STATE OF ARIZONA
FILED

APR 27 2012

DEPT. OF INSURANCE

REPORT OF TARGETED EXAMINATION

OF

GOLDEN RULE INSURANCE COMPANY

NAIC# 62286

AS OF

December 31, 2009

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

GOLDEN RULE INSURANCE COMPANY

NAIC # 62286

The above examination was conducted by Sandra Lewis, CIE, MCM, Examiner-in-Charge; James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist; Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; Sondra Faye Davis, Market Conduct Examiner; and John Kilroy, Market Conduct Examiner.

The examination covered the period of January 1, 2009, through December 31, 2009.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, Sondra Faye Davis, Market Conduct Examiner, and John Kilroy, Market Conduct Examiner, the examination of Golden Rule Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis
Sandra Lewis, CIE, MCM
Market Conduct Examinations Examiner-in-Charge

Subscribed and sworn to before me this 17 day of May, 2011.

Cindy Boes
Notary Public

My Commission Expires Nov 12, 2013

FOREWORD

This targeted market conduct examination of Golden Rule Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market conduct examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

The examination consisted of a review of all aspects of the Company's operations in Arizona, including but not limited to: Advertising, Sales and Marketing, Underwriting, Forms, Claims, Appeals and Grievances, Policyholder Services, and Terminations.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Department. The targeted market conduct examination of the Company covered the period from January 1, 2009, through December 31, 2009, for the lines of business reviewed. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. The standards applied during the examination are stated in this Report at page 21.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent

compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners used both examination-by-test and examination-by-sample. Examination-by-test involves the review of all records within the population, while examination-by-sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, the Examiners completed examinations-by-test and -by-sample as to those populations without the need to use computer software.

The Examiners based their file sampling on a review of Appeal, New Business, and Claims data provided by the Company. Samples were randomly or systematically selected by using Audit Command Language (ACL) software and computer data files provided by the Company's Representative, Dawn Jadin, Supervisor, Regulatory Affairs. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as "met". A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXECUTIVE SUMMARY

The Examiners completed this examination by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 21, and the examination findings are reported beginning on page 6.

1. The Company failed Standard No. 2, as follows:
   a. With regard to 25 individual medical advertising forms reviewed because the Company failed to identify the source of the statistic or the time period referred to by the advertising claim, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(F) and (P);
   b. With regard to 36 individual medical advertising forms containing untruthful or misleading statements that did not accurately describe policy benefits or advantages and/or exaggerated policy benefits or advantages in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (C)(2) and (C)(3);
   c. With regard to one short term medical advertising form that made incomplete and misleading comparisons with COBRA coverage, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1) and (C)(2); and
   d. With regard to one individual medical advertising form that listed specific policy benefits but failed to disclose a waiting period, related exclusions, reductions and limitations, and/or exclusions, reductions or limitations applicable to preexisting conditions, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (2), (7), (8), and/or (9).
2. The Company failed Standard No. 4, in apparent violation of A.R.S. § 20-448(B) by:
   a. Unfairly discriminating against existing insureds in the premiums and/or rates charged for a disability policy for individuals of the same class and of essentially the same hazard;
   b. Declining one 64½-year old applicant solely on the basis of age; and

c. Improperly applying a waiting period to 10 certificates issued under HIPAA "guaranteed issue."

3. The Company failed Standard No. 6, in apparent violation of A.A.C. R20-6-1205(B) by limiting benefits for AIDS and AIDS-related claims.

4. The Company failed Standard No. 12, in apparent violation of A.R.S. § 20-2110(A) by failing to provide a Summary of Rights to applicants at the time coverage is declined.

5. The Company failed Standard No. 13, as follows:

    a. By failing to perform an adequate investigation of seven (13%) of 55 claims prior to denying the claims, in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F);

    b. By failing to pay interest on four (9%) of 44 claims submitted by providers and not paid within 30 days after the claim was adjudicated, in apparent violation of A.R.S. § 20-3102;

6. The Company failed Standard No. 14, in apparent violation of A.R.S. § 20-2533(D) by using an Explanation of Benefits ("EOB") form that did not include a notice of the right to appeal the denied claim.

7. The Company failed Standard No. 19, by using certificates of creditable coverage forms that failed to meet the specifications of A.R.S. § 20-1379(L).

8. The Company failed Standard No. 21, as follows:

    a. By failing to provide accurate information in an appeals notice as required by A.R.S. § 20-2533(C); and

    b. By failing to advise two members of their right to proceed to an external independent review following a second level appeal, in apparent violation of A.R.S. § 20-2537(A).

9. The Company passed Standards 1, 3, 5, 7, 8, 9, 10, 11, 15, 16, 17, 18, 20, 22, 23, and 24.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of advertising used by the Company during the examination period, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
2	All advertising and sales materials are in compliance with applicable statutes and rules.	A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201 and R20-6-201.01

The Company provided an Excel spreadsheet, which listed 270 individual medical and short-term medical advertisements that were used by the Company during the examination period. The actual advertisements were provided on one CD-ROM titled "GRIC Attach A.I.D.". Forty-five of the advertisements did not meet the sample criteria and therefore at total of 225 advertisements were actually reviewed.

1. The Company failed Standard 2 with regard to 25 individual medical advertising forms reviewed because the advertisements stated "More than 70 million customers have entrusted UnitedHealthcare for their insurance needs." This statement is misleading because the Company failed to identify the source of the statistic or the time period referred to by the statement (i.e., in the Company's entire history or its current membership), in apparent violation of A.R.S. § 20-444(A) and R20-6-201(F) and (P). See PF #002.
2. The Company failed Standard 2 with regard to 36 individual medical advertising forms reviewed because the advertisements contained untruthful or misleading statements and did not accurately describe policy benefits or advantages and exaggerated policy benefits or advantages in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (C)(2) and (C)(3). See PF #002. The following are samples of untruthful and misleading statements that did not accurately describe policy benefits or advantages or that exaggerated policy benefits or advantages, and which statements are not supported by credible industry statistics:
    - "You will find we go far beyond the industry average"
    - "Processing an overwhelming majority of health insurance claims in less than two weeks"
    - "Offering strong discounts"

- "Our vast network of quality health-care providers"

3. The Company failed Standard 2 with regard to one short term medical advertising form reviewed that was misleading because it implied that short term medical insurance is a similar product to COBRA and can replace COBRA but failed to make a comparison which set forth the advantages of COBRA or the disadvantages of failing to exhaust COBRA benefits, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1) and (C)(2). See PF #002.
4. The Company failed Standard 2 with regard to one individual medical advertising form, which listed specific policy benefits such as prescription drugs and wellness/preventive care but failed to disclose the 14-day waiting period for illness coverage, any related exclusions, reductions and limitations, and/or any exclusion, reduction or limitation applicable to preexisting conditions, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(1), (2), (7), (8), and/or (9). See PF #007.

Some forms were cited in more than one preliminary finding. The Company has not met Standard No. 2 and appears to be in violation of A.R.S. § 20-444(A) and R20-6-201 with regard to 38 Individual and Short Term Medical advertising forms reviewed.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 4

Based on the Examiners' review of the Company's sales, marketing, and underwriting and rating practices, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
4	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups.	A.R.S. § 20-448

Discrimination in the Rate of Premiums Charged

During the examination period, the Company used sales, marketing, and rating practices that unfairly discriminate against existing insureds. The Company used 45 advertisements that contained the following statement "Lock in your initial rate for 12 months with an option on all plans to extend up to 24 months."

This promise is intended only for new customers and is not available to existing insureds. By providing for a locked in premium only for new policyholders, the Company unfairly discriminates against existing insureds in the premiums and/or rates charged for a disability policy for individuals of the same class and of essentially the same hazard. See PF #003.

The Company has not met Standard No. 4 and appears to be in violation of A.R.S. § 20-448(B). A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Discrimination Based on Age of the Applicant

The Examiners reviewed the 55 Association Group New Business RT/WD files provided by the Company in response to Request 010. Four files did not meet the sample criteria so 51 files were actually reviewed.

The Examiners identified one file (GR-AGRT/WD-054) where the Company declined to offer coverage to the applicant due to the fact that the plan that she applied for was not available to persons over the age of 64½ as of the proposed effective date. Person's age 64 years and six months are essentially of the same class and essentially the same hazard as person's age 64 years or 64 years and five months. Therefore, the declination of coverage based on age 64½ discriminates against individuals of essentially the same class and of essentially the same hazard. See PF #014.

The Company has not met Standard No. 4 and appears to be in violation of A.R.S. § 20-448(B) with regard to the declination of coverage on file GR-AGRT/WD-054.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

HIPAA Portability

The Examiners reviewed 110 Association Group New Business Issued Files provided by the Company in response to Request 007 and 55 Association Group New Business NTO Files provided by the Company in response to Request 008. As a result of that review, the Examiners identified files where the Company had determined that the applicants were eligible for HIPAA guaranteed issue coverage. Due to their eligibility for guarantee issue coverage, these applicants were issued a "Portability Policy" by the Company.

The Examiners found that 10 of the certificates, as indicated by the table below, were issued with a 14-day waiting period for the effective date of coverage for illness.

File Number	File Number
GR-AGISS-012	GR-AGNTO-018
GR-AGISS-058	GR-AGNTO-021
GR-AGISS-074	GR-AGNTO-052
GR-AGISS-110	GR-AGNTO-054
GR-AGNTO-014	GR-AGNTO-055

In their initial applications, all 10 applicants indicated that they had been covered by medical insurance within the past 62 days. Therefore, based on the Company's stated policies and procedures, the 14-day waiting period for illness should have been waived. Since it was not waived in these 10 certificates, the Company has discriminated against these insureds in the terms and conditions of their contracts, in apparent violation of A.R.S. § 20-448(B). See PFs #017 and #018.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 6

Based on the Examiners' review of the Company's policy forms submitted pursuant to Attachment A of the Coordinator's Handbook, as well as policies provided for purposes of claims review, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
6	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued.	A.R.S. §§ 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01, and A.A.C. R20-6-1205.

Limitation of Benefits for AIDS and AIDS-Related Claims

The Examiners reviewed 100 Association Group Denied NC1 Claim Sample files provided by the company in response to Request 034. One file did not fit the sample criteria and therefore, 99 files were actually reviewed. The Examiners reviewed 55 Association Group Denied Claim NC2 sample files provided by the Company in response to Request 035. The Examiners also reviewed 52 Association Group Denied Claim EL sample files provided by the Company in response to Request 036.

The review of these claim files included a review of the policy forms that were issued to the insureds and under which these claims were processed. The Examiners found that policies included in this review contained an endorsement titled "Limitation of Payment for AIDS or AIDS Related Claims," which had the effect of reducing benefits for treatment of AID or AIDS related claims in apparent violation of A.A.C. R20-6-1205, as follows:

1. Six of the 99 Association Group Denied NC1 Claim Sample files reviewed. See PF #022.
2. Two of the 55 Association Group Denied Claim NC2 sample files reviewed. See PF #024.
3. Two of the 52 Association Group Denied Claim EL sample files reviewed. See PF #024.

The Company has not met Standard No. 6 and appears to be in violation of A.A.C. R20-6-1205. A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 12

Based on the Examiners' review of the Company's marketing materials provided pursuant to Attachment A of the Coordinator's Handbook, as well as selected samples of association group declined files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
12	The Company complies with all notice of insurance information and privacy requirements.	A.R.S. §§ 20-2101, *et seq.*

Summary of Rights

The Company provided an Excel spreadsheet, which listed 270 individual medical and short-term medical advertisements that were used by the Company during the examination period. The actual advertisements were provided on one CD-ROM titled "GRIC Attach A.I.D.". Forty-five of the advertisements did not meet the sample criteria and therefore at total of 225 advertisements were actually reviewed.

The Examiners reviewed one marketing script (Form 37689-G-0308) that allowed the interviewer, acting on behalf of the Company, to tell the applicant that he/she is ineligible for the coverage requested, based on medical conditions, build, or non-residency. This notification of declination of coverage constitutes an adverse underwriting decision as per A.R.S. § 20-2102(1)(a).

The script does not provide for the interviewer, at the time of declination, to supply the applicant proposed for coverage with a summary of rights established by A.R.S. § 20-2110(A), as further prescribed by A.R.S. §§ 20-2108 and 20-2109. See PF #004.

The Examiners reviewed 55 Association Group New Business Declined files provided by the Company in response to Request 009 and 55 Association New Business Returned or Withdrawn files provided by the Company in Response to Request 010. Four of the Returned/Withdrawn files did not meet the sample criteria and therefore a total of 106 files were reviewed.

In two of the files reviewed, the Company declined to offer the coverage applied for due to a specific medical condition identified in the applicant's medical history. These declinations of coverage constitute an adverse underwriting decision as per A.R.S. § 20-2102(1)(A).

The Company, at the time of declination, failed to provide the applicant proposed for coverage with a summary of rights established by A.R.S. § 20-2110(A), as further prescribed by A.R.S. §§ 20-2108 and 20-2109. See PF #015.

The Examiners reviewed 55 Short Term Medical New Business RT/WD files provided by the Company in response to Request 013.

In two of the files reviewed, the Company declined to offer the coverage applied for by the applicant. These declinations of coverage constitute an adverse underwriting decision as per A.R.S. § 20-2102(1)(a).

The Company, at the time of declination, failed to provide the applicant proposed for coverage with a summary of rights established under subsection B and sections 20-2108 and 20-2109. See PF #019.

The Company has not met Standard No. 12 and appears to be in violation of A.R.S. § 20-2110(A) with regard to:

1. Advertising form 37689-G-0308;
2. Two association group new business files; and
3. Two short term medical new business files.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 13

Based on the Examiners' review of selected sample claim files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
13	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules.	A.R.S. §§ 20-461, 20-462, and 20-1215, and A.A.C. R20-6-801

Failure to Investigate Claims

The Examiners reviewed 55 Association Group Denied NC2 Claim Sample files provided by the Company in response to Request 035 and found that the Company failed to perform an adequate investigation of seven (13%) of the claims prior to denying the claims. See PF #027. Four of the claims were later reprocessed and paid prior to the commencement of the examination; one claim was paid during the claims review of this examination.

- One claim involved occupational therapy following a mastectomy. Despite the existence of a policy exclusion, these services must be covered pursuant to federal law and the Company has issued an internal memo to that effect. Nonetheless, the Company denied the claim using a reason code indicating that the policy does not cover these services.
- Five claims included a diagnosis of overweight, obesity, or morbid obesity. The Company denied the claims, relying solely on this diagnosis, under the policy provision excluding treatment for "weight modification." Procedure codes on the claims indicated that none of the claims was directly related to weight modification, and the Company did not perform an adequate investigation into the nature of the treatment or services before denying the claims.
- One claim included a diagnosis of "poisoning by unspecified drugs and medicinal substances." The claim was denied without investigation as a "self-inflicted condition."

Prior to the commencement of the examination, the Company had reopened, reprocessed, and paid four of the seven claims that were cited. The Company has failed Standard 13 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a reasonable investigation prior to denying a claim.

Subsequent Events.

During the examination, the Company reprocessed and paid GRIC-AGDC-NC2-037 in the amount of $27.92. Proof of this subsequent payment has been provided to the Department.

Payment of Interest

The Examiners reviewed 55 Association Group Denied EL Claim Sample files provided by the Company in response to Request 036. Three files did not fit the sample criteria and therefore, 52 files were actually reviewed. Of the 52 files reviewed eight appear to have been submitted by insureds and 44 appear to have been submitted by providers.

The Company failed Standard 13, in apparent violation of A.R.S. § 20-3102(B), by failing to pay interest on four (9%) of 44 Association Group EL provider claims not paid within 30 days after the claim was adjudicated. See PF # 025.

Subsequent Events.

During the examination, the Company paid the accrued interest on the four claims cited, as indicated by the following table. Proof of this subsequent payment has been provided to the Department.

Files Cited by PF #025	**Interest Paid**
GRIC-AGDC-EL020	$65.09
GRIC-AGDC-EL021	$80.17
GRIC-AGDC-EL023	$36.42
GRIC-AGDC-EL024	$21.85
Total Paid	**$203.53**

Summary of Findings – Standard 13 Claim File Review

Description	Population	Files Reviewed	Exceptions	Error Ratio	PF #
Association Group Denied NC2	573	55	7	13%	027
Association Group Denied EL	306	52	4	8%	025
Totals =	**879**	**107**	**11**	**10%**	

A 10% error ratio does not meet the standard; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 14

Based on the Examiners' review of the Company's claims and appeals procedures, as well as selected samples of appeal and claim files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
14	Notice of a denied claim provides the insured and, where appropriate, the provider with the reason for the denial in sufficient detail to effect a meaningful appeal and includes notice of the appeal rights allowed by law.	A.R.S. §§ 20-461 and 20-2530, *et seq*., and A.A.C. R20-6-801

The Examiners reviewed denied claim files from various samples and found six instances where the Company used an Explanation of Benefits ("EOB") form #EOB1-45R that did not include a notice of the right to appeal the denied claim. The Company has not met Standard 14, in apparent violation of A.R.S. § 2533(D). See PF #021.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 19

Based on the Examiners' review of the Company's appeal procedures and forms, as well as selected samples of appeal files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
19	Evidence of coverage is provided in accordance with the requirements of HIPAA and applicable state laws.	A.R.S. §§ 20-1379 and 20-2301, *et seq.*

The Examiners reviewed 110 Association Group New Business Issued files that were provided by the Company in response to Request 007.

The Company issued certificates of creditable coverage to 13 insureds after termination of their coverage. The Company was required to issue a certificate of creditable coverage to those insureds that complied with the requirements of A.R.S. § 20-1379(L). In the 13 files the certificate failed to contain a telephone number to call in order to obtain further information regarding the certificate. See PF #009.

The Company has not met Standard No. 19 and appears to be in violation of A.R.S. § 20-1379(L)(4) with regard to 13 Association Group New Business Issued files reviewed.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 21

Based on the Examiners' review of the Company's selected samples of appeal files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
21	The Company provides timely appeals from denied claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process.	A.R.S. §§ 20-2530, *et seq.*

Forms Review

The Company failed to provide accurate contact information for the Department in its correspondences and/or notices regarding appeals using form Number 32146R3. The Company has not met Standard 21, in apparent violation of A.R.S. § 20-2533(C)(10). See PF #010.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

File Review

The Examiners requested 54 second-level appeals for review (GRIC-REQ015). Of these, two files were eliminated as duplicate files, and one file was eliminated because it is being handled as a Department of Insurance complaint. The Examiners also requested one expedited second-level appeal for review (GRIC-REQ016). The Company informed the examiners that this appeal was not expedited and had been mislabeled. ADOI File Number ExpAPP001, therefore, was treated as a second-level appeal. The Examiners therefore reviewed a total of 52 2nd level appeals.

Following a second-level review, the next step in the mandated appeal process is an External Independent Review, as prescribed by A.R.S. § 20-2537(A).

1. With regard to ADOI File Number 2ndAPP015, the Company instructed the member and provider to file an additional second-level appeal.
2. With regard to ExpAPP001, the Company upheld the claim denial at the second-level of appeal, but failed to inform the member of the right to proceed to an External Independent Review.

The Company has not met Standard No. 21 and appears to be in violation of A.R.S. § 20-2537(A). See PF #011.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

RECOMMENDATIONS

Within 120 days of the filed date of this Report, the Company should:

1. Perform a self-audit of all claims denied because of a diagnosis of "overweight," "obesity," or "morbid obesity," using a reason code indicating that the coverage does not include benefits for weight modification to determine whether these claims were for procedures, treatment, or services unrelated to weight loss or weight modification;
2. Perform a self-audit of all provider claims not paid within 30 days of the adjudication date or 60 days form the receipt of the clean claim, whichever is sooner, to determine whether interest was paid in accordance with the provisions of A.R.S. § 20-3102;
3. Pay restitution including interest at the legal rate for any claim identified from the self-audits; and
4. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial. This letter must be approved by the Department prior to its use.

Within 90 days of the filed date of this Report, the Company should provide documentation that procedures and controls are in place to ensure that:

5. All statistical information used in advertising and marketing materials refers to the source of the statistical information and provides points of reference to enable the consumer to evaluate the impact of the statistics, to comply with A.R.S. § 20-444(A) and R20-6-201(F) and (P).
6. All advertising and marketing materials that compare the Company's performance to industry standards and averages are supported by credible industry statistics to comply with A.R.S. §§ 20-443(A)(1) and 20-444(A) and R20-6-201(C)(1), (C)(2) and (C)(3).
7. Advertising and marketing materials do not indicate that short-term medical insurance is a low cost alternative to COBRA without providing a complete and accurate comparison of the advantages and disadvantages of each, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(1) and (C)(2).

8. All advertisements and marketing materials that describe policy benefits disclose any related exclusions reductions of limitations, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(7).

9. All advertisements and marketing materials that describe policy benefits disclose the existence of a waiting period if a policy contains a period between the effective date of the policy and the effective date of coverage under the policy, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(8).

10. All advertisements and marketing materials that describe policy benefits disclose any related exclusions reductions of limitations applicable to a preexisting condition to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(9).

11. The Company provides rates for individual medical policies in a fair and nondiscriminatory manner to all eligible individuals and existing insureds, to comply with A.R.S. § 20-448(B).

12. The Company provides coverage to all eligible individuals of the same class and like hazard, and does not discriminate on the basis of artificial age distinctions, to comply with A.R.S. § 20-448(B).

13. The Company ensures that certificates issued to HIPAA-eligible applicants do not include waiting periods, to comply with A.R.S. § 20-448(B).

14. The Company provides benefits for AIDS and AIDS-related claims in the same manner as other illnesses covered under the policy, to comply with A.A.C. R20-6-1205.

15. The Company provides a summary of the rights at the time of an adverse underwriting decision, to comply with A.R.S. § 20-2110(A).

16. The Company performs an adequate investigation of claims prior to denying the claim, to comply with A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).

17. The Company pays interest at the legal rate on all clean provider claims not paid within 30 days of the adjudication date, or within 60 days of receipt of the clean claim, which is sooner, to comply with A.R.S. § 20-3102.

18. All EOB forms provide an appropriate notice of the right to appeal a denied claim, to comply with A.R.S. § 20-2533(D).

19. The Company provides certificates of creditable coverage that include all prescribed information, to comply with A.R.S. § 20-1379(L).

20. All appeal correspondence and notices contain accurate information, including but not limited to contact information for the Department, to comply with A.R.S. § 20-2533(C).

21. The Company provides accurate and timely notice regarding the next level of appeal, to comply with A.R.S. §§ 20-2530, *et seq*.

SUMMARY OF STANDARDS

A. Operations and Management

#	STANDARD	PASS	FAIL
1	Company maintains adequate records and produces records in a timely manner as required by the Examiners for the completion of the market conduct examination. (A.R.S. § 20-157 and A.A.C. R20-6-801)	X	

B. Advertising, Marketing, and Sales

#	STANDARD	PASS	FAIL
2	All advertising and sales materials are in compliance with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, 20-1137, and A.A.C. R20-6-201 and R20-6-201.01)		X
3	Producer compensation and commissions are appropriate and in compliance with applicable statutes and rules. (A.R.S. §§ 20-298, 20-1379, and 20-2304)	X	
4	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-448, 20-2313)		X
5	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers. (A.R.S. § 20-2304)	X	

C. Policy Forms

#	STANDARD	PASS	FAIL
6	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued. (A.R.S. § 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01; 20-2301, *et seq.* and A.A.C. R20-6-1205)		X
7	Individual insurance policy forms, except those for which no renewal is provided, contain a 10-day free look provision, which is prominently displayed on the first page of the policy. (A.A.C. R20-6-501)	X	

D. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
8	The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
9	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan. (A.R.S. § 20-2323)	X	
10	The Company does not impose exclusions or limitations for preexisting conditions except as permitted by law. (A.R.S. §§ 20-1379, 20-2308, 20-2310, 20-2321)	X	
11	The Company obtains prior written consent, using approved consent forms, before collecting or disclosing HIV-related medical information or conducting tests for HIV or genetic disorders. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1203)	X	
12	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)		X

E. Claims Processing

#	STANDARD	PASS	FAIL
13	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-461, 20-462, and 20-1215, and A.A.C. R20-6-801)		X
14	Notice of a denied claim provides the insured and, where appropriate, the provider with the reason for the denial in sufficient detail to effect a meaningful appeal and includes notice of the appeal rights allowed by law. (A.R.S. § 20-461 and A.A.C. R20-6-801)		X
15	Claim files are adequately documented in order to be able to reconstruct pertinent events of the claim. (A.R.S. § 20-461 and A.A.C. R20-6-801)	X	
16	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
17	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	

F. Policyholder Services

#	STANDARD	PASS	FAIL
18	Reinstatement of coverage is applied consistently and in accordance with policy provisions. (A.R.S. §§ 20-448, 20-1348)	X	
19	Evidence of coverage is provided in accordance with the requirements of HIPAA and applicable state laws.		X
20	The Company takes adequate steps to finalize and dispose of the complaints in accordance with policy provisions and applicable statutes and rules. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
21	The Company provides timely appeals from denied claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process. (A.R.S. §§ 20-2530, *et seq.*)		X

G. Cancellation, Non-Renewals, and Rescissions

#	STANDARD	PASS	FAIL
22	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law. (A.R.S. §§ 20-191, 20-1203, and 20-1347)	X	
23	The Company does not cancel or non-renew coverage except as allowed by law (A.R.S. §§ 20-448, 20-1342, 20-1346, 20-1347, 20-1378, 20-1380, 20-1402, 20-1404, 20-1411, 20-2110, 20-2309, 20-2321)	X	
24	Coverage is rescinded within the contestability period only as a result of a material misrepresentation. (A.R.S. § 20-1346)	X	