OHIO DEPARTMENT OF INSURANCE

A

TARGETED

MARKET CONDUCT EXAMINATION

OF

FORTIS BENEFITS INSURANCE COMPANY

NAIC #70408

As Of

June 30, 2004

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(NOTE: Print this page of final report on OH-DOI letterhead)

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

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

The report of examination is herewith respectfully submitted.

SCOPE OF EXAMINATION

This Target Market Conduct Examination was performed to determine Fortis Benefits Insurance Company's (hereinafter referred to as "Company" or "FBIC") 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 responses 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

Western Life Insurance Company was incorporated in 1910 under the laws of the State of Montana and operated as a Montana domiciled life insurance company from 1910 to 1962. In 1962, the Company changed its state of domicile by establishing a Minnesota domiciled life insurance company. The Company then reincorporated pursuant to Minnesota statutes.

On December 31, 1984, Western Life Insurance Company was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. The Company changed its name effective January 1, 1992, from Western Life Insurance Company to Fortis Benefits Insurance Company (FBIC). The company re-domesticated from Minnesota to Iowa, effective October 1, 2005. The Company changed its name to Union Security Insurance Company (USIC), effective September 6, 2005.

FBIC acquired 99% ownership of Dental Health Alliance, L.L.C. on February 20, 1997. The former Pierce National Life Insurance Company, a California corporation, merged into the Company effective July 1, 2001. In addition, FBIC owned GALA, Inc., an insurance agency in Alabama.

The long-term care business unit was sold to John Hancock Financial Services effective March 1, 2000. The variable insurance and mutual fund division, named Fortis Financial Group, was sold to Hartford Life, Inc. effective April 1, 2001.

Effective December 31, 2001, the parent of the Company, Fortis, Inc., entered into a transaction to acquire the Dental Benefits Division of Protective Life Corporation (the Transaction). The Transaction involved the acquisition of 100% of the stock of 24 prepaid dental managed care companies by an affiliate, Dental Care Holdings, Inc. As part of the Transaction, the Company entered into administrative service agreements with each of the prepaid dental managed care companies to supply basic services and employees for the operation of those companies. Two of the companies were dissolved in 2004 and eight were merged into USIC on November 1, 2005.

USIC's direct parent is Interfinancial, Inc., which in turn, is controlled by Assurant, Inc., in New York, New York. The ultimate controlling entities, which own 16% of Assurant, Inc., 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 SA/NV, a Belgian company, replaced Fortis (B) 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) on February 5, 2004.

Adequacy of Records

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

However, the Company initially stated that there were no individual market certificates in force. During the examination it was discovered that there were 219 certificate holders in force during the period under examination. Therefore, the certificate was tested. In addition, the Company completed a total withdrawal of the individual market when it rolled over the 219 certificate holders during the period under examination, and the rollover was not completed in compliance with Ohio and federal guidelines.

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 40 calendar days to respond to memorandum requests and 103 calendar days to respond to inquiries.

Previous Market Conduct Examination Reports

The Company indicated that no market conduct examinations were conducted during the period under examination.

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.*

All sales, advertising, and producer marketing materials were requested for testing during the Fortis Benefits Insurance Company (FBIC) examination. FBIC provided 15 small group marketing materials used during the period under examination.

FBIC only operates in the group market, and the Company indicated that the same products and marketing and sales materials are used for FBIC, as were used for FIC during the period under examination. The Company agreed that testing completed for FIC group marketing and sales materials would reveal the same issues for FBIC, as determined during testing for FIC, for compliance with HIPAA, WHCRA, NMHPA, and Ohio's statutes and rules.

FBIC did not offer plans in the individual market, except for conversion, during the period under examination.

The results of testing the 15 small group materials are indicated in the table below:

Total # of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	% Failed Ohio	% Failed HIPAA	% Failed WHCRA
15	5	5	0	11	73%	33%	33%

Small Group Marketing Materials

Issue No. 1 – 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. 2 – Small Group Marketing Materials (termination provisions)
Public Law 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. 3– Small Group Marketing Materials (termination provisions)

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. 4– Small Group Marketing Materials (termination provisions)

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 coverage must be continued.

Issue No. 5 – 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: 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 No. 6 – 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: 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 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. 7 – 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).

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.

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. 8 – 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 stated, "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.

R.C. 3923.38 does not state 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.*** Please see our response to similar concerns in the Company's response to Inquiry #5.

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. Furthermore, 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. 9 – 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."

For compliance with R.C. 3924.01 and R.C. 3924.03, 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.

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 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. 10 – 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).

For compliance with R.C. 3924.03, 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.

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 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, 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 misleading. An insurer must permit a group the option to choose any waiting period between zero and ninety days.

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. Furthermore, 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.

Issue No.11 – 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 violation of R.C. 3901.21. In addition, 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. 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.

Issue No. 12 – 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 an 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 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'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 coverage 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 underwriting 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's Guide 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 attempted to decline the coverage.

Issue No. 13– 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;
(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;
(C) An employee who worked 25 hours per week in another Issued Small Group was denied coverage.

COMPANY RESPONSE: The Company's response to (A) above, stated, "Agree: 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."

COMPANY RESPONSE: The Company's response to (B), stated in part, "Disagree: 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. . . ."

COMPANY RESPONSE: The Company's response to (C), stated, "Agree: 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. 14 – 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 Ohio Adm.Code 3901-1-16(E), R.C. 3923.16 and 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.

COMPLAINTS AND GRIEVANCES

Department Complaints

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, NMHPA, WHCRA and Ohio Statutes and Rules.*

The Company provided 13 Department complaints. Those complaints were compared with the Department's COSMOS listing of complaints received during the period under examination. Six health complaints appeared on the Department's COSMOS listing, but did not appear on the Company's listing. The Company indicated that one complaint was against Fortis Insurance Company, it located one file and provided the file for testing, and it was unable to locate four of the complaint files. Therefore, eighteen files (13+1+4 = 18) were tested.

An Excel spreadsheet was created for testing the Department complaints, and the results of the testing of the fourteen files are indicated in the table below:

Total # of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	HIPAA % Failed	Ohio % Failed
18	2	0	0	6	11%	33%

Issue No. 1 – Complaints and Grievances (maintenance of complaint files)
The Company failed to maintain four Department complaint files for the required three years, thus contravening Ohio Adm.Code 3901-1-60(H)(3). These complaints appeared on the Department's COSMOS listing but not on the Company's listing.

COMPANY RESPONSE: The Company's response to each request for these complaint records stated, "Unable to locate any reference to this complaint in our records."

Issue No. 2– Complaints and Grievances (coordination of benefits)
One file indicated an insured with an Individual Medical Plan (IMP), which was offered in the individual market, was failed because the certificate contained a coordination of benefits provision that provided for coordination with the benefits of Medicare Part B, even if the insured was not enrolled in Medicare Part B.

Neither R.C. 3902.13 nor the Federal Register Preamble (HIPAA) permits coordination of benefits with Medicare coverage an individual does not have, whether or not that individual is eligible for such coverage. The Company may only coordinate benefits with plans that *cover* the insured person.

The Certificate stated in part, "Coordination of Benefit Provisions . . .

4. Coverage under government programs or coverage required or provided by any statute, except Medicaid. Benefits and services provided by Part A and Part B of Medicare are included. If an Insured Individual is eligible for, *but not covered under both Part A and Part B* of Medicare for any reason, the benefits or services that would have been payable if he or she had been covered, will be included, . . .

Effect on Benefits

When This Plan is a Secondary Plan, benefits payable under This Plan will be reduced to the extent necessary so that when they are added to the benefits payable under all other Plans, they will not exceed the total Allowable Expenses incurred by the Insured Individual during the Claim period. Benefits payable under any other Plan include the benefits that would have been payable had the claim for them been duly made. *Except for Part A and Part B of Medicare, the Insured Individual must actually be covered by the other Plans."*

COMPANY RESPONSE: The Company disagrees. As we noted in our response to FIC Inquiry #3, we disagree that federal law prohibits coordination of benefits with Medicare as described above:

Upon reaching Medicare eligibility by virtue of age, correspondence is sent to the insured outlining the insured's available options and further notifying the insured that, if they elect to maintain their current coverage, Medicare will be considered primary. 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.

We further respectfully disagree that R.C. 3902.13 prohibits the above described practice because it addresses only the order of benefits for a "plan of health coverage" and does not address how to coordinate benefits with Medicare. In addition, we further respectfully disagree that the certificate language violates Ohio Adm. Code 3901-1-56. Specifically, 3901-1-56 (E) specifically allows for coordination of benefits with Medicare if a person could have been covered under Part B of Medicare. We respectfully note, however, that the different interpretations are rendered moot by the fact that there have not been any IMP certificates in-force in Ohio since 12/31/02, as previously noted.

EXAMINER RESPONSE: The Company referred specifically to Ohio Adm.Code 3901-1-56(E), which provides in some cases for coordination of benefits with coverage an individual could have had under Medicare Part B. However, that rule applies to a "group-type" contract, which the Ohio Adm.Code 3901-1-56(C)(4) defines as a contract "not available to the general public which is obtained and maintained only because of

membership in, or in connection with, a particular organization or group. *This term shall not include an individually underwritten and issued, guaranteed renewable policy . . . .*" The "IMP" certificate was individually underwritten and was guaranteed renewable.

Inclusion of a provision coordinating benefits in the individual market with coverage an insured does *not* have, violates: (1) R.C. 3902.13(A)(2), which provides that coordination is effected with benefits of a plan that *covers* a person; (2) the Federal Register Preamble Supplementary Information II (C), page 16989, which provides that coordination with Medicare is permitted *to the extent that Medicare pays.*

Issue No. 3 – Complaints and Grievances (market withdrawal)
The Company failed to provide the required 180 days notice upon market withdrawal for two certificate holders tested. Both were covered under an "IMP" certificate. The complaint resulted from the plan's forced roll-over to a FIC plan.

One of the two files included a letter and endorsement of the certificate providing only 90 days' notice of the market withdrawal. The Company's practice of not providing 180 days' notice to insureds contravened R.C. 3901.20, 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR Sec. 148.122. Both files were failed because the Company stated that it rolled all the certificate holders with "IMP" certificates into FIC certificates. Therefore, all 219 certificate holders that were rolled into the FIC plan were not provided 180 days notice in violation of R.C. 3901.20, 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR Sec. 148.122.

The insureds' quarterly rate under the discontinued FBIC plan was $2,977.47. The insureds were initially quoted $3,299.73 for the FIC plan but were billed $4,588.77, and paid that amount to avoid a gap in coverage. The Company stated the new amount should have been $4,397.67, not $3,299.73. Due to its misquote, which the Company described as "administrative in nature," and subsequent to the complaint to the Department, the Company refunded $1,097.94, the difference between the original quote of $3,299.73 and the correct new amount of $4,397.67, and delayed the premium increase for one quarter.

***COMPANY RESPONSE*:** The Company's response to the issue of the premium increase, stated, "Disagree: The error was administrative in nature. When the error was brought to our attention it was corrected timely. As noted above, the insureds in Complaint Sample #6 disputed the premium amount billed for the replacement coverage. In our response to the insureds on December 13, 2002 and in the follow-up letter to the Ohio Department of Insurance dated January 13, 2003, we acknowledged a billing error resulting from the selection of different network plans and noted our refund of premium to the insureds."

***EXAMINER RESPONSE*:** The refund of the incorrectly billed premium was provided only after the insured complained to the Department. The end result of the Company's actions was a rollover of the insured into a FIC plan that had not been filed with the

Department and a premium increase of 48%. In addition, the Company did not withdraw from the individual market for a period of five years in compliance with R.C. 3901.20, 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR Sec. 148.122.

***COMPANY RESPONSE*:** The Company responded to the issue of the automatic roll-over, stating, "Agree: As we noted in our response to FBIC Inquiry #1, however, the Company took the action described in Inquiry #1 in part to prevent the displacement of longstanding customers. Had we formally withdrawn from the market, providing the Commissioner and insureds with 180 days notice, the insureds would have to obtain other coverage, sacrificing any deductible and out-of-pocket amounts satisfied and subjecting themselves to pre-existing conditions and the possibility of being unable to obtain coverage."

***EXAMINER RESPONSE*:** The Company could have provided the required 180 days notice in compliance with federal and state statutes and still have arranged for the offer of the FIC plan. In addition, the Company allowed itself to re-enter the individual market at any time, even though it had completed an individual market withdrawal.

Complaints and Grievances Standard #2 *– Sample internal complaints 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 Department Complaints (14) and Grievances (17), the Internal Complaints/Appeals were not sampled or requested for testing. It was determined that the testing of Department 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 rules.

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

The Company was requested to provide a listing of all the Grievances during the period under examination. The Company listing indicated there were 17 policy/certificate holders that took an issue to grievance during the period under examination. All the files were tested.

An Excel spreadsheet was created for testing of Grievances, and the results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	% Failed
17	0	0	0	0	0%

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, NMHPA, WHCRA and Ohio Statutes and Rules.*

Issue No. 1 – Termination of benefits

The only employer group certificate (FIC Form No. C99.100.SIG.OH, FBIC Form EM2K) 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.") *The Company agreed stating,* ***"We will be taking the necessary corrective action to address this issue."*** The Company did not indicate the corrective action.
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). In its response, the Company stated, "*Disagree. We respectfully note the federal law requires that coverage be terminated when an insured is engaged in the military for more than 31 consecutive days in order for the protections of "USERRA" and "COBRA" to be afforded.* ***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."*** The Company did not indicate the corrective action.
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). In its response, the Company stated, ***"Agree. We will be taking the necessary corrective action to address this issue."*** The Company did not indicate the corrective action.

All three provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The Company was also requested to provide a valid reason for Provision (5). FBIC 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. The Company's response stated, *"Disagree. 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."*** The Company did not indicate the corrective action.

Issue No. 2 – 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. The Company response stated, "Disagree. *Please be advised that our review practices entail establishing a direct (i.e., material) relationship between the misrepresentation and underwriting guidelines in place at the time of underwriting.* ***Our current practices require that in Ohio, the misrepresentation be "material"*** *which means that it would have affected the acceptance of the risk, and it induced us to accept the risk and, if the accurate information would have been shared, we would have issued the small employer coverage at a different rate. The process is designed to preclude any consideration of any misrepresentations, intentional or otherwise, that are not factually material to our issuance of coverage. . ."*
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.)* The Company response stated, *"Disagree. We note that our administrative practice is in compliance with state and federal law. It is not our practice to terminate all businesses which cease to operate on a full-time basis or which loses its identity by means of liquidation, merger, or otherwise. In contrast, 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." The Company did not indicate the corrective action.

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. Many groups operate in re-organization under bankruptcy protection. The group is only required to make premium payments.) The Company response stated, *"Disagree. We note that our administrative practice is in compliance with state and federal law. It is not our practice to terminate all groups placed in bankruptcy or receivership. In contrast, 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."*** The Company did not indicate the corrective action.

All three provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 3 – WHCRA benefits

The Company's group market certificate, during the period under examination, did not provide benefit language in compliance with the requirements of the Women's Health and Cancer Rights Act of 1998 (WHCRA) and Ohio Bulletin 2001-1. Therefore, the certificate's provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 4 – WHCRA benefits

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 cosmetic services are not provided. Their certificates would allow for denial of the mandated benefits of WHCRA, which was not in compliance with WHCRA or Ohio Bulletin 2001-1. Therefore, the certificate's provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

***COMPANY RESPONSE*:** The Company response stated in part, ". . . 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." In addition, the Company stated in part, ". . . Because our plans cover the medically necessary treatment of illness or injury, coverage would not be extended to prophylactic mastectomy . . . since a prophylactic mastectomy would not be covered under our plans and the insured is not "a participant or beneficiary who is receiving benefits in connection with a mastectomy", the provisions of WHCRA would not be extended or apply."

EXAMINER RESPONSE: The group certificate was failed, for failure to provide the mandated benefits of WHCRA and Bulletin 2001-1.

Issue No. 5 – Prosthetic device coverage
The group certificate stated, "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 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 then 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.

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 will amend other forms referenced, consistent with the above, following completion and approval of our form 225/227 filings. . . .***

EXAMINER RESPONSE: However, as indicated above, the Company's 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 the Company did not indicate it would eliminate the restrictions noted above for breast prosthetic devices (breast prostheses), and mastectomy bras. Therefore, the certificate's provisions were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 6 – 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. 7 – Discontinuation of health insurance coverage

The Company failed to withdraw from the individual market in compliance with R.C. 3923.57.

The Company withdrew from the market by terminating its individual plans:

1. without providing 180 days' notice to its certificate holders. The Company provided only 90 days' notice. Failure to provide 180 days' notice to insureds contravenes R.C. 3923.57(D)(2), Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR § 148.122.

   The Endorsement (Form No. EA-406-7) to the IMP contract stated:

"B. . . . If you are a Qualified Individual the Insurance will terminate on the earliest of the following: . . .

5. the date we stop writing new business for health insurance in the individual market. We will give you *90 days advance notice* from the date we stop writing new business."

This provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

COMPANY RESPONSE: *The Company agrees.* As we noted in our response to FBIC Inquiry #1, however, the Company took the action described in Inquiry #1 in part to prevent the displacement of longstanding customers. Had we formally withdrawn from the market, providing the Commissioner and insureds with 180 days notice, the insureds would have to obtain other coverage, sacrificing any deductible and out-of-pocket amounts satisfied and subjecting themselves to pre-existing conditions and the possibility of being unable to obtain coverage.

2. without formally withdrawing from the individual market *for the required five years.* Therefore, it positioned itself to re-enter the market at any time if it chose to do so. This provided the Company with a competitive advantage over other similarly situated insurers who exited the market according to the provisions of R.C. 3923.57. Failure to formally withdraw from the market for five years contravenes R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR § 148.122.

COMPANY RESPONSE: The Company agrees. However, we would note that the Company (FBIC) ceased marketing and issuing plans in the individual market in approximately 2000.

3. without providing any notice *to the Department* of its intentions. R.C. 3923.57 requires 180 days' notification to the Department before an insurer exits a market. The Company transferred the 219 certificate holders to a FIC Trust plan. Failure to provide 180 days' notice to the Department contravenes R.C. 3923.57, which is supported by Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR § 148.122.

COMPANY RESPONSE: The Company agrees. As we noted in our response to FBIC Inquiry #1, however, the Company took the action described in Inquiry #1 in part to prevent the displacement of longstanding customers. Had we formally withdrawn from the market, providing the Commissioner and insureds with 180 days notice, the insureds would have to obtain other coverage, sacrificing any deductible and out-of-pocket amounts satisfied and subjecting themselves to pre-existing conditions and the possibility of being unable to obtain coverage.

4. by forcing a roll-over of certificate holders from its filed "IMP" certificate to an unfiled FIC certificate. FIC form 227 had not been approved by the Department.

Therefore, all 219 FBIC certificate holders and their dependents were rolled over to the unapproved product. Failure to file certificates with the Department contravenes R.C. 3923.02.

***COMPANY RESPONSE*:** The Company agrees. However, as noted in our response to FIC Memo Request #19, Form 227 was filed with the Ohio Department of Insurance in April of 2004.

EXAMINER RESPONSE*:** In a letter to the insured, the Company stated, "To keep your health insurance plan up-to-date with the plans we currently sell, we are replacing your Fortis Benefits Insurance Company Individual Member Plan with our newest health plan, which is issued by Fortis Insurance Company. Coverage under your current plan will end and your new coverage will begin on October 1, 2002. You don't need to worry about any gaps in coverage – your health insurance will continue uninterrupted, provided you continue to pay your premiums. Since you will be automatically enrolled ***in our newest plan, you don't need to do anything. . . " "Our," was referencing a new FBIC plan, yet the Company was rolling the certificate holders into a FIC plan.

The Company's response in reference to the letter stated, "Disagree: Fortis Health is our marketing name, under which are the legal entities FIC and FBIC. Please note, "our" is in reference to Fortis Health. Because FBIC was no longer marketing health insurance products in the individual market, insureds were offered all FIC plans then offered in the individual market. Please note, because FBIC no longer markets health insurance products in the individual market, this situation will not arise in the future."

In a letter to the EIC explaining the roll-over, the Company stated in part, "As we discussed, Fortis Benefits ceased marketing and issuing products in the individual market at the end of 2001. However, the company had a run-off block of individual market business in Ohio that was in force during the first two quarters of the examination period. These certificate forms, referred to internally as 'IMP' ('Individual Medical Plan', issued under a group trust sitused in Mississippi) were discontinued in 2002. All Ohio insureds covered under these forms were offered coverage under Fortis Insurance Company Certificate Form 227 (also a group trust product, sitused in Illinois.) We have requested data and obtained the following, which reflects the number of FBIC 'IMP' forms that were discontinued and replaced with FIC Certificate Form 227 . . . ."

The Company also stated, "The substantive issues presented above will be addressed in detail below. However, we would note that the IMP forms referenced here were discontinued and replaced in part because the forms were outdated and did not meet current requirements. In recognition of this, along with FBIC's decision to cease marketing health insurance products in the individual market, certificateholders were offered similar, updated plans issued by affiliated company Fortis Insurance Company (FIC). The roll to the FIC plans was instituted in large measure to prevent displacement that a full market withdrawal would entail, leaving affected insureds without coverage. As conducted, the discontinuance and replacement of the IMP plans were consistent with requirements for discontinuance and replacement of a policy form by a carrier in the

individual market. Insureds were afforded 90 days advance notice and were afforded the opportunity to select from all FIC plans then offered in the individual market, including the Basic and Standard plans. Deductible and out-of-pocket credit and full pre-existing condition limitation credit was applied. It is also worth noting that, based on the examiner's review, this process, involving 219 individuals and families, generated two complaints. One of those complaints was due to administrative errors that resulted in incorrect premiums applied. In addition, we would note that the last IMP plan was discontinued and replaced in December of 2002."

The Company failed to discontinue its individual plans in compliance with R.C. 3923.57, Public Law 104-191, and Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122.

Issue No. 8 – Emergency Services
The "IMP" certificate stated in part, "Major Medical Insurance Coverage . . ."

> 'Emergency' means a sudden onset of a serious of (*sic*) life-threatening condition that demands immediate attention."

The certificate failed to provide the definition of "emergency" set forth in R.C. 3923.65. Failure to accurately define an "emergency medical condition" contravenes R.C. 3923.65. In addition, the certificate definition did not address the welfare of a pregnant woman or her unborn child.

COMPANY RESPONSE: The Company disagrees. We respectfully note no requirement in section 3923.65 that the language provided in this section be expressly contained in the certificate for insurance. Regardless, we note no violation of the statute because IMP provided coverage for emergency services consistent with the requirements of the statute.

Another Company response indicated that the statutory definition of "emergency medical services" did not require coverage of emergency medical services in all circumstances. The Company stated, "The interpretation conveyed in the Inquiry that Ohio statutes require coverage of any emergency services would render policy exclusions and, in the case of coverage issued in the individual market, exclusion riders, meaningless. The ability of the insurer to assess and underwrite risk would be irreparably compromised.

EXAMINER RESPONSE: The Company's inaccurate definition of "emergency services" enabled the Company to deny coverage for some medical services that did not fall within its definition. Therefore, its definition was misleading and deceptive in violation of R.C. 3901.21(B).

Issue No. 9 – Complaint procedures
The "IMP" certificate failed to include the Company's "complaint procedures."

Ohio Adm.Code 3901-1-60(H)(2) requires the Company to include third party payer's complaint procedures in every benefit plan or certificate. Therefore, failure to include the complaint procedures in the certificate contravenes Ohio Adm.Code 3901-1-60(H)(2).

COMPANY RESPONSE: The Company's response stated in part, ". . . Ohio Adm.Code 3901-1-60(H)(2): **Agree**: The IMP Certificate form did not explicitly contain the complete complaint procedures available to insureds. However, we consistently followed our complaint procedure for the review of oral and written complaints. We further note that there have been no IMP contracts in force since 12/31/02. . . ."

EXAMINER RESPONSE: The Company agreed that the complaint procedures were not included in the certificate in violation of Ohio Adm.Code 3901-1-60(H)(2).

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. 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	49	49	100%	100%

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(E)(2), which provides *". . . Such waiting periods shall not be greater than ninety days."*

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.**

***EXAMINER RESPONSE*:** To indicate to agents that 100% participation is required for life insurance is untrue, deceptive, and misleading when the Company then denies such coverage to certain individuals. To perform such acts contravenes R.C. 3901.21(B).

Issue No. 7 – Treatment of married employees

One file in the Small Groups Terminated files and two files in 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. Furthermore, 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 stated, "***Agree***: 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 stated, "**Agree**: 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), R.C. 3924.03(E), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A), and 45 CFR § 146.150. All three of the Small Groups Issued with two employees 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, and the results of the testing is indicated in the table below.

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

Small Groups Terminated for Fewer than Two Participants

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. HCFA Bulletin, Transmittal No. 99-03, dated September 1999, 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 Bulletin, Transmittal No. 99-03, dated March 1999.

Issue No. 2 – Small Groups Terminated for fewer than two participants
One of the 19 files was also failed because the 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, to do so was a violation of 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 was failed twice 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 agrees. 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'. (2) 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. The Company practices and procedures for denying coverage for non-compensated employees during the period under examination has been a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and R.C. 3924.01(G).

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 50 small group certificates terminated. One file was for 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	13	14	27%	29%

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 (as noted above) 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 HCFA Bulletin, Transmittal No. 99-03(V), dated September 1999.

(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.

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) issued 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 and FBIC 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 small group applications. Of these, one was an application for a life only policy. Therefore, it was omitted from testing. The four 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
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 stated 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' (sic) 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 indicates an unfair practice, which discriminates amongst small groups in violation of R.C. 3901.21(M). All qualified small groups are in the same class. The Company's practice was also a violation of 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 with 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. To deny group coverage for this reason would be 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 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."

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."

EXAMINER RESPONSE: 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 filed by 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: The Company responded, "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

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. The Company did not offer individual plan forms during the period under examination. The Company only offered a JALIC plan (J-1110) to conversion eligible individuals. FBIC does not offer the Ohio Standard and Basic plan forms. Therefore, the Company's conversion practices and procedures for offering conversion were failed for not complying with R.C. 3923.122, because the J-1110 is not substantially similar to the Ohio Standard and Basic plan forms.

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) at the time the applicant applied for conversion coverage. Three of the five conversion applicants were confirmed as FEIs during testing. 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 that 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."* R.C. 3923.122(B) provides 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 mode. In addition, the annual mode of payment was 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."

The Company has to accept every conversion eligible individual that applies for conversion coverage. Therefore, the Company procedures for conversion coverage also appear 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 . . ."*

The Ohio Standard Plan (Policy Form 186) has maternity coverage with no preexisting conditions limitation. Maternity coverage is not offered in the Ohio Basic Plan (Policy Form 185). The JALIC Conversion plan 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. There was no maternity coverage for individuals who became pregnant while the coverage was in force. In addition, the J-1110 provided a lifetime maximum amount of $250,000 versus the $1,000,000 maximum for the Ohio Standard plan and an unlimited maximum for the Ohio Basic plan. The Ohio Basic and Standard plans clearly indicate coverage for the mandated benefits of WHCRA and Ohio Bulletin 2001-1, where the J-1110 does not clearly indicate such benefits. Therefore, the J-1110 is not substantially similar to the Ohio version of the Basic and Standard plans in benefit design.

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.

FBIC indicated it did not create an Ohio Standard and Basic plan. Therefore, the Company was requested to clarify how it wished to alter its response for FBIC versus its comments for FIC. For FIC it indicated it would determine federal eligibility and offer its Standard and Basic plans for federally eligible individuals. FBIC's response stated in

part, "You had asked for clarification with respect to FBIC and conversion offers from FBIC employer-group plans. You have noted that, unlike FIC and JALIC, FBIC does not have individual market offerings and, specifically, does not offer a Basic and Standard Plan. As with FIC . . ., FBIC also believes its offering of the J-1110 meets the statute's requirements in R.C. 3923.122(1) for the reasons outlined in our response. Moreover, FBIC believes that the J-1110 qualifies as substantially equivalent to the Basic and Standard plans, and offers it to all conversion eligible individuals under Section 3923.122, not just the federally eligible individuals. Therefore, the Company believes it met the requirements of the statute by offering the JALIC product (form J-1110) as there is no specific requirement that the Basic, Standard or substantially equivalent plan must be issued by the insurer itself."

EXAMINER RESPONSE: FBIC's and FIC's responses and their procedures are not in compliance with the mandates of R.C. 3923.122 and R.C. 3923.581. As indicated above, the J-1110 is not substantially similar in benefits when compared to the Ohio Standard and Basic plans, and FBIC does not offer the Ohio Standard and Basic plans to FEIs.

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.

CLAIMS PAID AND DENIED

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 of claims paid and denied. Two mastectomy paid claims files were sampled for testing.

No exceptions were noted during the testing of paid mastectomy claims as indicated in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
2	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 of claims paid and denied. Four denied breast reconstruction claims files were sampled.

No exceptions were noted during the testing of denied breast reconstruction claims as indicated in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
4	0	0	0%	0%

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 procedures for breast reconstruction, breast reduction/mammoplasty, or gynecomastia during pre-authorization. The listing indicated there were seven pre-certification denials during the exam period, and all seven were sampled for testing.

No exceptions were noted during the testing of denied pre-certification files for breast reconstruction procedures as indicated in the table below:

# of Files	Failed WHCRA	Failed Ohio	WHCRA % Failed	Ohio % Failed
7	0	0	0%	0%

ASSOCIATIONS

During the period under examination all of the Company's Ohio health plans were offered through an association or trust. The FBIC 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, e.g., the association plan is deemed a group plan, but not an employer group plan, and the other plan is an individual policy offered in the individual market. 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. 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.*

2. A Company small group brochure indicated that it could 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.*

3. 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.*

4. 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.*

5. 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.

6. 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.*

7. 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 in 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.*

8. The Company's small group Ohio variations form failed to provide state continuation when the covered person was totally 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 in 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.*

9 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.

10. 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 in 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.*

11. 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 in 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.*

12. 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 in 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.*

13. 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.*

14. 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 in 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.*

15. The Company failed to maintain four complaint files in compliance with Ohio Adm.Code 3901-1-60(H)(3). The Company agreed. *See Complaints and Grievances Standard #1.*

16. An individual market holder's certificate contained a coordination of benefits provision with Medicare Part B even if the certificate holder has not signed up for Medicare Part B. An insurer is only allowed to coordinate benefits with Medicare in the individual market, "to the extent that Medicare pays." The provision is a violation of R.C. 3902.12(A)(2) and HIPAA (preamble). The Company disagreed with the violation, but agreed to discontinue the practice. *See Complaints and Grievances Standard #1.*

17. The Company provided 90 days notice for two insureds that were being rolled from a FBIC individual market plan to a FIC plan. The rollover constituted an individual market withdrawal for FBIC. Therefore, the Company was obligated to provide all insureds with a 180 days notice, and it should have told the Department that it was completing a market withdrawal for compliance with R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR § 148.122. *See Complaints and Grievances Standard #1.*

18. 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.*

19. 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. Therefore, the language was untrue, deceptive and misleading in violation of

R.C. 3901.21(B). 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.*

20. 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. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). 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.*

21. 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 language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). 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.*

22. 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. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). 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.*

23. 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. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). 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.*

24. The Company's group market certificate did not contain language in compliance with the requirements of the WHCRA and Ohio Bulletin 2001-1. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). The certificate should be amended to comply with the requirements of WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

25. None of the Company's certificates or policies offered in the 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 language was untrue, deceptive and

misleading in violation of R.C. 3901.21(B). 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.*

26. The Company's group certificate language refuses COBRA continuation rights to any individual entitled to Medicare, when first eligible for COBRA continuation. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). The Company has amended the certificate language to comply with 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.*

27. The Company failed to provide 180 days notice to certificate holders when it completed a withdrawal of the individual market in violation of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. In addition, the contract allowed for 90 days notice to certificate holders when the Company stopped writing business. Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B). The Company agreed. *See Contract/Policy Language Standard #1.*

28. The Company failed to inform the Department and make a formal withdrawal from the individual market for the required five years in violation of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742, and 45 CFR § 148.122. The Company agreed. *See Contract/Policy Language Standard #1.*

29. The Company failed to obtain approval for the FIC certificate that the certificate holders were rolled into. Certificates must be filed for compliance with R.C. 3923.02. The Company agreed. *See Contract/Policy Language Standard #1.*

30. The Company's individual market certificate did not define "emergency services" in compliance with R.C. 3923.65(A) and (B). The Company's certificates and procedures should provide emergency services, and claims should adhere to the proper definition of an emergency service in compliance with Ohio law. The language was misleading in violation of R.C. 3901.21(B). *See Contract/Policy Language Standard #1.*

31. The Company's individual market certificate failed to provide the Company's complaint procedures in violation of Ohio Adm.Code 3901-1-60(H)(2). The Company agreed. *See Contract/Policy Language Standard #1.*

32. 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.*

33. 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.*

34. 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.*

35. 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 indicated it would reinforce with appropriate staff the importance of adhering to the Company's employer contribution rules. *See Underwriting Standard #1.*

36. 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.*

37. 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.*

38. 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.*

39. 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.*

40. 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 through 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.*

41. 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.*

42. One of the nineteen employer small groups 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.*

43. One of the nineteen employer small groups that 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.*

44. 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.*

45. 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.*

46. 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. This requirement is also found in the Company's advertising. The Company should eliminate the practice that the employer "must" provide the items, when in fact the employer may not have either item. *See Underwriting Standard #3.*

47. The file indicated in No. 84 had 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.*

48. 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.*

49. One small employer 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.*

50. The Company 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.*

51. The Company 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.*

52. The Company 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.*

53. The JALIC Conversion plan (provided for FBIC), 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 meets the statutes requirements.*" *See Underwriting Standard #4.*

ACKNOWLEDGEMENT

In addition to the undersigned, Yvonne Sainsbury, AIE, AIRC, participated in this examination.

Respectfully submitted,

_____

Thomas D. McIntyre, CIE, CPCU, FLMI, AIRC, ACS, APA
Examiner-In-Charge
For the State of Ohio
Department of Insurance

HUFFTHOMAS

AFFIDAVIT OF THOMAS MCINTYRE

STATE OF }
} ss
COUNTY OF }

Thomas D. McIntyre, being duly sworn, deposes and says that the foregoing Target Market Conduct Report of Examination of Fortis Benefits Insurance Company as of June 30, 2004, subscribed by him is true to the best of his knowledge and belief.

_____
Thomas D. McIntyre, CIE, CPCU, FLMI, AIRC, ACS, APA
Examiner-in-Charge
For the State of Ohio
Department of Insurance

Subscribed and sworn to before me on the _____ day of _____, 2006.

_____
Notary Public for the State of Ohio
My Commission Expires:

APPENDIX A – MANAGEMENT LETTER OF REPRESENTATION

STATE OF OHIO

DEPARTMENT OF INSURANCE

IN THE MATTER OF:	)	
	)	
FORTIS BENEFITS INSURANCE COMPANY (NOW KNOWN AS UNION SECURITY 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 Benefits Insurance Company, now known as Union Security Insurance Company ("the Company"), an Iowa-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 Benefits Insurance Company, NAIC #70408 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 22, 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 policy forms were identified containing termination provisions that were not in compliance with state and federal laws. These products were sold prior to 2001.

2. The Company failed to inform the Superintendent of its intention to do so and failed to file a formal withdrawal notice from the individual health insurance market.

3. The Company required groups interested in purchasing health insurance to purchase group life insurance for all of the group's enrollees.

4. 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").

5. The company failed to offer sufficient coverage plans to conversion eligible certificate holders. In addition, it offered only an annual mode of premium payment for conversion plans.

6. The Company failed to determine whether its customers were Federally Eligible Individuals ("FEIs") during the application process for conversion coverage.

7. The Company failed to provide maternity coverage in its conversion plan if the insured's group did not have maternity coverage.

The findings as described in Section I of this Consent Order and the findings detailed in the Examination Report are symptoms of a lack of internal controls over the Company's compliance risk resulting in a failure to comply with federal and state laws. 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.

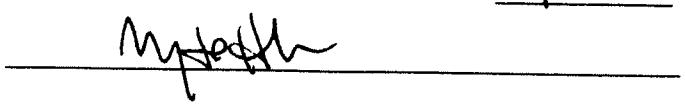
4. One hundred-eighty (180) days following the Company's execution of this Consent Order, the Company shall begin a self-audit of up to sixty (60) days duration to determine whether it has successfully implemented the Plan ("Self Audit"). The detailed results of the Self-Audit shall be provided to the 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 Benefits Insurance Company, now known as Union Security 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 Benefits Insurance Company, now known as Union Security 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 Benefits Insurance Company, now known as Union Security Insurance Company, to the terms and conditions of this Consent Order.

FORTIS BENEFITS INSURANCE COMPANY, NOW KNOWN AS UNION SECURITY INSURANCE COMPANY

By: _____

Print or type name: Julia Hix-Royer

Title: Vice President Regulatory Compliance

Date: June 27, 2008