual, even though she had sufficient creditable coverage. The applicant's coverage was foreign coverage (Switzerland group). CMS issued a Bulletin in 2005 to clarify handling of foreign health coverage and that is why the file was not failed. R.C. 3924.03(A)(4)(a) indicates that "Creditable coverage" has the same meaning as in section 2701(c)(1) of the "Health Insurance Portability and Accountability Act of 1996.

CMS Transmittal 05-01, dated March 2005, "Coverage through a Foreign Government, the U.S. Government, and a State Children's Health Insurance Program, is Creditable Coverage for Purposes of Identifying Eligible Individuals under HIPAA." The Transmittal provides in part, "Any public health plan, including a plan established or maintained by the U. S. government, or a foreign country . . . is creditable coverage for purposes of identifying eligible individuals. . . ."

COMPANY RESPONSE: The Company acknowledges the Bulletin and will comply with the Bulletin's required definition of creditable coverage going forward.

Issue No. 3 – Declination letters

Prior to the review of declinations, testing of Complaints indicated the Company only provided medical information about adverse underwriting to the doctor if a declined applicant requested the reason for the declination. However, during testing of declinations, 12 of 50 files had letters indicating the applicant was provided with a declination letter that indicated the specific reason(s) for the declination. Testing indicated the other 38 files failed. Twenty of the failed files did not have a declination letter; two files had letters indicating the applicant would have to contact his doctor; and 16 files had letters indicating the applicant was declined because of Lab Results,

"Confidential Medical Information," "Confidential Information," or "Medical Records." Failure to provide a letter, or, to provide a letter without the specific adverse underwriting reason is a violation of R.C. 3904.10.

COMPANY RESPONSE: The Company agrees. Prior to the HIPAA Privacy standards, company practice with regard to potentially sensitive medical information on applicants entailed directing the applicant to their medical provider in order to prevent potential mis-communication of medical information.

We respectfully note that the Company has modified its administrative practices such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice.

Underwriting Standard #10 *- Test a sample of individual plans rescinded to determine if rescinded in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Regulations.*

The Company provided a listing of 94 Individual Policies/Certificates Rescinded during the period under examination. The entire population was sampled for testing. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	Failed Adv. Notice	% Fail HIPAA	% Fail Ohio	% Fail Adv. Notice
94	7	13	62	7%	14%	66%

Issue No. 1 – Determination of student status

For one Rescission file, the applicant for a Student Select Certificate did not check either the "Yes" or "No" box on the application where it asked if the applicant was a full-time student. There is no indication that the Company called her at the time of application to determine her student status. She did not make a false statement during submission of the application, or a willfully false statement. In addition, she did not commit fraud. Therefore, the Company rescinded this individual's coverage on the basis of an omission, in violation of R.C. 3923.14. Although the Company indicated the student was carrying 8 credit hours, not the required 9, FIC did not have the legal right to rescind in the absence of a willfully false statement.

It took the Company 15 months to retrospectively determine her eligibility for the plan, during which time the student would have believed she had insurance in effect. At the end of the 15 months, all claims were denied. If the Company had required proof of full-

time status at the time of application, this would not have occurred. This method for verifying initial eligibility takes too long and is unfairly discriminatory.

COMPANY RESPONSE: The Company agrees. We agree this was an isolated incidence that occurred outside of our normal process. It is the Company's current process to contact an applicant in the case of an incomplete application before issuing coverage. The Company sends the applicant a copy of their incomplete application to complete which the applicant must then return by mail before coverage is issued.

Issue No. 2– Rescission of coverage

For another Rescission File, an applicant who had a history of breast implants, 1) thought she felt something unusual in her breast and requested a mammogram; and 2) had a mammogram, which the doctor stated was "normal"; 3) also had what the doctor referred to as dysfunctional uterine bleeding with cyst or polyp. She had a biopsy and was told the biopsy result was normal.

In a letter to the insured, the Company indicated the insured had made misrepresentations that would have affected the issuance of coverage. However, it does not appear that the applicant made willfully false statements to obtain acceptance of coverage. Therefore, it appears the Company has not acted in compliance with R.C. 3923.14. The applicant did not misrepresent what she believed was her health history.

1) The Company indicated the applicant misrepresented question 18L. Question 18L stated, "Tumor cyst or growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date." The applicant had a mammogram because she thought there *may be* a problem. She was told in part, "No mammographic abnormality found **Patient advised mammogram is normal**." Therefore, the applicant answered this question without a willfully false misstatement. In addition, the Company indicated the insured should have had a rider (Rider 157) added to her coverage. The Company has the right to underwrite and Rider coverage in Ohio when applicable. However, it does not have the right to underwrite a condition that does not exist. Since the applicant did not have an abnormal mammogram prior to the effective date of coverage, it was a violation of R.C. 3923.57 to offer the Rider.

2) The applicant had a cyst or polyp, and there appeared to be dysfunctional uterine bleeding more than a year prior to signing the application. Therefore, the applicant had a biopsy at the recommendation of her doctor. The biopsy result was ***normal.*** How does an applicant make a willfully false statement when a doctor tells her the condition is normal? The Company has indicated the applicant misrepresented question 18N1. Question 18N1 stated, "Any disorder of the reproductive organs, including but not limited to disorders of the penis, testes, vagina, ovaries and cervix, uterus, diagnosed or treated for infertility or irregular menstruation." The Company must believe that the applicant understood she had a "disorder of the vagina or uterus," in order to validate a rescission. The polyp was removed and the doctor told her it was normal, and she had not had further contact with her doctor for this condition. However, she had had irregular menstruation (although the insured may have thought this was cured by the polyp

removal). Therefore, it appears that the Company could have chosen to rider this condition.

R.C. 3923.57 provides in part, ". . . every individual policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state is subject to the following conditions, as applicable:

(A) Pre-existing conditions provisions shall not exclude or limit coverage for a period beyond twelve months . . . and may only relate to conditions during the six months immediately preceding the effective date of coverage."

COMPANY RESPONSE:

1) The Company disagrees. Question 18.l on the application for insurance reads as follows:

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYISICIAN CONCERNING: . . .

l) Tumor, cyst, growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date."

The response on the application, which was signed 5/3/04, was "no". The chronology of events reflected in the medical records is as follows:

4/12/04: Insured calls provider, indicating "left breast tenderness" and requesting that a scheduled mammogram be rescheduled earlier.
4/28/04: Insured sees physician for complaints of breast tenderness "this month" and question is referred for a questionable mass on the left breast. The office notes indicate "? bumps behind nipple".
5/3/04: Insured completes application for insurance and indicates "no" in response to question 18.l).
5/17/05: Bilateral diagnostic mammogram with spot compression: scattered densities are present in both breasts.

These records establish that the insured consulted with a physician immediately prior to completing the application for insurance for a "breast disorder". That subsequent testing established no mass in the breast does not alter the fact that the applicant knowingly misrepresented her response to the question on the application. The insured was sufficiently alarmed by the symptoms to request a rescheduling of a diagnostic test, which establishes she had knowledge of the condition and knew the response to question18l was false.

2) The Company disagrees. Upon review of the above medical history, we applied the underwriting guidelines that we would have utilized had the information been disclosed during the application process. The underwriting guidelines for "lumps,

masses, cysts, densities, calcifications, or nodules found by exam or mammogram that are benign" specify application of Rider #157. The company was not afforded the opportunity to consider the mammogram results, even though the proximity of the test placed it between the application for insurance and the issuance of coverage (at the specific request of the insured). Had we known the test was performed, we would have postponed issuance until all information was provided.

3) The Company disagrees. The application for insurance, signed 5/3/04, contained the following question:

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*: . . . .

n) 1. Any disorder of the reproductive organs, including but not limited to disorders of the penis, testes, vagina, ovaries and cervix, uterus, diagnosed or treated for infertility or irregular menstruation?

The applicant responded "no" to this question. However, medical records contained in the file indicate the following history:

2/25/03: Dysfunctional uterine bleeding; pelvic ultra sound completed. Impression: Nabothian type paracervical cyst; endometrial echo complex upper range of normal at 1.4 cm for premenopausal patient; 2.0 cm simple left adnexal cyst.
3/13/03: Patient notified of the results of the 2/25/03 exam; notified of need for endometrium biopsy.
6/9/03: EMB (endometrium biopsy) performed
6/13/03: results received at . . . ; no evidence of malignancy identified. This record contains a note reading: "6/16/03 pt aware dc".

These medical records document that the patient had diagnosis and consultation with a physician regarding a disorder of the reproductive organs, as described in the question on the application. In addition, the records specifically note the insured had knowledge of the condition. The "no" response to the question was therefore willfully false.

As a result of these findings, and consistent with our underwriting guidelines, the coverage was reformed and the insured was required to acknowledge and accept the placement of exclusion rider #134, excluding coverage for "Menstrual disorders, including diagnostic procedures, treatment, surgery or complications thereof."

Please note that coverage was not initially rescinded but rather reformed. The insured had the option to retain coverage in force with signed acceptance of the two exclusion riders noted above. Coverage was rescinded only upon the refusal of the insured to accept the reformed health plan.

We maintain that the rescission of coverage in this case was in compliance with Section 3923.14 of the Ohio Revised Code. We are only able to evaluate the information that is provided at the time of the application. Further, these false statements materially affected the acceptance of the risk. Had we been aware of this information at the time of application, coverage would have been offered with the exclusion riders for the conditions not disclosed on the application for insurance. The medical records noted above establish that the insured was an active participant in her health care treatment and clearly document an awareness of conditions not disclosed in response to direct questions on the application. Because the applicant knew her answers were false, they were willfully and fraudulently made. Prudential Ins. Co. v. Car, 199 N.E.2d 412 (Ohio Com.Pl. 1964).

EXAMINER RESPONSE: The insured's visit to the doctor, which generated the Company's "claim investigation," was for a biopsy of her thyroid (a gland located at the base of the neck). The claim was not associated with lumps in her breasts or her reproductive organs.

The Company may have had the right to rider the previous history of abnormal uterine bleeding, which appeared to be caused by a cyst. If the removal of the cyst alleviated the bleeding problem the applicant had no reason to believe she had a disorder of her reproductive organs. The applicant thought she felt a lump in her breast, and as a prudent person, she had testing to determine if there was an abnormality in her breast. The testing was completed between the time of signing the application and the effective date of coverage. However, testing revealed no evidence of abnormal tissue in her breast. Therefore, she provided truthful information about this condition, and as such, the Company did not have the legal right to provide a rider for this condition. Therefore, the rescission was completed in violation of R.C. 3923.14.

The proposed reformation of the contract (mandatory acceptance of riders) was a violation of R.C. 3923.57(C)(1) and (2), Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. In addition, her claims were denied in violation of Ohio Adm.Code 3901-1-07(C)(1) and (10).

The file was failed as indicated above, and it was also failed because the applicant appeared to be a federally eligible individual at the time of application, in which case she could have been issued coverage without any pre-existing conditions limitations. The Company did not make the determination of her eligibility that is required by R. C. 3923.581. None of the files tested during the FIC examination indicated the Company was complying with the provisions of R.C. 3923.581.

Issue No. 3 – Rescission of Coverage

For another Rescission File, the applicant told his agent (confirmed by the agent) that he had a history of elevated cholesterol test results in the past. The applicant also told his agent he had been losing weight and exercising, and had changed his diet to lower his

cholesterol. However, there was no mention of current medication for elevated cholesterol, and none of the doctors' records ***indicated current medication.***

The insured/applicant retained legal counsel, who indicated that the Company could not prove the insured's intent to misrepresent the facts. The attorney stated in part, "ORC § 3923.14 . . . false statement . . . cannot even be used at trial unless it is 'clearly proved such statement is willfully false and that it was fraudulently made'. In this case, (the insured) informed your agent that he had been diagnosed with high cholesterol previously. Thus, he never made a false statement, much less willfully so . . ."

Therefore, the insured's coverage was rescinded in violation of R.C. 3923.14. It is noted that the Company reversed its decision to rescind after the attorney became involved. However, an individual should not have to bear the additional cost of an attorney unless the Company can prove that the individual's coverage is being rescinded because he/she made a false statement that was willfully or fraudulently made to obtain health insurance coverage. The insured had other health coverage in effect at the time of application.

COMPANY RESPONSE: The Company disagrees. The applicant completed and signed the application for insurance on 7/1/02. The application included responses to questions 18B, 22 and 24, to which the applicant responded "no".

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, OR CONSULTED WITH A PHYISICIAN CONCERNING: . . . .

b) The heart or circulatory system including but not limited to high bleed (sic) pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis, or elevated cholesterol? (provide last blood pressure reading and cholesterol level if known)

22. Had surgery or diagnostic testing, treatment or surgery been recommended or scheduled that has not been completed?

24. Had an electrocardiogram, chest x-ray, or blood test or any other diagnostic testing of any kind or been hospital confined in the past 10 years? If yes, give name of physician or hospital and results.

The examiner's statement that 'none of the doctor's records indicate current medication' is incorrect. Medical records for the insured established long-standing treatment for hypercholesterolemia beginning with the first dated note of 9/25/98 indicating "stop Lipitor – start Tricor . . . rev lipid/liver in 6 months". Succeeding notes dated 2/12/99, 3/15/99, 2/29/00 and 6/26/03 (date of application 7/1/03) in the physicians progress record references lipid panels, the need for 6-month follow-up testing and/or continued prescription medication Tricor. The notes for 6/26/03 read: "rev L/L in 2 months".

These records demonstrate that the "no" responses to questions 18.b), 22 and 24 of the application for insurance were false statements, the false statements were willfully made,

they materially affected our acceptance of the risk posed, and that coverage would not have been issued had the true facts been known. Accordingly, we notified the insured on July 8, 2004 of our intention to rescind coverage.

Subsequent to our actions, we received an appeal from the insured's attorney alleging that the insured had disclosed his condition to the agent that took the application for insurance. We requested and received a statement from the agent dated 10/31/04. In that statement, the agent indicates: "[The applicant] told me at one time he knew his cholesterol was elevated some. He informed me he simply changed his diet, started walking and lost some weight. He said he had it checked and it was alright. I asked him if he was ever medicated for this problem, he said no. . . [The applicant's] attorney would indicate that I had COMPLETE knowledge of [the applicant's] cholesterol problem. Obviously, I did not!"

A follow-up letter from the applicant's attorney dated 12/30/04 contained a second statement from the agent, dated 11/20/04, which stated: ". . .I completed the application form for [the applicant] and during that conversation with [the applicant] he told me he had an elevated cholesterol test in the past. . . No mention was made of [the applicant's] ever having been prescribed any medication for elevated cholesterol . . . ."

Because there were conflicts in the two statements from the agent regarding discussion of medication, we overturned our original determination and reinstated coverage, which remains in effect as of this date. However, we maintain that our actions were made in good faith, based on objective information that, when compared with the attested responses on the application for insurance, demonstrated willfully false statements made fraudulently.

We would further note that the applicant's attorney at no time challenged or contested our findings that the applicant's responses to questions 22 and 24 were anything but false statements, willfully made and that, except for such false statements, we would not have issued coverage.

EXAMINER RESPONSE: The attorney did not have to argue those points because the applicant had provided the information to the agent; and as an agent of the Company that information is deemed provided to the Company. The agent told the Company that he asked about medication, and he told the attorney there was no mention of medication. An individual cannot be aware of elevated cholesterol, and be taking medication for cholesterol without medical testing. He had been tested for cholesterol and had been taking medication. The Company's initial rescission of coverage was in violation of R.C. 3923.14, because the elevated cholesterol had been disclosed by the applicant.

The insured's first visit to the doctor after the effective date of coverage was due to a myocardial infarction.

The file was failed for the reasons indicated above. It was also failed because the applicant appeared to be a federally eligible individual at the time of application, in

which case she could have been issued coverage without any pre-existing conditions limitations. The Company did not make the determination of eligibility that is required by R. C. 3923.581.

Issue No. 4 – Rescission of coverage

One Rescission File indicated the insured/applicant's coverage was rescinded after the Company discovered that the applicant had not disclosed on the application that she had had an ultrasound when she was pregnant, which indicated that there was evidence of cholelithaisis. The diagnosis stated "maternal gallstones are noted with right sided hydronephrosis."

The Company sent the insured a letter, which indicated the insured would lose her preferred rates and had to accept an exclusionary rider for, "Gallbladder stones, including any diagnostic procedures, treatment, surgery or complications thereof," if coverage was to continue. The insured did not accept the rider, which would have eliminated coverage for her gallbladder surgery.

The insured wrote to the Company, indicating she had no knowledge of an ultrasound showing gallstones. The Company accepted the insured's appeal, but maintained the necessity of the rider and the removal of preferred rates. The Company received a fax from the insured, with a letter from the insured's doctor. The insured reiterated that her doctor never told her about the gallbladder stones. In addition, the doctor stated that his records did not indicate that he ever told the insured about the gallbladder stones, and this may be because she did not have symptoms and the ultrasound was due to a pregnancy. The doctor stated in part, "It is entirely possible that I did not mention the gallstones to this patient. . . . I think it is likely that she had no knowledge of the presence of gallstones. In any case, had she known that she had gallstones she surely would have mentioned this to the emergency room doctor when she was in pain."

The Company overturned its decision to rescind the policy. However, the notes in the file state, "1-21-04 Committee decision is to overturn & offer with a rider need to do special letter to indicate our reason – Although she didn't intend to misrep, the history existed and had we known, we would've ridered." A letter sent to the insured, stated in part, "Your doctor states that it is his practice to inform his patients of such findings and your medical records show the existence of the gallstones on an ultrasound done prior to the application for coverage. In keeping with Fortis Insurance Company medical underwriting guidelines, an exclusion rider would have been necessary and placed on the policy at the time of issue in order to bring the scope of your coverage in line with the preferred rate that you received based on your application responses and the corresponding risk of loss that we intended to assume based on your application. Review of this file indicated that our actions, resulting in the reformation have been handled appropriately and are in compliance with our underwriting guidelines and procedures."

The Company's underwriting procedures have no bearing on whether the applicant made a willfully false statement in order to gain coverage. For the reasons explained previously, an insurer is never allowed to add a rider retrospectively unless it has the right

to rescind that contract. To apply a rider and delete preferred rates on the basis of information that comes to light after the certificate was issued, but which was unknown to both the applicant and the insurer at the time of application is unfairly discriminatory. Every time the Company has applied this business practice, it has acted in violation of R.C. 3901.21(M).

The business of insurance is to accept risk(s) that are unknown, in exchange for premium. Once an offer is made and accepted, the contract is valid. Neither party can change a health insurance contract without the other party's consent, or unless mandated to do so. In this case, there were no willfully false statements, or fraudulent statements made by the insured. In addition, the applicant did not make an intentional misrepresentation of a material fact. Therefore, the insured's coverage could not be terminated, and should have continued as issued, and as guaranteed by state and federal guaranteed availability statutes and regulation.

The Company acknowledged it did not have the right under R.C. 3923.14 to rescind coverage. The appeal recommendation stated in part, "Given the fact that . . . may not have reported the history of gallstones, the fact that there is no evidence of symptomology prior to the application, the fact that claims associated w/the ER visit support . . . . assertion that . . . had no knowledge of gallstones when evaluated and the fact that OH is an intent state, I would recommend overturning the reformation & rescission of coverage. . . . Would offer to reinstate as of the effective date, provided the premium is returned."

The Company should have reinstated the coverage by indicating that coverage was back in effect as issued, and informed the insured that premium for the period of coverage (from issue date to rescinded date) had to be returned to the Company.

COMPANY RESPONSE: The Company agrees. We respectfully maintain that our rescission process is in compliance with Ohio law. If an insured makes a misstatement on the application for insurance, we have the opportunity to issue a rider so as not to rescind coverage. **However, in this specific case, the Company agrees that it cannot establish that the insured had knowledge of the condition when completing the application for insurance.** Further, because this is a policy from 2003, we decline to take any further action regarding this policy.

EXAMINER RESPONSE: The insured illegally lost coverage for gallstone surgery, emergency visits, office visits, and medications, etc. The Company should find a remedy for the claims which were denied in violation of R.C. 3901.21.

Issue No. 5 – Rescission of coverage

Testing of rescission letters mailed to insureds indicated that 61 of the 94 letters provided the specific reason for its adverse underwriting decision as "material misrepresentation." For another file, the Company failed to provide an adverse underwriting decision letter or could not locate the letter. Therefore, 62 of the files were failed because the letters were issued in violation of R.C. 3904.01(A)(2).

The letters (notices) did not provide the applicants with the specific reason(s) for the rescission. The letters indicated the applicant had made a material misrepresentation or just a misrepresentation without any further detail or information (other than to indicate that questions were answered incorrectly on the application). In order to rescind, the applicant must have provided a false statement that was willfully false, or was fraudulently made, and that would have resulted in non-issuance of coverage in its current form or at all.

R.C. 3904.01 (A)(2) provides in part, "Notwithstanding division (A)(1) of this section, none of the following actions is an adverse underwriting decision, but the insurance institution or agent responsible for their occurrence shall nevertheless provide the applicant or policyholder with the ***specific reason or reasons*** for their occurrence: . . . .

(c) The rescission of a policy"

COMPANY RESPONSE: The Company disagrees. The letters cited by the examiner do not indicate the applicants made a misstatement. The April 8, 2004 letter to this insured included the names of the providers that supplied the information upon which the determination was based, added that the information "was not reported on the Application/Enrollment Form of Insurance, dated 04/14/2003, a copy of which is included in the policy." Further, the letter notes the "information is material, and had we known about it at the time the application/enrollment form was processed, we would not have issued coverage. We plan to rescind you (sic) policy based on misrepresentations of questions 1 and 18H." Finally, the letter provides 15 days for the insured to contest or provide further explanation of the information reviewed and invites questions and/or comments.

The letter contained in this file is a form letter, and the information is replicated, as appropriate, in the other files referenced by the examiner. It is our position that the information in the letters complies with the requirements of Section 3904.10 of the Ohio Revised Code in that it provides the specific reason for the adverse determination (material misrepresentation) and provides the insured with notice that additional information is available upon request.

Please note that the remarks from the Company cited by the examiner "in two previous responses" were in reference to a different form letter that was in use for declinations, rating determinations, or an offer the (sic) included placement of an exception rider. These letters inappropriately noted only "confidential information" as the reason for the adverse determination. Letters notifying insured's of our intent to rescind have not included this language and therefore were not included in our reference to corrections to adverse underwriting notices. As noted above, we maintain that the "notice of rescission" letters meet the requirements of the statute.

EXAMINER RESPONSE: The correct reason for the applicant's/insured's rescission of coverage was due to medical history that was not disclosed at the time of application. Therefore, it appears the Company must be able to prove that it would not have granted

coverage based on the Company's medical guidelines that would not allow for such coverage to be issued because of the disease(s) or medical condition(s) that was not disclosed. The adverse notice requirement of R.C. 3923.01 requires an insurer to inform the applicant of the ***reasons*** for a rescission and why the applicant/insured would not have been granted coverage due to the specific medical condition(s) or disease(s).

Furthermore, every file that was passed during testing of the adverse notices was for an applicant/insured who was notified of his or her actual condition in the reformation of coverage letter indicating that the insured would have to accept a medical exclusionary rider for the condition(s) or disease(s), or coverage would be rescinded. In addition, the Company has agreed that when an applicant is declined coverage, the applicant should be informed of the medical conditions which affected the non-acceptance of the risk. Both R.C. 3923.10 and R.C. 3923.01 indicate that the ***"specific reason or reasons"*** must be presented to the applicant/insured. In the case of a rescinded policy/certificate holder there are specific ***reasons***. The Company should state that the coverage was rescinded for a willfully false statement or fraud, due to a response(s) provided on the application, and be specific as to the condition(s) or disease(s) that was not disclosed, and which proves that the answers on the application were false or fraudulent.

Issue No. 6 – Rescission of coverage

For one file, the Company supplied the application but could not produce the medical records. Therefore, the underwriter's documentation was the only medical information available for testing. Therefore, the Company was failed for not providing a file in its entirety.

Furthermore, from the underwriter's documentation, it did not appear the applicant made a false statement on the application. The applicant indicated her doctor was . . . and the Company indicated that the information in . . . records was used for the rescission. Therefore, it does not appear that the insured hid medical information from the Company.

The Company indicated the insured had neck, shoulder and hand pain with numbness during 1995. The doctor's impression (not diagnosis) is DJD C spine. She did not see a doctor again until 1999, when she complained of neck pain radiating into shoulders and arms. The patient did not appear to have recurrent problems with this pain when the application was submitted to FIC. It does not appear that an individual would understand that she had a back or spinal disorder when she had only been to the doctor twice in seven years and had not taken medication for her back. She did take medications for bone spurs in 1995, but nothing since.

The insured had a needle localized breast biopsy in 1997. The biopsy revealed no problems with the insured's tissue. The Company indicated the applicant should have answered "yes" to question 18L, "Tumor, cyst or growth of any kind; any breast or skin disorders? Provide location, state if treated or removed and date." The applicant would not answer "yes" because there was only testing, no tumor or cyst, and no treatment or removal. She had "microcalcifications." Taber's medical dictionary defines calcifications as tissue which is hardened by the deposition of lime scales in the tissue.

The doctor noted at first that they were suspicious, nothing more, and testing indicated no problem. The applicant did not make a false statement in connection with her answer, and therefore, she did not make a willfully false statement concerning the biopsy in connection with obtaining coverage.

In a letter provided to the applicant/insured, the Company stated the applicant made misstatements on questions #s 18A, 18I, 18L and 24. She answered question #24, "yes." Therefore, it is not understood why FIC indicated this was answered incorrectly. It does not appear that the applicant falsely answered questions 18I or 18L as indicated above. It does appear that she should have answered question #18A as "yes." Her doctor indicated an impression of asthmatic bronchitis with *nebulizer* use during January, 1999. There had been no treatment for bronchitis from this time until the application date, and the applicant had other insurance at the time of application, and told the Company who her doctor was on the application. Therefore, all this information was available to the Company at the time of application. There was no "intent" on the part of the applicant to hide her medical history from FIC. However, it did appear the Company could have placed a rider (reformed coverage) on her coverage for her bronchitis.

COMPANY RESPONSE: The Company disagrees. The insured signed the application for insurance on 9/25/02 and completed the Personal Health History Interview (PHHI) on 9/27/02. Among the questions requiring response during the PHHI was question 18.a):

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*:

a) The lungs or respiratory system including but not limited to hay fever or other allergies, sinus infections, asthma, bronchitis, tuberculosis, pneumonia or emphysema?

The applicant responded "no". However, medical records subsequently received and reviewed revealed that the applicant was seen multiple times in 1999 by . . . for a continuing cough, for which the physician's impression was "acute bronchitis" and "asthmatic bronchitis". He further notes that use of a nebulizer was not providing relief. These records document that the insured should have responded "yes" to question 18.a) and, furthermore, that the "no" response was a false statement, a knowingly and fraudulent false statement. Had this information been disclosed during the PHHI, we would have obtained an Attending Physician's Statement (APS) to verify the diagnosis, the symptoms, the frequency and duration of attacks, the date of the last attack, the treatment given and the prognosis. The APS could have materially affected whether coverage could be issued or not. Because the records document recurrent diagnoses of "bronchitis", "acute tracheo bronchitis" and "asthmatic bronchitis" over a 4 year period, this would be determined to be chronic and declinable under our guidelines as chronic obstructive pulmonary disease.

Also among the questions requiring response was question 18.i):

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*: . . . .

i) The muscular, skeletal or connective tissue disorder including but not limited to arthritis, lupus (SLE) temporomandibular joint disease (TMJ), any back or spine disorder or treatment of any muscular or neuromuscular disorder or any manipulation therapy?

The applicant responded "no". However, the medical records from . . . relate five separate office visits documenting neck, shoulder, wrist and back pain, bone spurs, with impressions listed by the physician as "DJD C Spine, sprain neck and shoulders. . ." The records also note the applicant had ceased wearing a wrist splint because it provided no relief. These records document that the "no" response to question 18.i) was a willfully false statement. Had this history been disclosed, coverage would have been issued with an exclusion rider for osteoarthritis.

Also among the questions requiring response was question 18.l):

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*: . . . .

l. Tumor, cyst or growth of any kind, any breast or skin disorders? Provide location, state if treated or removed and date.

The applicant responded "no". However, the medical records reviewed from . . . reveal the following:

2/97: Discussed mammo results. Mult areas of asymmetry that require magnifying views.
4/97: Discussed add'l mammo views. Suspicious microcalcifications L breast.
5/97: PATHOLOGY: periductal fibroplasia w/ focal duct dilation and cystic change.

These records document that the insured's "no" response was a false statement and that she had discussed breast disorders with her provider. Had we been aware of this history at the time of application, we would have issued coverage with a rider excluding treatment for "Benign breast conditions including but not limited to fibroadenoma, cyst, hyperplasia, dysplasia, fibrocystic disease, mass, scar, papillomatosis, intraductal papilloma, mastitis, sclerosing adenosis, fat necrosis and any diagnostic procedures, treatment, surgery or complications thereof."

In Ohio, riders must be condition specific. Had we been aware of the asthmatic bronchitis (which would have applied the underwriting guidelines for COPD), cervical degenerative disc disease, continued pain and calcifications of the left breast, we would not have been able to extend an offer of coverage.

We maintain that the rescission of coverage in this case was in compliance with Section 3923.14 of the Ohio Revised Code. We are only able to evaluate the information that is provided at the time of the application. Further, the false statements detailed above materially affected the acceptance of the risk. Had we been aware of this information at the time of application, coverage would not have been offered. The medical records noted above establish that the insured was an active participant in her health care treatment and clearly document an awareness of conditions not disclosed in response to direct questions on the application. Because the applicant knew her answers were false, they were willfully and fraudulently made. Prudential Ins. Co. v. Car, 199 N.E.2d 412 (Ohio Com.Pl. 1964).

EXAMINER RESPONSE: This file was failed for two reasons, 1) the Company could not produce the medical records used by the underwriter to rescind coverage, and therefore, it is unknown what other information was documented by the doctor, other than what was stated in the underwriter's notes. 2) The Company appeared to have the right to add a rider for asthmatic bronchitis. There was not a valid reason for the applicant to answer yes to Question #18l. She had a breast biopsy, which revealed lime deposits, not a tumor, cyst or growth of the breast. Therefore, she truthfully and correctly answered question #18l.

It is agreed that the Company could have requested reformation based on the medical history of bronchitis. Additionally, the insured would have had a consultation about the possibility of DDD/DJD, if the Company's presentation of the medical information was accurate. There was no diagnosis of DDD/DJD, and the last time it was mentioned was 1999 and there was no medication mentioned. The lack of information from the applicant for DDD/DJD and bronchitis appears to be reasons for reformation of coverage (per the Company's procedures), not rescind reasons to rescind coverage. Therefore, the insured/applicant's coverage was rescinded in violation of R.C. 3923.14.

Issue No. 7 – Rescission of coverage

The Company sent a letter to the applicant/insured indicating there were misstatements on question #1 and 18C. The insured answered question #18C, "yes," and indicated on the application that she had stomach pain. She was given medication for GERD from 1999 through 2002. She was not medicated at the time of application. In addition, she provided the name of the doctor who treated her for GERD. The doctor's notes state in part, "Probably GERD," Will need to rule out gallbladder . . . stomach problems improved." She did not provide a false statement on the application. She in fact had stomach pain as indicated on the application, and as indicated by the doctor.

The applicant also indicated on the application that she weighed 175 pounds. The Company indicated, and the doctor's notes indicated, that the insured weighed 196

pounds on 7/14/2003. The insured signed the application 6/11/03. She also weighed 196 pounds on 9/17/01. However, everyone's weight fluctuates from time to time. Furthermore, the insured provided the name of the doctor who recorded her weight her on the application. Therefore, she did not hide her weight, and the Company cannot provide evidence the insured made a false statement, or willfully false statement about her weight. The Company should not rescind or reform coverage for a weight differential of less than 10%, unless the Company has an accurate weight on the date of application. Therefore, the Company rescinded the applicant's coverage in violation of R.C. 3923.14.

The Company indicated the applicant would have to accept a rider for GERD (and associated treatments and complications there from), and would have to accept a rate up for build and pay the additional premium for the rate up, or have her coverage rescinded.

An insurer is never allowed to go back and add a rider or request additional premium (except for misstatements about age, occupation, or other insurance) to a policy unless the applicant/insured has committed fraud, or made a willfully false statement for in order to obtain coverage. If adding a rider or requiring additional premium after coverage is issued was an acceptable practice, every insured that had a medical emergency (i.e. heart attack), two or three months after coverage was issued, would be told that he/she should have known that it was coming, and now that the insurer also knows, the insurer could apply a retrospective rider for heart attacks and deny reimbursement of the claim. To apply a rider or request additional premium, due to knowledge an insurer gains after issuance of coverage is unfairly discriminatory (unless there is satisfactory evidence for rescission). Every time the Company has applied this Company business practice, the Company has acted in violation of R.C. 3901.21(M).

COMPANY RESPONSE: The Company disagrees. The application for insurance was signed on 6/11/03, the Personal Health History Interview (PHHI) was conducted on 6/17/03, and the coverage on this plan was issued effective 7/3/03. It is important to note that when applicants complete Part 1 of the application (the portion signed on 6/11/03) they are provided with a copy of the questions they will be asked in the PHHI. This would include basic information such as height and weight.

As the examiner notes, the applicant reported her weight as 175 pounds on 6/17/03. The primary care physician's notes for 9/17/01 list her weight as 196 pounds. A Clinical Polysomnogram Report for testing conducted on 3/10/03 and reported her weight as 214 pounds. Subsequent physician's office notes for 7/14/03 list her weight as 196 pounds. The applicant knew that her weight was not 175 pounds and provided a false statement on the application.

Had we known her true weight, coverage would have been issued with a 35% rating for body build under our underwriting guidelines.

The PHHI requires response to the following question:

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*: . . . .

c) The digestive system including but not limited to ulcer, gastritis, heartburn, intestinal disorder, colitis, gallbladder, hemorrhoids, hernia, disorder of the pancreas, spleen or liver, including but not limited to, hepatitis, jaundice, or cirrhosis?

The applicant responded "yes" to this question. In response to a request for complete details for each "yes" response, the applicant reported the basis for this response to question 18.c) as follows:

Details Question Number: 18C
Person: . . .
Condition: Stomach pain
Dates: 2000 – 08/01
Treatment: Ulcer medication for one year did ultrasound and everything normal no gallbladder problems no symptoms for 1 ½ years.
Results: Full recovery
Doctor Info: Primary Care Dr.

However, the medical records reviewed from her primary care physician reflect GERD, treated with the prescription drug Aciphex beginning 12/31/99 and continuing through refilling the prescription as late as 4/2/02. The applicant new that treatment for the reported condition extended beyond 8/01 and that the characterization of the results as "Full recovery" was a false statement.

Pursuant to our underwriting guidelines, had we known of the use of Aciphex as treatment of this condition to within one year of application, coverage would have been offered with a rider excluding coverage for: "Esophagitis, reflux esophagitis, heartburn, indigestion, gastroesophogeal reflux disease, duodenitis, or hiatal hernia, including any diagnostic procedures, treatment, surgery or complications thereof."

Accordingly, on 10/1/03, we notified the insured that due to material misrepresentation on the application for insurance, we required signed acceptance of amendments of application applying a special class premium of 35% for body build and a Special Exception Rider excluding coverage as described above. The amendment of application was not accepted, and, consequently, on 11/5/03 coverage was rescinded as of the effective date of coverage.

We maintain that the rescission of coverage in this case was in compliance with Section 3923.14 of the Ohio Revised Code. We are only able to evaluate the information that is provided at the time of the application. Further, the false statements detailed above materially affected the acceptance of the risk. Had we been aware of this information at the time of application, coverage would have been offered with a special class premium

of 35% and a Special Exception Rider. The medical records noted above establish that the insured was an active participant in her health care treatment and clearly document an awareness of conditions not disclosed in response to direct questions on the application. Because the applicant knew her answers were false, they were willfully and fraudulently made. Prudential Ins. Co. v. Car, 199 N.E.2d 412 (Ohio Com.Pl. 1964).

EXAMINER RESPONSE: The applicant's first visit to the doctor, which instigated the review of medical records was for a blood test (not associated with stomach pain). She disclosed her stomach pain to the Company and records were available for review in association with the stomach pain. She told the Company the stomach pain was caused by an ulcer, which was treated. An ultrasound was performed and the result was "normal." Therefore, she did not provide a willfully false statement about the medical condition. Everyone's weight can fluctuate. It is possible that she was close to the actual weight disclosed on the application at the time of application. Therefore, neither medical reason for reformation was valid, and the Company rescinded coverage in violation of 3923.14, and attempted reformation in violation of R.C. 3923.57(C)(1) and (2), Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. Therefore, her claims were denied in violation of Ohio Adm.Code 3901-1-7 (C) (1) and (10).

The file was failed as indicated above, and it was also failed because the applicant appeared to be a federally eligible individual at the time of application in which case she could have been issued coverage without any pre-existing conditions limitations. The Company did not make the determination of federal eligibility, which is required for compliance with R. C. 3923.581.

Issue No. 8 – Rescission of coverage

A letter to the applicant/insured indicated she had answered question #18b, 24 and 18i incorrectly. She had an EKG, and the result was "normal." An application question asks if the applicant had a diagnosis, treatment or consulted with a physician about heart or circulatory system including high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol. She told the doctor her heart was racing from stress. However, the EKG readings were normal. An applicant would not provide an insurer with information concerning a medical condition she does not believe that she has. The doctor submitted a letter to FIC during the insured's appeal, which stated, "The EKG was normal except for a heart rate of 59, and her comprehensive blood profile, which included thyroid function, was also normal. She did not have her echocardiogram for financial reasons. I saw . . . in follow-up on January 29, 2002. Her palpitations were gone and she explained how stressful her life was. I made a decision, the echocardiogram was not needed as all this information to date was sufficient to diagnose her heart palpitations secondary to stress. I reassured . . . and it was decided not to proceed further unless other circumstances warranted it. She has not had any problems with her heart palpitations since that time." The doctor indicated that stress appeared to be the cause, and it appeared the stress was gone, and the EKG was normal. Therefore, with her stress gone, the applicant believed everything was normal when she signed the application.

The insured should have answered "yes" to question 24, because she did have the EKG (diagnostic testing). However, she did not conceal this information, because she provided the name of the doctor associated with those records, on the application, and the Company had access to the records at the time of application. Therefore, it does not appear that the insured intended to mislead the Company.

During the appeal process, the FIC Underwriting appeal team recommended a "change in action" to modify its action (rescission) and placed an "X" in the "no" box, **indicating not to maintain the rescission.** The notes from the team stated, "*Regarding the back and anxiety: the records and the client's recent TVRS seem to verify that history. I don't see that we would have taken any action on either issue. In the case of the palpitations, the client did have a normal EKG. Bardycardia is mentioned on the EKG and the Dr. alludes to that when he states the heart is 59. Per our own guidelines, that rate is in the standard category. I believe that a strong enough case has been presented and no action should be taken."*

These findings were sent to the medical review team. The FIC medical review team stated, "Would rescind, would not take any action on the knee or shoulder. However, the palpitations are worrisome as new onset at age 55 & they were recurrent as they were noted again in 3/02 which the MD letter does not address. Would maintain decline as a complete work up was not done." However, the insured's doctor was satisfied with the information concerning her condition, and indicated it was simply stress related. The visit to the doctor on 3/02 was for a viral infection.

The Company's appeal committee made the argument that the certificate/policy should not have been rescinded. Therefore, it was not reasonable to expect the insured to understand that she was providing a willfully false misstatement at the time of application, if the Company did not agree that she provided information in that manner. The Company did not provide evidence that the insured made a willfully false statement to obtain coverage, or committed fraud. Therefore, the Company rescinded the applicant's coverage in violation of R.C. 3923.14.

The insured's first visit to the doctor after coverage commenced, was 10 months after the effective date and was for a colonoscopy, which was not related to the medical conditions referenced for the rescission of coverage.

COMPANY RESPONSE: The Company disagrees. The application for insurance was signed on 4/9/03 and coverage was issued effective 6/20/03. Among the questions requiring response on the application was 18.b):

WITHIN THE LAST 10 YEARS HAS ANY PROPOSED INSURED:

18. HAD ANY DIAGNOSIS, RECEIVED TREATMENT FOR, *OR CONSULTED WITH A PHYISICIAN CONCERNING*: . . . .

b) The heart or circulatory system including but not limited to high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or elevated cholesterol? (Provide last blood pressure reading and cholesterol level, if known).

The applicant responded "no". However, review of medical records from . . . revealed that on 1/9/02, the applicant was seen for complaints of "months irregular heart beats; 'hard' heart beats". The diagnosis, following an EKG, was cardiac arrhythmia, bradycardia with a recommendation to schedule an echocardiogram. The echocardiogram was not completed due to expense. On 3/19/02, the applicant was seen for complaints of "pain L chest radiating into back on & off x 3 weeks" and "heart racing at times x 2 days". The records demonstrate that the applicant had knowledge of the conditions noted above, sought and received medical advice and treatment, and knowingly answered question 18.b) falsely.

Had we been aware of this history at the time of application, coverage would not have been issued. Evaluation of the symptoms reported above was never completed. The physician, in a letter to the company, does not address the complaints and symptoms noted on the 3/19/02. The examiner correctly cites the results of our appeal review, wherein we reversed determinations regarding other conditions on appeal but maintained that the knowingly false response to question 18.b) warranted rescission of coverage. As our medical team noted in review of the appeal, we would have declined an applicant with this history, absent a complete work-up for the heart symptoms.

We maintain that the rescission of coverage in this case was in compliance with Section 3923.14 of the Ohio Revised Code. We are only able to evaluate the information that is provided at the time of the application. Further, the false statements detailed above materially affected the acceptance of the risk. Had we been aware of this information at the time of application, coverage would not have been offered. The medical records noted above establish that the insured was an active participant in her health care treatment and clearly document an awareness of conditions or symptoms not disclosed in response to direct questions on the application. Because the applicant knew her answers were false, they were willfully and fraudulently made. Prudential Ins. Co. v. Car, 199 N.E.2d 412 (Ohio Com.Pl. 1964).

EXAMINER RESPONSE: The Company's personnel could not agree that the insured/applicant's coverage should be rescinded. That alone should indicate a rescission of coverage was not merited. In addition, the Company cannot expect an applicant to provide information about a medical condition that he/she does not understand to be a medical condition.

The agent wrote to the Company and stated in part, ". . . The incident you are talking about was a non-factor in her health; she needed no follow-up and was diagnosed as stress. . . . needs to have all the information you have that caused you to make a decision. . . . We know you made an error in this case. Please correct the problem before legal action is taken against Fortis . . ." The doctor's letter stated in part, " . . . was seen . . . for

symptoms of heart palpitations. . . . She had not chest pain or SOB or dizziness. Her physical exam for the cardiorespiratory . . . . The EKG was normal except for a heart rate of 59, and her comprehensive blood profile, which included thyroid function, was normal. . . . I saw . . . in follow-up . . . Her palpitations were gone and she explained how stressful her life was. I made a decision, the echocardiogram was not needed as all this information to date was sufficient to diagnose her heart palpitations secondary to stress. I assured . . . and it was decided not to proceed further unless other circumstances warranted it." The doctor clearly stated that he told her she was fine and her problems were secondary to stress and she did not need further testing.

She *had* had a diagnostic test. Therefore, she made a misstatement. However, it was not material to the coverage. Therefore, the Company rescinded coverage in violation of R.C. 3923.14. The Appeal committee's conclusion stated, "***Per our own guidelines, that rate is a standard category. I believe that a strong enough case has been presented and no action should be taken."***

CLAIMS PAID AND DENIED

The Company was requested to provide information about its claims processing. The Company stated, "*There are no differences in the processing of an electronic claim versus a paper claim for either FIC or JALIC."* In addition the Company stated, "*Each of the three Assurant Health companies provides PPO coverage through contractual arrangements with established provider networks. We do not maintain any direct contractual relationships with medical providers."*

The Company was also asked to describe its method by which receipt dates are determined for re-pricing network claims verse non-network claims. The Company stated, "*The received date for all claims, whether repriced or not, is the date that they are* ***received by Assurant Health and John Alden***." In addition, the Company stated, *"Interest is paid on claims that are processed in excess of the time frames provided in Ohio law."*

By the Company's own admission it does not properly count the 30 days to provide claims payments or deny claims in compliance with R.C. 3901.381(B). An insurer must begin to count the days to adjudicate claims from the earlier of the date the insurer or its network receives the claims, including time to re-price claims with its networks. Furthermore, when claims went to one of its networks first and the Company did not begin its count until the date it received the claim, the Company failed to correctly count the days from receipt. Therefore, when the Company made claims payments within 30 days of its receipt of the claims, but greater than 30 days from the time a network received the claims, the Company violated R.C. 3901.389 for not including interest with payment of the claims.

Claims Paid and Denied Standard #1 **–** *Sample and test Paid Claim files, as determined from CPT codes selected, to determine if breast reconstruction benefits are provided in compliance with WHCRA and Ohio Bulletin 2001-1.*

The Company provided a listing with 402 paid and denied claims with a mastectomy and breast reconstruction procedure code. The denied claims were omitted from this testing. A total of 42 paid mastectomy claims were sampled for testing.

Testing indicated none of the 42 files had a claim associated with the benefits of WHCRA (N/A), therefore, none of the files passed or failed. The failure results of testing are shown in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
42	0	0	0%	0%

Claims Paid and Denied Standard #2 *– Sample and test Denied Claims files, as determined from CPT codes selected, to determine if breast reconstruction benefits are provided in compliance with WHCRA and Ohio Bulletin 2001-1.*

The Company provided a listing with 402 mastectomy and breast reconstruction claims paid and denied. The paid claims were omitted from this testing. A total of 23 denied breast reconstruction claims were sampled for testing.
Testing indicated no files passed, 22 files did not have a claim associated with the benefits of WHCRA (N/A), and one of the files was failed. The failure results are shown in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
23	1	1	4%	4%

Issue No. 1 – WHCRA benefits
One file was failed because a letter issued to an insured indicated the Company only pays for breast reconstruction benefits if the individual had a mastectomy while insured by FIC. This indicates the Company would not pay for breast reconstruction benefits if the insured paid for his/her mastectomy, or if another carrier paid for the mastectomy, both of which are a violation of WHCRA and Ohio Bulletin 2001-1.

WHCRA, at Section 2706 and 2752 of the PHS Act, which further incorporates by reference Section 713 of the Employee Retirement Income Security Act of 1974 (ERISA 713), provides in part:

Sec. 713 Required Coverage for Reconstructive Surgery following Mastectomies.

(a) In General.--A group health plan, and a health insurance issuer providing health insurance coverage in connection with a group health plan, that provides medical and surgical benefits with respect to a mastectomy shall

> provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—

The Company letter stated in part, "The following are not covered under this plan: Charges for Cosmetic Treatment or Surgery and any complications arising from such treatment or surgery, except as provided in the Reconstructive Surgery provision. . . . This does not include charges for Cosmetic Treatment or Surgery that follows the *Medically Necessary surgical removal of all or part of a diseased breast, provided the surgical removal was done while the Covered Person was covered under this plan."*

COMPANY RESPONSE: The Company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy. The plan is currently administered so that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred.

As indicated previously, our administrative practices were in compliance with WHCRA during the time period of the examination. **However, we recognize that our contract language was not in full compliance during the time period of the exam.** We would respectfully note that it is not accurate to conclude from policy language quoted in a letter to an insured (i.e., "provided the surgical removal was done under the this plan") that the company's practices throughout the examination period were not in compliance with the requirements of WHCRA, particularly when the phrase in question has no bearing on the response to the provider that had requested information. Our correspondent was merely working to communicate that the plan language cited specifically excludes coverage for the requested service, a reduction mammoplasty.

EXAMINER RESPONSE: Because there were no violations of the Company's claims practices noted during testing of breast reconstruction claims, it is agreed the letter does not indicate the Company's practice was to deny claims in violation of WHRCA and Bulletin 2001-1 as noted in its contract language. However, it does not matter the intent of the letter, because the content and message to an insured violates WHRCA and Bulletin 2001-1.

The insured was told that breast reconstruction is only available if the mastectomy (breast tissue removal) was completed while covered under her current FIC plan. That restriction in not in compliance with WHCRA. The only criteria for determining whether the benefits of WHCRA apply, is to determine if the insured has a history of a mastectomy.

Claims Paid and Denied Standard #3 - *Sample and test policy/certificate holders denied requests for Pre-Certification of Breast Reconstruction and/or prosthesis to determine if the denial was completed in compliance with WHCRA and Ohio Bulletin 2001-1.*

The Company supplied a Listing of all the policy/certificate holders denied breast reconstruction, breast reduction/mammoplasty, and/or gynecomastia during pre-

authorization. The listing indicated there were eight pre-certification denials during the exam period. All eight files were requested for testing.

The results of the testing indicated none of the eight files contained a request for benefits related to WHCRA. The results of the testing are indicated in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
8	0	0	0%	0%

ASSOCIATIONS

During the period under examination all of the Company's Ohio plans are offered through Associations or Trusts, except for its Short-term medical plan and the Ohio Standard and Basic Plans. All other FIC plans issued a certificate to each of the insureds through a master policy issued to the applicable Association or Trust. Generally testing of this Phase is completed because the Company has an Association or Trust plan and an equivalent plan in the same market, i.e. the Association plan is deemed a group plan, but not an employer group plan, and the other plan is an individual plan. Although both are offered in the individual market, both are not individual plans in the State of Ohio. The Company did not have competing plans; therefore, the Department determined that the Association Phase of the examination was unnecessary for testing.

SUMMARY OF RECOMMENDATIONS

1. The Company should avoid contradictions betweens its individual guide (marketing materials) and underwriting guidelines for cesarean section deliveries. The contradiction made the marketing materials misleading in violation of R.C. 3901.21(B). The Company has updated the agent guide to include specific information regarding maternity coverage per the Department's recommendation. *See Marketing and Sales Standard #1.*

2. The individual guide is misleading in violation of R.C. 3901.21(B), in that it instructs an insured to request adverse underwriting information, and if the information is confidential, the adverse underwriting decision will only be sent to a medical practitioner of the insured's choosing. *The Company agreed by indicating that it will revise its marketing materials and its practices to comport with Ohio statutes. See Marketing and Sales Standard #1.*

3. An insurer is to provide four items during its small group solicitation process in compliance with Public Law 104-191, Part A - Group Market Reforms, Sec. 2713, 45 CFR § 146.160, and R.C. 3924.033. The Company failed to provide one document and therefore, did not supply two of the mandated items. The Company agreed by stating "*While Form 20426 (Rev. 5/2000) was available for use by the sales force in Ohio on the same basis as all other solicitation material, Form 20426 was not consistently utilized in the intended manner. . . . Please note, we will take the necessary steps to remind the sales force to include successor form [Form 20426 (Rev. 12/2004)] with any materials provided to interested employers during the solicitation process." See Marketing and Sales Standard #1.*

4. A Company small group brochure indicated that it can terminate coverage for non-payment of premium at the time it is due. Ohio allows a grace period for employer's to pay premium. Therefore, the statement was misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). *The* Company stated it administratively complies with the law, but would amend the language in the brochure to clarify the termination provision. *See Marketing and Sales Standard #1.*

5. The Company small group brochure indicated the Company could terminate coverage for a material misrepresentation. However, state and federal law guarantee renewability of a group certificate unless there is an intentional misrepresentation of a material fact. Therefore, the brochure was misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should include the word "intentional." The Company stated in part, "*. . . we will amend the language to include "an intentional misrepresentation of a material fact*." *See Marketing and Sales Standard #1.*

6. The Company small group brochure indicated the Company could terminate coverage when a business ceases to operate on a full-time basis. However, state and federal law does not allow this as a valid reason to terminate coverage. Therefore, the brochure was misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should remove the wording from its brochure. The Company stated n part,

"We will amend this language to indicate that termination may occur when a business ceases to operate as a viable business." The Company's attempt to correct the brochure was not valid either, because "non-viability of a business" is not a valid reason for excluding the guaranteed renewability provisions of either state or federal law. *See Marketing and Sales Standard #1.*

7. The Company's small group guide stated that a business must be in existence for a minimum of six months and be a viable business at the time of application. Small employer group coverage is guaranteed issue. Therefore, the business does not have to be in existence for six months, or be a viable business. Therefore, the guide was misleading in violation of R.C. 3901.21(B). The Company stated, "*Agree. Company practice with regard to the 6 month durational requirement found on page 4 of the Agent's Guide has been discontinued and is no longer applied to small employer applicants. We will amend language in the Agent's Guide to reflect this change." See Marketing and Sales Standard #1.*

8. The small group guide stated that a group may be terminated when the number of employees insured in a group is fewer than two persons. This Company procedure and the information in the guide are not allowable in compliance with the guaranteed renewability provisions of state and federal law. Therefore, the guide was misleading in violation of R.C. 3901.21(B). The Company's response stated in part, "*In view of the information noted from the HCFA Bulletin Transmittal No 99-03, we will amend practices to provide termination at the end of the plan year (i.e., the group's renewal date following our determination that they no longer qualify as a small employer."* The Company's response did not indicate that it would correct its termination practices to comply with the requirements of the Bulletin. The Company's termination practices should ensure that all small employer groups that decline to one employee; are not terminated until the first renewal date following the beginning of the new Plan Year. *See Marketing and Sales Standard #1.*

9. The small group guide indicated that guaranteed issue of a small group plan is prohibited when more than 20% of the total employees in the business are on state/federal (COBRA) Continuation. State and federal law provide for guaranteed issue of all small employer groups. Therefore, the Company's practice was not allowable, and the guide was misleading violation of R.C. 3901.21(B). The Company stated in part, *"Agree: We will be taking the necessary corrective action to address this issue. Please note that the information provided . . . found that no groups were declined coverage based on the number of participants on State/Federal Continuation. Consequently, there were no violations of small group guarantee issue requirements resulting from this practice during the examination period." See Marketing and Sales Standard #1.*

10. The Company's small group Ohio variations form failed to provide state continuation when the covered person was total disabled (use of the Company definition of "total disability"); the participating employer was bankrupt; or there was discontinuance of the participating employer's business. None of the three provisions were a permissible reason for denying continuation coverage to terminated employees. Therefore, the form

was misleading violation of R.C. 3901.21(B). The Company indicated it administratively complies with state continuation requirements, and also stated in part, "*We are willing to modify the language to reflect that an employer's coverage will be terminated if the employer is no longer a participating employer under the policy, and we will be taking the necessary corrective action to address this issue." See Marketing and Sales Standard #1*.

11. The Company's small group Ohio variations form failed to provide the employer with the required choice of a waiting period from zero to 90 days. The Form allowed a choice of a 30 or 60 days waiting period only. Therefore, the form is misleading in violation of R.C. 3901.21(B), and should be corrected to meet the requirements of Ohio law. The Company's response stated, "*The Company will amend the 'Small Group Ohio State Variations' to reflect options for waiting periods of 0 and 90 days. See Marketing and Sales Standard #1*.

12. The Company's small group Ohio variations form failed to provide the employer with the required choice of a zero day waiting period. Therefore, the form is misleading violation of R.C. 3901.21(B). The Company's response stated, "*We agree that § 3924.03 (E)(1)(2) permits the employer the option of imposing a waiting period. We also agree that this waiting period, by law, may not be greater than 90 days. However, the statute does not require the insurer to allow the employer the option of picking any waiting period, so long as it is 90 days or less. The law state (sic)'[t]he decision of whether . . . to impose a service waiting period shall be made by the employer.' The insurer merely must present the employer with a waiting period (or choice of waiting periods) that the employer may accept or reject. As a result, we maintain that we are in compliance with §.(sic) 3924.03 (E)(1)(2) of the Ohio Revised Code*." In addition, the Company stated, "*The Underwriting Department refers to the State Grid which reads that 0, 30, 60, or 90-day waiting periods are allowed.*" The Company's response, its procedures, and its grid did not allow the employer to choose from a zero to 90 days waiting period in compliance with Ohio law. *See Marketing and Sales Standard #1*.

13. The small group guide stated that if the husband and wife are both employees of the same business, they must be covered as separate employees for all lines of coverage issued. However, during testing it was noted that this standard was not used for all employer groups. Therefore, the guide was misleading violation of R.C. 3901.21(B). The Company stated in part, "*Agree: We will amend our business practices to ensure consistent application of our treatment of married employees . . . . See Marketing and Sales Standard #1*.

14. The Company's marketing materials did not indicate that life insurance coverage was mandatory for employers that wished to purchase a small group health insurance plan. However, the Company has such a provision. One material indicated that life was "optional," another stated life "may be available," and another stated life may be mandatory. Therefore, the materials were misleading violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2), because to mandate life coverage would be a violation of guaranteed availability of a health plan in the small group market. The Company

indicated during another Phase of the examination that it will discontinue mandatory life coverage in its group certificates. In addition, the Company stated in part. *". . . the Company has elected to change its business practices and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage." See Marketing and Sales Standard #1.*

15. The Company's small group guides stated that an eligible employee is an individual that works 30 hours per week. The Company indicated the Ohio variations form indicated that eligibility was to be based on 25 hours per week in compliance with Ohio law. However, testing of files indicated the Company occasionally used the standard of 30 hours per week for some groups. Therefore, the guide was failed for providing misleading information in violation of R.C. 3901.21(B), which appeared to be incorrectly used by underwriting. The Company disagreed that the advertising materials were incorrect, but agreed it had inappropriately applied a 30 hour work week requirement in some cases. *See Marketing and Sales Standard #1.*

16. The Company's small group guides indicated that maternity coverage was optional for groups of three to nine insured lives, and mandatory for groups of two, or ten or more insured lives. In the small group market, all products that are approved for sale in that market, and that the issuer is actively marketing, must be offered to all small employers applying for a small group plan. Therefore, the guides were misleading violation of R.C. 3901.21(B). The Company should make all products in the small group market available to all small groups. The Company stated it disagreed, but also stated in part, *". . . the Company respects Ohio's position on this matter, and will change its practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group." See Marketing and Sales Standard #1.*

17. The Company's marketing materials for its student select optional maternity rider stated that medically necessary postpartum care for the mother was limited to two visits once discharged from the hospital. Ohio law does not provide for such a limit. Therefore, the materials were misleading violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company's response indicated it disagreed, but it also stated in part, *"we are willing to modify this language, and will be taking the necessary corrective action to address this issue." See Marketing and Sales Standard #1.*

18. The Company's commission schedules for its Ohio basic or standard plans provided a first year commission of 2 percent for agents, and renewal commissions of 2 percent for every year thereafter. R.C. 3923.58 indicates that commissions are mandated for five percent at initial placement, and four percent at renewal. Therefore, the schedules were misleading in violation of R.C. 3901.21(B). The Company should discontinue the practice, and should reimburse the agents that were not paid the proper amounts during the period under examination. The Company responded twice, it first stated in part, "*Agree. We will be taking the necessary corrective action to address this issue . . .",* and later, "*Disagree. . . . Section 3923.58 requires commission rates of 5% for initial placement and 4% for renewal of Basic and Standard Plans. Therefore, we believe that the Commission schedule set forth in Section 3923.58(K) is reasonable and have taken*

the necessary corrective action to address this issue . . . ." See Marketing and Sales Standard #1.

19. The application for the student medical certificate is provided within the marketing materials for the plan. The application does not provide a format for the Company to determine who is a federally eligible individual. Therefore, the materials are misleading violation of R.C. 3901.21(B). The Company's lack of procedures for determining federal eligibility for the plans is not in compliance with Ohio law. The Company's response stated in part, "*The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage.*" The Company's response and its modification to its practices did not alleviate the problems with the application. The Company is still placing the onus on the applicant to determine if they want to apply for an Ohio Basic and Standard plan. It is the Company's responsibility for determining who is an eligible individual. See *Marketing and Sales Standard #1.*

20. The Company should maintain complaint files in compliance with Ohio Adm.Code 3901-1-60(H)(3). The Company agreed it could not provide one file in its entirety. *See Complaints and Grievances Standard #1.*

21. For one Department complaint file, the Company stated it would only send an adverse notice with private information to a medical provider and not to the insured. The Company also indicated that was its practice. The Company should provide the adverse underwriting notice to the applicant for compliance R.C. 3904.10. The Company's response stated, "*We respectfully note that the Company had modified its administrative practices such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice." See Complaints and Grievances Standard #1.*

22. For two Department complaint files, the Company failed to make a determination of their federal eligibility at the time of application in violation of R.C. 3923.581. Both were federally eligible and neither was offered the Ohio basic and standard plans. The Company should determine federal eligibility for every applicant at the time of application in compliance with R.C. 3923.581. The Company agreed to both violations and indicated it is implementing procedures to conform to the provisions of R.C. 3923.581. *See Complaints and Grievances Standard #1.*

23. For a Department complaint, the insured had a miscarriage and the Company denied the claims indicating she had not miscarried. The Company also denied the insured's appeal and the first grievance. The Company should not deny claims, which are a covered benefit in the insured's certificate. To deny the claims was a violation of Ohio Adm.Code 3901-1-07(C)(1), (7) and (10). The Company's response stated in part, "*Based on these facts, the charges were processed correctly. However, due to the specific circumstances in this case, the decision was overturned.*" Claims are always

settled based on the specific circumstances. *See Complaints and Grievances Standard #1.*

24. The Company first indicated that Rider 2669 was provided with individual market Certificates Form 225 and 227. The examiners later discovered it was not provided with those certificates, and the only place where the Ohio mandated benefits for child health supervision services for children from birth through age nine was in that rider. Therefore, all Certificates form 225 and 227, in force during the examination period did not provide child health supervision services in compliance with R.C. 3923.55. The Company's response stated, "*Agree. Please note that the benefits delineated in R.C. 3923.55 have been added to Certificate of Insurance Forms 225 & 227 in the pending filing with the Ohio Department of Insurance." See Complaints and Grievances Standard #1.*

25. For one Department complaint, the Company applied the language in its maternity rider, which indicates that its procedures for Certificate forms 225 and 227 are equivalent to those indicated in the maternity rider. The Company indicated that maternity benefits are only available when a health care practitioner determines that pregnancy began more than 270 days after the effective date of the rider. The rider and the Company procedures are a violation of R.C. 3901.21(O). Ohio law allows for a "service waiting period" of 270 days, it does not allow a 270 day "look forward provision" (time when an insured cannot conceive) for maternity benefits, which the Company's maternity rider allows. The Company should discontinue this practice and procedure, and should pay for all the claims during the period under examination, and to date, where insureds were denied maternity coverage because of this maternity rider provision. *See Complaints and Grievances Standard #1.*

26. The Company failed to maintain records for three files in violation of Ohio Adm.Code 3901-1-60(H)(3). It is recommended that the Company retain all documents collected for complaints in compliance with Ohio law. The Company agreed. *See Complaints and Grievances Standard #3.*

27. The student select certificate, form 554, was not filed with the Department in violation of R.C. 3923.02. In addition, none of the riders were filed with the Department. Prior to use, all certificate and policies and associated riders must be filed with the Department. The Student Select Certificate form 554 and associated Riders were filed and approved by the Department on November 8, 2006. *See Contract/Policy Language Standard #1.*

28. The individual market forms, certificates 225 and 227 were not filed with the Department in violation of R.C. 3923.02. In addition, none of the riders were filed with the Department. Prior to use, all certificate and policies and associated riders must be filed with the Department. Certificate forms 225 and 227 were filed and approved by the Department on February 17, 2006. *See Contract/Policy Language Standard #1.*

29. The Company's only conversion certificate is a JALIC plan that was not filed with the Department in violation of R.C. 3923.02. In addition, none of the riders were filed

with the Department. Prior to use, all certificate and policies and associated riders must be filed with the Department. The Company indicated that once the Basic and Standard plans filed by John Alden Life Insurance Company for use as conversion plans were approved by the Department, the Company would file the Basic and Standard plans for use as conversion plans. *See Contract/Policy Language Standard #1*.

30. The Company allowed six certificates issued in other states, to be continued for coverage in Ohio, without filing for approval with the Department. Prior to use, all certificate and policies and associated riders must be filed with the Department. All of these forms were discontinued and replaced with form 227. *See Contract/Policy Language Standard #1*.

31. All of the Company's individual and group market certificates and policies carve-out benefits for Medicare even if the policy/certificate holder does not take Medicare Part B. For compliance with HIPAA, an insurer is only allowed to coordinate benefits with Medicare, when Medicare pays. The Company's first response stated it would not change its procedures for carving-out Medicare benefits. The Company's second response stated in part, "*. . . this addendum is provided to advise that the Company has determined to amend COB practices such that, with respect to all guaranteed renewable coverages in the individual and small employer markets, we will coordinate benefits with Medicare only to the extent that benefits are payable or paid by Medicare. The necessary steps to implement this change are in process and contract language and marketing materials will be amended to reflect this change as soon as practicable." See Contract/Policy Language Standard #1*.

32. The Company's certificate forms 225, 227 and 554, indicate that an individual will be terminated once eligible for Medicare. This provisions is a violation of the guaranteed renewability provisions of R.C. 3923.57, Public Law 104-191, Part B—Individual Market Rules, Section 2742, and 45 CFR § 148.122. The Company indicated it does not administratively terminate coverage for Medicare eligible individuals. The Company should eliminate the provision from its individual market plans. The Company has eliminated provisions permitting termination upon Medicare eligibility in the filings of certificate forms 225, 227 and 554 that were approved by the Department on February 17, 2006 (225, 227) and November 8, 2006 (554). *See Contract/Policy Language Standard #1*.

33. The Company's certificate forms 225, 227, and 554 indicate that an individual can be terminated for a material misrepresentation. However the guaranteed renewability provisions of R.C. 3923.57, Public Law 104-191, Part B—Individual Market Rules, Section 2742, and 45 CFR § 148.122, indicate that an individual must make an intentional misrepresentation of a material fact. The Company should correct the provision to conform to state and federal law. The Company disagreed that the language was not in compliance. However, in a response to a violation noted in the Marketing and Sales Phase of the examination (recommendation No. 9 above), the Company stated in part, "*. . . we will amend the language to include "an intentional misrepresentation of a material fact*." Certificate forms 225 and 227 were approved by the Department on

February 17, 2006 and certificate form 554 was approved by the Department on November 8, 2006. *See Contract/Policy Language Standard #1.*

34. The Company's Ohio basic and standard plans allow for nonrenewal on the renewal date occurring on, or after and nearest, each anniversary. This provision is a violation of R.C. 3923.57, P.L. 104-191, Part B - Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. Therefore, the Company should eliminate this provision. The Company plans to re-file these forms upon receipt of approval of the John Alden variants of these forms. *See Contract/Policy Language Standard #1.*

35. The student medical certificate, form 554, provides that if there are Omissions or misstatements in the application coverage can be rescinded." R.C. 3923.14 indicates an insurer must establish the applicant made a willfully false statement, or committed fraud, and that without the statement coverage would not have affected. Therefore, the Company should remove the provision. The Company has filed amended language with the Department and form 554 was approved on November 8, 2006. *See Contract/Policy Language Standard #1.*

36. The maternity rider for the Company's certificate forms 225 and 227 does not indicate that maternity benefits include 48 hours for a vaginal delivery, or 96 hours for a c-section. Therefore, the rider is not in compliance with R.C. 3923.63 and NMHPA. The Company should provide the mandatory verbiage in its maternity rider. The maternity rider was filed and approved for use by the Department on February 17, 2006. *See Contract/Policy Language Standard #1.*

37. The Company's certificate forms 225 and 227 do not include follow-up care in compliance with R.C. 3923.63(A)(2). The Company should provide the mandatory coverage and verbiage in its maternity rider. The Company filed Rider 2804 at the same time they filed Certificate forms 225 and 227. Rider 2804 was approved for use on February 17, 2006. *See Contract/Policy Language Standard #1.*

38. The Company's student select maternity rider (form 2343) provides medically necessary postpartum care for the mother, but restricts the number of visits to two visits. In addition, the maternity rider (form 2804) for certificate forms 225 and 227, did not indicate that postpartum care is a covered benefit. Therefore, both riders are provided in violation of R.C. 3923.63. Therefore, both riders should be revised for compliance with Ohio law. Maternity rider, form 2343, was filed and approved was filed and approved for use by the Department on November 8, 2006. Maternity rider, form 2804, was filed and approved for use by the Department on February 17, 2006. *See Contract/Policy Language Standard #1.*

39. Maternity rider 2804 provides that coverage charges are applicable when a health care practitioner determines that pregnancy began 270 days after the effective date of the rider. The provision is a violation of R.C. 3901.21. Ohio law allows for a 270 day waiting period, not a 270 day look forward provision. The Company should eliminate this provision, discontinue its practices and procedures for coverage of maternity

benefits, and should pay for all the claims during the period under examination, and to date, where insureds were denied maternity coverage because of this maternity rider provision. Maternity rider, form 2804 was filed and approved for use by the Department on February 17, 2006. *See Contract/Policy Language Standard #1*.

40. The group certificate stated that a certificate could be terminated for providing false, incomplete or misleading information. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

41. The group certificate stated that a certificate could be terminated when an individual joins the military forces. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

42. The group certificate stated that a certificate could be terminated the date life coverage terminates. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

43. The group certificate stated that the employer's certificate could be terminated for making a misrepresentation. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. Therefore, the provision should be changed to meet the requirements of state and federal law. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

44. The group certificate stated that the employer's certificate could be terminated when the participating employer's business ceased to operate on a full-time basis. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

45. The group certificate stated that the employer's certificate could be terminated when the participating employer is placed in bankruptcy or receivership. This provision is not permissible for compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. The group certificate was amended by rider 28902 that was approved for use by the Department on October 12, 2006. *See Contract/Policy Language Standard #1*.

46. None of the Company's certificates or policies offered in the individual market (including the Ohio basic and standard plans), or group market, contained language in compliance with the requirements of the WHCRA and Ohio Bulletin 2001-1. Therefore, the certificates and policies should be amended to comply with the requirements of WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

47. None of the Company's certificates or policies offered in the individual market or group market, provided for breast prostheses in compliance with WHCRA and Bulletin 2001-1, when the insured has a history of a mastectomy. Therefore, the certificates and policies should be amended to comply with the requirements of WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

48. The Company's certificate form 227, and rider B021, allowed newborns to be enrolled 30 days after birth, or after adoption of a child. This is not in compliance with R.C. 3923.26, and R.C. 3923.40, which indicates an insured has 31 days to enroll a newborn or adopted child. The certificate form 227 has been revised to reflect the requirements of § 3923.26 of the Ohio Revised Code, including the 31-day period in which to add and pay premium for a Newborn or Adopted Child, in the filing of this form with the Ohio Department of insurance that was approved on February 17, 2006. *See Contract/Policy Language Standard #1.*

49. The application for the student medical certificate is not provided in a format for the Company to determine who is a federally eligible individual. The Company's lack of procedures for determining federal eligibility for these plans is not in compliance with Ohio law. The Company's response stated in part, "*The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage.*" The Company's response and its modification to its practices did not alleviate the problems with the application. The Company is still placing the onus on the applicant to determine if they want to apply for an Ohio Basic and Standard plan. It is the Company's responsibility for determining who is an eligible individual. *See Contract/Policy Language Standard #1.*

50. The application for certificate forms 225 and 227 did not provide a format for the Company to determine who is a federally eligible individual. In addition, the Company procedures and practices are to only determine FEI when the applicant requests the Ohio basic and standard plans. The Company's lack of procedures for determining federal eligibility at the time of application was a violation of R.C. 3923.581. The Company's response stated in part, "*Agree: The Company acknowledges that we did not consistently determine the HIPAA eligibility status of all applicants during the examination period. . . . The Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product Certificate Forms 225 and 227 or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals. . . . The Company will ensure that an offer of the Basic and Standard plan is made to each HIPAA eligible applicant, regardless of whether or not an offer of fully*

underwritten coverage may be made. A corrective action plan is not available at this time, as the Company needs to ensure all areas impacted by these workflows are involved in the corrective action process. We will update the Department of Insurance when a corrective action plan is implemented." See Contract/Policy Language Standard #1.

51. Twenty two of the 29 certificates in force, but not currently being issued were failed because each maternity rider was not provided in compliance with R.C. 3923.63. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1.*

52. Twenty three of the 29 certificates in force, but not currently being issued were failed because each provided for termination due to Medicare eligibility in violation of R.C. 3923.57(C), 45 CFR § 148.122, and Public Law 104-191, Part B – Individual Market Rules, Sec. 2742. *The Company agreed.* Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1.*

53. Twenty four of the 29 certificates in force, but not currently being issued were failed because each certificate allowed for "carve-out" of Medicare benefits. This provision is a violation of HIPAA. The Company has provided a second response for its position on Medicare carve-out as noted above in No. 51. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1.*

54. Eight of the 29 certificates in force, but not currently being issued were failed for providing a provision permitting the Company to terminate coverage in violation of R.C. 3923.57(C), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1.*

55. Ten of the 29 certificates in force, but not currently being issued were failed because they allowed for termination of coverage, and/or rescission for a material misrepresentation. This is not in compliance with R.C. 3923.14, R.C. 3923.57(C), 45 CFR § 148.122, and Public Law 104-191, Part B – Individual Market Rules, Sec. 2742. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1.*

56. Twenty two of the 29 certificates in force, but not currently being issued were failed because they indicated they could be discontinued without the proper notice of 90 days (and without an option to replace with any other policy issued), or 180 days notice for an individual market withdrawal. The lack of the provisions indicated a violation of R.C. 3923.57(D), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

57. Thirteen of the 29 certificates in force, but not currently being issued were failed because they indicated that coverage could be terminated for having other coverage in force. This provision was a violation of R.C. 3923.57(C), 45 CFR § 148.122, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

58. All 29 certificates in force, but not currently being issued were failed because they did not contain provisions for the mandated benefits of WHCRA or Ohio Bulletin 2001-1. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

59. All 29 certificates in force, but not currently being issued were failed because they had limitations on the coverage of prosthetic devices in violation of WHCRA and Ohio Bulletin 2001-1. *The Company agreed*. . Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

60. Twenty five of the 29 certificates in force, but not currently being issued were failed because they did not provide the mandated benefits for mammograms and Pap screening in violation of R.C. 3923.52. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

61. Eight of the 29 certificates in force, but not currently being issued were failed because they did not provide for an eligible covered family member to exercise continuation or conversion rights within 31 days in compliance with R.C. 3923.32(D). *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with

respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

62. Twenty four of the 29 certificates in force, but not currently being issued were failed because each contained a provision which indicated there were no benefits if the insured had other individual coverage in force, which should have made the plan primary at all times. This provision is a violation of R.C. 3902.11, R.C. 3902.12 and R.C. 3902.13. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

63. All 29 certificates in force, but not currently being issued were failed because they did not provide the mandated benefits for child wellness services in compliance with R.C. 3923.55. *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

64. Twenty five of the 29 certificates in force, but not currently being issued were failed because they provided a waiting period of 15 days for sickness or illness. This waiting period for a sickness or illness would provide for a pre-existing conditions exclusionary period for all sickness and illnesses, which would be a violation of the definition for pre-existing conditions cited at R.C. 3923.58 (referenced group cite R.C. 3923.581). *The Company agreed*. Each of the referenced forms was discontinued and replaced with Certificate form 227 during the exam time frame. Any identified deficiencies with respect to these discontinued forms have been rectified by virtue of their replacement. *See Contract/Policy Language Standard #1*.

65. The Company's certificate forms 225 and 227 failed to provide the mandated benefits of R.C. 3923.55, for child health supervision services. The Company's certificates should provide the mandated benefits in compliance with Ohio law. Certificate forms 225 and 227 were filed and approved by the Department on February 17, 2006. The approved forms contain provisions that comply with R.C. 3923.55. *See Contract/Policy Language Standard #1*.

66. The Company's group certificate language refuses COBRA continuation rights to any individual entitled to Medicare, when first eligible for COBRA continuation. The Company has amended the certificate language to comply with the federal guidelines regarding COBRA eligibility. The amended language was approved by the Department in rider 28902 on October 12, 2006. *See Contract/Policy Language Standard #1*.

67. The Company failed to allow an employer to choose a 90-day waiting period in violation of R.C. 3924.03(E)(2). A small employer is allowed to choose from a zero through 90 days waiting period. *See Underwriting Standard #1*.

68. The Company allowed an employer to choose a 180 day waiting period in violation of R.C. 3924.03(E)(2). A small employer is allowed to choose from a zero through 90 days waiting period. The Company agreed to the violation. *See Underwriting Standard #1.*

69. The Company used an employee enrollment form, which indicated that if the employee or the employee's dependent(s) waived coverage, and then later applied for coverage, that evidence of insurability would be required. This requirement was a violation of R.C. 3901.21(T)(1), 3924.03(C) and (D), Public Law 104-191, Part A – Group Market Reforms, Secs. 2702(a)(1)(G) and 2711(a)(1)(B), and 45 CFR §§ 146.121(a)(1)(vii) and 146.150(a)(2), because an insurer may not use health information to deny coverage. The Company's response stated in part, "*Agree. The noted representations in the contract are being revised to remove these references. Please note that the Company has not required "Evidence of Insurability" (proof of medical fitness) for enrollment purposes . . . ." See Underwriting Standard #1.*

70. For one employer group, the Company imposed an employer contribution percentage, which was not uniformly imposed on all groups, thereby unfairly discriminating between small groups in violation of R.C. 3901.21(M). The Company's response stated, "*Agree: A review of the file and follow-up questions to the underwriter that processed this application found that this was underwriter error. The Company will reinforce with appropriate staff the importance of adhering to the Company's employer contribution rules. See Underwriting Standard #1.*

71. For nine employer groups enrolling for coverage the Company made the purchase of life insurance and accidental death and dismemberment insurance (AD&D) mandatory (it was unknown if any of the employers wanted life coverage because it was mandatory for a FIC group certificate). To force the sale of Life and AD&D insurance upon a small employer that wishes to purchase a small group health plan violates the guaranteed availability requirements of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a), and 45 CFR § 146.150(a), and is an attempt to transfer adverse risks (unhealthy groups) in violation of R.C. 3901.21(V). The Company has elected to change its business practices and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage. *See Underwriting Standard #1.*

72. The Company declined life insurance coverage for individuals in two small employer groups. The Company's marketing materials and guidelines make life insurance mandatory. However, in practice, the Company underwriter's underwrite the life and AD&D coverage and declined unhealthy individuals for life and AD&D, which was a violation of R.C.3901.21. The Company disagreed, but stated in part, "*Nonetheless, we would inform you that the Company has elected to change its business practice and documentation to permit employers to purchase life coverage as an option, rather than requiring all qualifying enrollees to take the coverage." See Underwriting Standard #1.*

73. For one employer group the Company permitted a husband and wife to be covered as an employee and a dependent, and in another employer group required a husband and wife to be covered as employees. The Company's actions were unfairly discriminatory in violation of both R.C. 3901.21(M), and not in compliance with the Company's underwriting standards. The Company's response stated in part, *"Agree: . . . We will amend our business practices to ensure consistent application of our treatment of married employees and compliance with § 3901.21 of the Ohio Revised Code. We propose doing the following . . ."* The Company provided three proposals for compliance. However, its third proposal would also be a violation of R.C. 3901.21(M). The Company should eliminate, or correct the third proposal. *See Underwriting Standard #1.*

74. For three employer groups the Company failed to enroll eligible employees that worked 25 hours per week, which is a violation of R.C. 3924.01(G) and its Ohio underwriting guidelines. Additionally, when the Company permits eligibility of some employees who work 25 or more hours but denies the same to other employees, or employers, it is also a violation of R.C. 3901.21(M). The Company's response stated in part, *"Agree: In the cases of both groups . . . the noted employees were not initially recognized as full time due to oversight by the underwriters. See Underwriting Standard #1.*

75. The Company's underwriting procedures and guidelines do not provide the same options for coverage to all groups of fewer than 15 employees with respect to maternity coverage, by offering such coverage to groups with three though nine employees, but requiring it for groups of two or ten or more eligible employees. To discriminate in plans offered amongst small employer groups is a violation of R.C. 3901.21(M), 3924.03(E), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A), and 45 CFR § 146.150. The Company disagreed, but also stated in part, *". . . the Company respects Ohio's position on this matter, and will change its practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group." See Underwriting Standard #1.*

76. All nineteen employer small groups that were terminated for falling to one participant were terminated in violation of R.C. 3924.03(B)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, 45 CFR § 146.152, and HCFA Transmittal No. 99-03, dated March 1999. The Company's response stated, *"Agree: As we noted in our response to Inquiry #24A (and as cited by the examiner in this Inquiry), we have referred for implementation the amendments to current processes for termination of groups with fewer than two employees. Revised processes will comply with the requirements outlined in HCFA Bulletin 99-03." See Underwriting Standard #2.*

77. One of the nineteen employer small groups that was terminated for falling to one participant was also failed for being terminated, inadvertently reinstated, and then terminated again for the original reason for termination. This action was a violation of R.C. 3923.04(D). The Company's response stated, *"**Agree:** Staff will be reminded that*

acceptance of premium results in reinstatement of coverage in cases where coverage has otherwise been terminated." See Underwriting Standard #2.

78. One of the nineteen employer small groups that was terminated for falling to one participant, was also failed because the letters for termination indicated employees were being terminated because they were working less than 30 hours. To impose a 30 hour per week standard violates R.C. 3924.01(G). To impose eligibility of an employee based on a 30 hour work week is a violation of R.C. 3924.01(G), which indicates an eligible employee is one who is working 25 or more hours per week. The Company disagreed, but also stated in part, "B*oth letters . . . inappropriately reference a 30 hour per week minimum. The company acknowledges the error and will remind staff of the importance of adhering to state-specific guidelines. See Underwriting Standard #2.*

79. Nine employer groups terminated indicated that employees were not provided certificates of creditable coverage (CCC) at the time of termination. Failure to provide terminated employees and dependents with CCCs is a violation of R.C. 3924.03(A)(3), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701(e)(1)(A), and 45 CFR § 146.115(a)(1)(i). The Company's response stated in part, *". . . our systems were not programmed to automatically generate a CCC letter if a group lapsed for non payment of premium prior to that date (10/1/03). The system had been programmed to automatically generate a Certificates* (*sic*) *of Creditable Coverage if a group terminated for other reasons . . . The automation of CCC issuance upon lapse of a small employer plan was implemented on 10/1/03."* Therefore, no employees or dependents for lapsed employer groups received CCCs prior to October 1, 2003. *See Underwriting Standard #2.*

80. A small employer group employee that was terminated from coverage was supplied with a CCC that indicated a waiting period of zero days, and the actual waiting period for the group was 90 days. Failure to accurately reflect an insured's coverage on a CCC contravenes R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, and 45 CFR § 146.115. The Company's response stated in part, *"Agree: . . . incorrect data reflected on the Certificate of Creditable Coverage resulted from an input error in a system field for 'Waiting Period.' . . . We have corrected the identified problem. Current processes provide for the administration system to automatically populate the 'Waiting Period' field with the correct waiting period selected by the employer for all enrollees and the possibility of a recurrence of the above scenario is not possible with these system enhancements."* This could have resulted in employee having a 63 day gap in coverage according to the certificate, when in fact they did not. *See Underwriting Standard #2.*

81. An employer group was denied coverage because it failed to provide a state unemployment withholding form and a business check. Declining a small employer coverage because it was not able to supply either item is a violation of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. *See Underwriting Standard #3.*

82. The same file as No. 116 contained an email indicating coverage is not allowed if more than 25% of the individuals in a small group are 1099 subcontractors. Declining a small employer coverage because of the number of 1099 subcontractors it utilizes is a violation of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. *See Underwriting Standard #3.*

83. Three declined small employer group files were failed because the small employer was not provided with the specific reason for the declination in violation of R.C. 3904.10. The groups were told they were ineligible, nothing further. The Company should provide the employer applicants with the specific reason for declination, e.g., "did not meet participation requirements," "employer is a large group and the Company only markets in the small group market." As noted in marketing and sales, several of the Company's practices and procedures for group eligibility were not in compliance with Ohio law. Therefore, this lends greater credence for the Company to provide the specific reason for declining coverage to a small employer, because small groups are guaranteed availability of health coverage. The Company indicated it would implement procedures to provide more detail regarding the eligibility determination in declination letters to employers that apply for small group coverage. *See Underwriting Standard #3.*

84. One small employer group file was declined coverage because the employer was in business for less than six months. To decline a small employer group health coverage for this reason was a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and R.C. 3924.03(E)(1). The Company should provide guaranteed availability of small group health to all small group employers. The Company's response stated "*Agree: . . . Company practice with regard to the 6 month durational requirement . . . has been discontinued and is no longer applied to small employer applicants." See Underwriting Standard #3.*

85. FIC only offers a John Alden Life Insurance Company (JALIC) conversion plan for conversion to its conversion eligible certificate holders. This practice is a violation of R.C. 3923.122, which indicates that an insurer must offer any of the (all) plans it currently markets in the individual market, and in the case of a federally eligible individual it must offer a basic and standard plan. The Company response stated in part, "*Although the Company believes that offering of the substantially similar JALIC form J-1110 meets the statute's requirements, the Company would also be willing to offer these FIC forms 185 and 186 to all conversion eligible individuals.* FIC forms 185 and 186 are the Ohio standard and basic plans. However, as noted in contracts, these plans need to be corrected. *See Underwriting Standard #4.*

86. FIC does not determine who is an eligible individual when an employee applies for conversion coverage. This practice is a violation of R.C. 3923.122, which indicates that an insurer must offer a federally eligible individual the Ohio basic and standard plans. The Company response stated in part, "*Although the Company believes that offering of the substantially similar JALIC form J-1110 meets the statute's requirements, the Company would also be willing to offer these FIC forms 185 and 186 to all conversion eligible individuals.* FIC forms 185 and 186 are the Ohio standard and basic plans. The

Company is mandated to offer the Ohio basic and standard plans to all who are FEI's. Therefore, the Company must determine who is eligible, in order to offer the plans to those that are eligible. *See Underwriting Standard #4.*

87. FIC only allowed an annual payment for its conversion plans. This provision is a violation of R.C. 3923.122(B), which indicates that an insurer must offer a quarterly mode of payment. The annual mode of payment also is a violation of R.C. 3901.21(V), because it discriminates amongst the unhealthy by attempting to avoid adverse risks, by making affordability of paying premium very difficult for an unhealthy applicant. Two conversion applicants were quoted annual premium of over $25,000. The Company's response stated in part, "*Though we have been unable to find any other specific authority in Ohio law prohibiting annual premium payments, the Company will agree to extend monthly and quarterly premium payment options to convertees. See Underwriting Standard #4.*

88. The JALIC Conversion plan (provided for FIC), did not allow maternity coverage if the insured's prior group coverage did not have maternity coverage. If the insured's group plan had maternity coverage, the plan allowed maternity coverage for individuals who were already pregnant on the inception date of the conversion policy, and to no one else. Therefore, the plan is not substantially similar to the individual market certificate forms 225, 227 or 554 (all have optional maternity), or the Ohio standard plan (maternity included). Therefore, the JALIC plan was offered in violation of R.C. 3923.122. The Company's procedures and practices for maternity coverage in a conversion plan, attempts to avoid adverse risks in violation of R.C. 3901.21(V), because it avoids coverage for future maternity claims. The Company's response stated in part, "*The Company acknowledges and agrees to offer maternity coverage to all individuals eligible for conversion and will immediately implement measures to ensure that all enrollees are provided with maternity services as an ongoing, covered benefit under JALIC form J-1110. The Company believed its practice of issuing the J-1110 form (a substantial equivalent to the Basic and Standard Plans)* without requiring evidence of insurability and without pre-existing condition limitations and without requiring conversion applicants to produce evidence of prior coverage exceeds the requirements of group conversion section 3923.122. The Company is also willing to offer the additional FIC forms 185 and 186 to all eligible conversion individuals. *See Underwriting Standard #4.*

89. All of the individual market issued files were failed because the Company did not determine if the applicants were FEIs at the time of application. This Company practice and procedure was a violation of R.C. 3923.581. The Company's response stated in part, "*Agree: The Company acknowledges that we did not consistently determine the HIPAA eligibility status of all applicants during the examination period . . . . The Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product Certificate Forms 225 and 227 or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals. . . . The Company will either file HIPAA Eligibility Form 25238, or an updated version of the form, with the Ohio Department of Insurance as part of the applications for the forms or*

will develop processes that will otherwise provide for the offer of the Basic and Standard plans to HIPAA eligibles. . . . The Company will ensure that an offer of the Basic and Standard plan is made to each HIPAA eligible applicant, regardless of whether or not an offer of fully underwritten coverage may be made. A corrective action plan is not available at this time, as the Company needs to ensure all areas impacted by these workflows are involved in the corrective action process. We will update the Department of Insurance when a corrective action plan is implemented. See Underwriting Standard #7.

90. All the student medical certificates issued were failed because the Company did not determine if the applicants were FEIs at the time of application. This Company practice and procedure was a violation of R.C. 3923.581. The Company's response stated in part, "*The Company agrees to modify its practices to better educate consumers who are applying for Student Medical coverage regarding the potential availability of HIPAA guarantee issue coverage."* The Company's response, and its modification to its practices did not alleviate the problems with the application. The Company is still placing the onus on the applicant to determine if they want to apply for an Ohio basic and standard plan. It is the Company's responsibility for determining who is an eligible individual. *See Underwriting Standard #7.*

91. The Company failed to provide four individuals with an automatic issue CCC at the time their coverage was terminated. Therefore, the Company was in violation of R.C. 3957.57(F), Public Law 104-191, Part A - Group Market Reforms, Sec. 2743, and 45 CFR § 148.124. The Company agreed. *See Underwriting Standard #8.*

92. The Company failed to provide 24 individuals with an automatic issue CCC within a reasonable time in violation of R.C. 3923.57(F), Public Law 104-191, Part B - Individual Market Rules, Sec. 2743, and 45 CFR § 148.124. HIPAA defines a reasonable time frame to issue a CCC as 14 days from the time an insurer becomes aware of termination of coverage. Testing of individual plans terminated, indicated that 50% of the CCCs were issued within 7 calendar days. Therefore, it is not reasonable for FIC to argue that the standard of 14 days is unreasonable. The Company should issue CCCs in compliance with state and federal law. *See Underwriting Standard #8.*

93. All 50 individual market declined applicants were failed, because the Company did not determine the FEI status of the applicants at the time of application in violation of R.C. 3923.581 (See response to No. 125 above). *See Underwriting Standard #9.*

94. Thirty-eight of the 50 declined applicants were failed because the Company did not provide an adequate adverse underwriting notice in violation of R.C. 3904.10. The Company agreed, and stated, "*We respectfully note that the Company had modified its administrative practices such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice . . . ." See Underwriting Standard #9.*

95. Two of the three student select plans rescinded, were rescinded in violation of R.C. 3923.14. The Company agreed that one student should not have been rescinded, but disagreed that it did not have grounds for rescinding the other's coverage. The Company should never rescind coverage when it cannot prove the insured provided a false statement in the application, where clearly such false statement was willfully false or fraudulently made, and without such false statement the certificate would have been materially altered, or not issued. *See Underwriting Standard #10.*

96. One of the rescinded individual market applicants was rescinded in violation of R.C. 3923.14. The Company should never rescind coverage when it cannot prove the insured provided a false statement in the application, where clearly such false statement was willfully false or fraudulently made, and without such false statement the certificate would have been materially altered, or not issued. The Company never argued that the insured made a false statement, or the merits of the rescission. During a meeting, the Company verbally indicated that it did not have grounds for rescinding the coverage, but disagreed on paper, by indicating that it applied its underwriting standards correctly. However, the file is also failed for not applying its underwriting standard correctly. The Company indicated the insured had to accept a rider that was not applicable to his conditions in violation of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. Without a false statement by the applicant, the coverage (as issued) must be renewed. *See Underwriting Standard #10.*

97. Another of the rescinded individual market applicants was rescinded in violation of R.C. 3923.14. The Company should never rescind coverage when it cannot prove the insured provided a false statement in the application, where clearly such false statement was willfully false or fraudulently made, and without such false statement the certificate would have been materially altered, or not issued. The Company agreed. *See Underwriting Standard #10.*

98. Eighteen other rescinded individual market applicants were rescinded in violation of R.C. 3923.14. The Company should never rescind coverage when it cannot prove the insured provided a false statement in the application, where clearly such false statement was willfully false or fraudulently made, and without such false statement the certificate would have been materially altered, or not issued. *See Underwriting Standard #10.*

99. One of the rescinded individual market files was failed because the Company failed to provide the file in its entirety. The Company should retain records in a manner which allows a market conduct examination to be completed on such files. *See Underwriting Standard #10.*

100. Fourteen of the rescinded files were failed because the Company attempted to reform coverage in violation of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. A health insurer is never allowed to add a rider retrospectively unless the applicant has committed fraud, or made a willfully false statement, where clearly such false statement was willfully false or fraudulently

made, and without such false statement the certificate would have been materially altered, or not issued. *See Underwriting Standard #10.*

101. Three rescinded files were failed because the applicants had the potential to be federally eligible individuals, and the Company failed to make a determination of their eligibility at the time of application. Therefore, the Company failed to comply with R.C. 3923.581. *See Underwriting Standard #10.*

102. Sixty-one rescinded files were failed because the adverse underwriting notices did not provide the specific reason(s) for the Company's adverse underwriting decision in violation of R.C. 3904.01(A)(2). The Company adverse underwriting notices for rescinded applicants should provide the specific reason(s). *See Underwriting Standard #10.*

103. The Company should discontinue its method of counting days for payments or denial of claims. *See Claims Paid and Denied.*

104. One claim file was failed because a letter issued to an insured stated what the certificate provides; that the Company only pays for breast reconstruction benefits if the individual had a mastectomy while insured by FIC. If an insurer provides benefits for mastectomies (all the Company certificates do), it is mandated by WHCRA and Bulletin 2001-1 to pay for breast reconstruction benefits if the insured has a history of a mastectomy. Whether the insured or another carrier paid for the mastectomy is irrelevant. The insured was not harmed, but the Company should correct its certificates to provide the benefits of WHCRA and Bulletin 2001-1, so it does limit or inform insured's that it does not provide mandated breast reconstruction benefits. *See Claims Paid and Denied Standard #2.*

ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

May 16, 2006

Thomas McIntrye, CIE, CPCU, FLMI, AIRC, APA
For: Ohio Department of Insurance
Huff Thomas & Company
4700 Belleview Suite 208
Kansas City, MO 64112

Re: Representation Letter

Dear Mr. McIntyre:

In connection with the target market conduct examinations of Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company (collectively, "the Company") in the time period of July 1, 2002 through June 30, 2004, for the purpose of determining the Company's compliance with policy provisions and the Ohio Insurance Code and Rules and Regulations in regard to all phases of health insurance lines, I hereby represent, to the best of my knowledge and belief, that the following:

1. The Company uses its best efforts to conduct its transactions and business in compliance with the statutes, rules and regulations and procedures of the State of Ohio which pertain to health insurance companies.

2. All corporate powers are exercised by or under the authority of the duly qualified and constituted Board of Directors of the Company. The business affairs and transactions of the Company are managed under the direction of the Board of Directors, in accordance with the duties and responsibilities conferred upon the Board by its Articles of Incorporation, By-laws and applicable state law.

3. Pursuant to Ohio Rev. Code 3916.11, we have made available to you all books, records, accounts, papers, documents, computer records and recordings in the Company's possession which you have requested to review in connection with the examination.

4. To the best of my knowledge and belief,

    a. The Company has not taken disciplinary action or terminated any company employee for irregularities which relate to the record keeping system or the internal controls of the Company as it relates to compliance with Ohio health insurance laws or regulations for the examination period.

b. Reports from any other state insurance agencies regarding alleged noncompliance with applicable state regulatory requirements and our response to those reports are collected and review by our domiciliary state Department of Insurance.

5. The examiner has been provided access to information concerning any lawsuits brought in the State of Ohio for the examination period.

6. The Company has provided any requested information regarding events occurring subsequent to June 30, 2004 to the examiner.

7. You have represented to us that your market conduct examination was conducted in accordance with the examination standards established by the Ohio Department of Insurance, and procedures established by the National Association of Insurance Commissioners.

Time Insurance Company
Union Security Insurance Company
John Alden Life Insurance Company

Julia Hix-Royer, Vice President Compliance — 5/16/06
(Title of officer) (Date)

(Signature)

STATE OF OHIO

DEPARTMENT OF INSURANCE

IN THE MATTER OF:	)	
	)	
FORTIS INSURANCE COMPANY (NOW KNOWN AS TIME INSURANCE COMPANY) TARGETED MARKET CONDUCT EXAMINATION	)))	**CONSENT ORDER**

The Superintendent of the Ohio Department of Insurance ("Superintendent" and "Department," respectively) is responsible for administering Ohio insurance laws pursuant to Ohio Revised Code ("R.C.") §3901.011. Fortis Insurance Company, now known as Time Insurance Company ("the Company"), a Wisconsin-domiciled life and health insurer, is authorized to engage in the business of insurance in the State of Ohio pursuant to R.C. section 3911.01 and, as such, is under the jurisdiction of the Superintendent. The Superintendent conducted a targeted market conduct examination of the Company covering the period July 1, 2002, through June 30, 2004 ("Examination").

The focus of the Examination was to determine the Company's compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); the Women's Health and Cancer Rights Act ("WHCRA"); the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"); as well as the Ohio Revised Code and Ohio Administrative Code.

The details of the Examination are contained in *The Ohio Department of Insurance, A Targeted Market Conduct Examination of Fortis Insurance Company, NAIC #69477 as of June 30, 2004* ("Report"), which is incorporated by reference herein. After the Consent Order is executed by all parties, the Consent Order and Report and the Company's response letter of January 7, 2008, will become a public record.

SECTION I

BASED UPON THE EXAMINATION, THE SUPERINTENDENT DETERMINED:

The Company's sales and marketing, policy drafting, underwriting, and information technology processes failed to comply with federal and Ohio laws during the examination period. The examination report includes numerous findings in these general areas, including, but not limited to, the following findings:

1. Company individual and short term medical policy forms were marketed without being filed with the Department.

2. Company individual and short term medical policy forms were marketed without being updated to provide for various mandated benefits and/or the deletion of inappropriate termination language.

3. The Company failed to determine whether its customers were Federally Eligible Individuals ("FEI") during the application process.

4. The Company required groups interested in purchasing health insurance to purchase group life insurance for all of the group's enrollees.

5. The Company specifically excluded from continuation benefits any consumer entitled to Medicare when that person first became eligible for continuation under the applicable terms of the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

The findings as described in Section I of this Consent Order are symptoms of a lack of internal controls over the Company's compliance risk. Corrective actions should be taken that are appropriate to address the specific failures noted in the Examination Report and the Consent Order. The response should incorporate compliance as a standard risk management activity utilizing risk management principles described in literature and particularly in Section One – Risk-Focused Examinations, page 1-12 of the National Association of Insurance Commissioners ("NAIC") Financial Condition Examination Handbook.

SECTION II

IT IS HEREBY AGREED AND CONSENTED TO BY THE PARTIES THAT:

A) The Superintendent and the Company enter into this Consent Order to resolve the allegations as set forth in Section I of this Consent Order and further enumerated in the Examination Report. Further, the Company admits to the allegations set forth in Section I of this Consent Order.

B) The Company has been advised that it has a right to a hearing before the Superintendent pursuant to R.C. Chapter 119; that, at a hearing, it would be entitled to appear in person, to be represented by an attorney or other representative who is permitted to practice before the agency; and that, at a hearing, it would be entitled to present its position, arguments or contentions in writing and to present evidence and examine witnesses appearing for and against it. The Company hereby waives all such rights.

C) The Company consents to the jurisdiction of the Superintendent and the Department to determine the issues set forth herein. The Company waives any prerequisites to jurisdiction that may exist.

D) The Company hereby waives all rights to challenge or to contest this Consent Order, in any forum now available to it or in the future, including the right to any administrative appeal, or an action or appeal filed in state or federal court.

E) The Company has reviewed this Consent Order with counsel and knowingly and voluntarily enters into this Consent Order.

F) The Company agrees that the failure to adhere to one or more of the terms and conditions of this Consent Order shall constitute a violation of a lawful Order of the Superintendent, an actionable violation in and of itself without further proof, and may subject the Company to any and all remedies available to the Superintendent.

G) By filing the Consent Order in this cause, the parties intend to and do resolve all issues arising out of actual or alleged violations of the laws and regulations as detailed in the Report.

H) The Company agrees that upon the signing of this Consent Order by its authorized representative, it shall be subject to the following additional terms and conditions:

1. The Company shall pay a civil penalty in the amount of one hundred thousand dollars ($100,000), with one hundred thousand dollars ($100,000) suspended pending the outcome of any target examination that may be conducted by the Superintendent by October 1, 2009. If this targeted examination is initiated by that date and violations of the laws and regulations that are the subject matter of Section I are found, the Company may, in the Superintendent's discretion, be required to pay up to the remaining one hundred thousand dollars. All payments shall be made within thirty (30) days of the Company's receipt of an invoice from the Department and will be paid by check or money order made payable to: "Ohio Treasurer Richard Cordray." If the Superintendent has not initiated such target examination by October 1, 2009, the Company shall then certify to the Superintendent, in a writing signed by an authorized officer of the Company that the Company is in compliance with the requirements of this Consent Order and has corrected the violations set forth in Section I, herein.

2. The Board of Directors ("Board") of the Company shall determine whether appropriate policies and procedures were in place to prevent the violations that occurred. If the policies were in place, the Board shall assess the failure to adhere to these policies and initiate corrective action. If these policies were not in place, the Board shall develop such policies and a plan to implement them. A report on the Board's findings with an appropriate Corrective Plan of Action ("Plan") shall be submitted to the Superintendent no later than sixty (60) days after the last date this order is signed, for approval by the Superintendent within thirty (30) days of receipt. The Plan will provide, at minimum, the following, for each item in the Plan:

(a) Identification of each corrective action to be taken in response to each violation noted in Section I, including the section of law to which each action relates;

(b) How each corrective action is to be addressed, including, without limitation, what will be done, by whom it will be done, and the date it will be (or was) completed;

(c) What actions the Board of Directors has taken to assure that such violations described in Section I will not recur as well as specific improvements in the Company's compliance achievement processes in the areas of self-enforcement activities and management's continuous involvement and accountability in same; and

(d) The name of the Company officer, including his/her title, office location, and telephone number, responsible for assuring that all the corrective action necessary is documented in the Plan, and that each corrective action is undertaken and completed in a timely manner and in full compliance with the terms and conditions of this Consent Order and the Plan, as approved by the Superintendent.

3. The Company, if it has not already done so, shall begin immediately, in good faith, to correct the problems identified in Section I of this Consent Order. Any corrective action taken before the Plan's formal approval by the Superintendent should be noted in the Plan when submitted.

4. One hundred-eighty (180) days following the Company's execution of this Consent Order, the Company shall begin a self-audit of up to sixty (60) days duration to determine whether it has successfully implemented the Plan ("Self Audit"). The detailed results of the Self-Audit shall be provided to the Superintendent within twenty (20) business days following the end of the Self-Audit period.

5. The Company will address and resolve all other issues arising out of actual or alleged violations of the laws and regulations detailed in the Report.

NOW, THEREFORE, the agreement by and between Fortis Insurance Company, now known as Time Insurance Company, and the Superintendent on behalf of the Department, consisting of the terms and conditions set forth above, is approved.

FURTHER, all terms and conditions are hereby ORDERED.

APPROVED AND ORDERED this 7th day of July 2008.

MARY JO HUDSON
Superintendent of Insurance

ACKNOWLEDGEMENT AND ACCEPTANCE

By execution hereof, Fortis Insurance Company, now known as Time Insurance Company, consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions, and shall be bound by all provisions herein. The undersigned represents that he/she has the authority to bind Fortis Insurance Company, now known as Time Insurance Company, to the terms and conditions of this Consent Order.

FORTIS INSURANCE COMPANY,
NOW KNOWN AS TIME INSURANCE COMPANY

By: Julia Hix-Royer

Print or type name: Julia Hix-Royer

Title: Vice President Regulatory Compliance

Date: June 27, 2008