

# **OHIO DEPARTMENT OF INSURANCE**

**A**

**TARGETED**

**MARKET CONDUCT EXAMINATION**

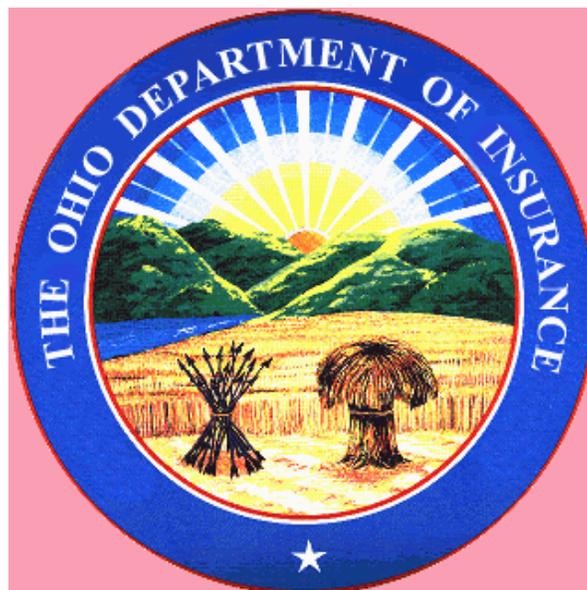
**OF**

**JOHN ALDEN LIFE INSURANCE COMPANY**

**NAIC #65080**

**As Of**

**June 30, 2004**



## Table of Contents

Salutation	1
Scope of Examination	2
Company Operations and Management	4
Marketing and Sales	5
Complaints and Grievances	19
Contract/Policy Language	30
Underwriting	95
Claims Paid and Denied	118
Summary of Recommendations	121

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:

John Alden Life Insurance Company  
501 W. Michigan  
P.O. Box 3050  
Milwaukee, WI

The Company was a Wisconsin domiciled life, health and annuity insurance company hereinafter referred to as "JALIC" or the "Company." The examination was performed as of June 30, 2004, at the Company's office located in Milwaukee, WI. After the examination period the Company has re-domiciled in Iowa.

A report of the examination is enclosed.

Respectfully submitted,

---

Lynette A. Baker  
Assistant Chief, Market Regulation Division

---

Date

## **SCOPE OF EXAMINATION**

This Target Market Conduct Examination was performed to determine John Alden Life Insurance Company's (hereinafter referred to as "Company" or "JALIC") 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: Policies 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 Department.

All unacceptable or non-complying practices may not be discovered during the course of the examination. 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

Gamble Alden Life Insurance Company was incorporated under the laws of the State of Minnesota on May 17, 1973. The Company went through a series of mergers between 1973 and 1979. Following a merger on March 31, 1979, the Company changed its name to John Alden Life Insurance Company (JALIC).

On August 31, 1998, JALIC along with its holding company, John Alden Financial Corporation and all its subsidiaries were acquired by Fortis, Inc. U.S., as an indirect wholly-owned subsidiary of Fortis S/NV (Belgium) and Fortis N.V. (Netherlands). Upon acquisition, JALIC's corporate headquarters were relocated from Miami, Florida to Milwaukee, Wisconsin where it became part of Fortis Health. JALIC is domiciled in the State of Wisconsin.

As of February 4, 2004, Fortis Health became known as Assurant Health. Fortis, Inc. merged with the newly established Assurant, Inc., which is domiciled in the State of Delaware. JALIC is an indirect subsidiary of Interfinancial Inc. and operates as part of the Assurant, Inc. group of life / health insurers.

All of the business marketed in the State of Ohio by JALIC is directed through North Star Marketing, a wholly-owned subsidiary of JALIC. The operations of the Company are conducted in 48 states and the District of Columbia through independent licensed agents under the supervision of John Alden's subsidiary, North Star Marketing Corporation. The Company offers PPO plans for individuals, families and small employers. It also offers short term medical health insurance products, and dental and life insurance coverage.

The Company indicated it does not utilize Managing General Agents (MGA's) or Third Party Administrators (TPA's) as these entities are defined by Ohio insurance laws.

### 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 or policies in force during the period under examination except for the certificates and policies currently being issued. During the examination it was discovered that there were 219 certificate holders in force with the Company's Jalicare plan during the period under examination. Therefore, the certificate was tested. However, the Jalicare plan was not issued during the period under examination.

Furthermore, the Company was requested to provide its group plans for testing of the certificate language. The Company provided certificate J-4000, which it indicated was

the current issued group plan, and the only certificate issued during the period under examination. However, during testing it was discovered that the certificate provided was not the same as those issued during the period under examination. Therefore, the Company was again requested to provide certificate J-4000 as issued in Ohio. The Company provided the J-4000 and the J-3000 certificates, and indicated they were the only plans in force during the period under examination. However, the second attempt at providing the J-4000 was again not the same certificate as the certificates that were issued during the period under examination. Therefore, the Company was requested to provide any employer group certificate issued during the period under examination to an Ohio employer group. After testing had begun on the issued certificate, the Company located a correct version of the Ohio J-4000 certificate and provided it for testing.

#### 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 24 calendar days to respond to memorandum requests and 97 calendar days to respond to inquiries.

#### Previous Market Conduct Examination Reports

The Company indicated there were no reports issued for market conduct examinations 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.*

The Company indicated it would agree that all of the individual market operations for Fortis Insurance Company (FIC) are identical to the operations for John Alden Life Insurance Company (JALIC,) except JALIC does not offer the student select plan. Therefore, the testing of Marketing and Sales in the individual market for FIC was duplicated into this Phase of the JALIC examination, except where the violation was in reference to the student select plan.

JALIC indicated that FIC certificate 225 was identical to JALIC certificate 390, and FIC certificate 227 was identical to JALIC certificate 397. The FIC responses addressed certificates 225 (association plan) and 227 (trust plan). Therefore, for all the FIC responses throughout this report, which referenced FIC certificate 225, it would be in reference to JALIC certificate 390, and when FIC certificate 227 is referenced, it would be in reference to JALIC certificate 397.

## **Individual Marketing Materials**

### **Issue No. 1 – Individual Guide (maternity services)**

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

This contradiction would result in an agent (without reference to the Individual Guide, and for an applicant with a history of C-section delivery), submitting an application, and the Company accepting the application electing maternity coverage, while another agent, after referring to the same Individual Guide, advises the applicant (also with a previous history of C-section delivery) that she cannot elect maternity coverage. Therefore, the language was misleading in violation of R.C. 3901.21(B).

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

**COMPANY RESPONSE:** The Company disagrees. We note no violation of Co (sic) Stat. § 3923.15 . . . . The agent guide is not provided to the insured. Further, all agents are provided with the same Agent’s Guide. Therefore, we note no violation of Ohio law. *In an effort to amicably resolve this matter, we will be taking the necessary corrective action to address this issue.*

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

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

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

The Guide is misleading in that it is in direct conflict with Ohio statutes, and which if supplied to an applicant, would be in contravention of R.C. 3901.21(B) as materially misleading or deceptive. Additionally, R.C. 3904.10(A) requires that in the event of an adverse underwriting decision, the insurer or agent shall provide *the applicant* with the specific reason(s) for the decision in writing or advise the applicant that (s)he should request and receive in writing, the specific reason(s) for the decision. During testing of files, it was determined that the Company’s form letter to declined applicants follows this

procedure and does not permit *the applicant* to receive the specific reason(s) for adverse underwriting decisions from the Company. The letter provides that the applicant may only receive this information from his or her physician. Each issuance of the form letter to a declined individual was a contravention of R.C. 3904.10(A), which provides in part, “In the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall provide the applicant, policyholder, or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing, or advise such person that upon written request he may receive the specific reason or reasons in writing.”

**COMPANY RESPONSE:** The Company agrees. We respectfully note that the Company had modified its administrative practices such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice. Among the documentation planned for revision to comport with current company practice is the Agent’s Guide.

**Issue No. 3 – Specialty Products Marketing Materials (agent commissions)**

When issuing an Ohio Basic or Standard Plan, during the period under examination, the Company provided a first year commission of 2% for agencies/agents, and renewal commissions and fees of 2% for every year thereafter. Therefore, every commission paid to an agent for issuance and renewal of an Ohio Basic and Standard plan has been in violation of R.C. 3923.58(K), which mandates a five percent at initial placement, and four percent at renewal commission.

R.C. 3923.58, provides in part:

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

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

In addition, reducing commissions is a violation of guaranteed availability of the State of Ohio’s Alternative Mechanism for FEIs as indicated in HCFA Bulletin, Transmittal No. 98-01, dated March 1998. To set commissions so low that it discourages agents from selling the Ohio Basic and Standard Plans violates R.C. 3923.581(C) and (D), which indicates the plans are guaranteed available to all FEIs. The Bulletin provides in part, “. . . insurance practices that are inconsistent with the guaranteed availability provisions of . . . (HIPAA) . . . . Setting agent commissions for sales to HIPAA eligible individuals and/or small groups so low that agents are discouraged from marketing policies to, or enrolling, such individuals . . . .”

**COMPANY RESPONSE:** The Company agrees. We will be taking the necessary corrective action to address this issue, consistent with the provisions of Section 3923.58 (K) of the Ohio Revised Code.

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

**EXAMINER RESPONSE:** The Company appears to be responsible for retrospectively (1) calculating the commissions it should have paid to agents who sold Basic and Standard Plans and (2) reimbursing those agents in compliance with R.C. 3923.58(K).

The Company’s commissions paid during the period under examination were a violation of R.C. 3923.58(K), and restricted the guaranteed availability provisions of HIPAA.

### **Small Group Marketing Materials**

#### **Issue No. 4 – Small Group Marketing Materials (coverage options)**

Two JALIC small group brochures (Forms J4-1842 (Rev.3/2004) and J4-1360 (Rev. 1/2003) stated in part:

- Maternity benefits are an option for groups initially insuring three to nine employees for medical coverage and automatically included for groups initially insuring ten or more employees for medical coverage.
- Mental health/substance abuse benefits are automatically included for groups initially insuring three or more employees for medical coverage.
- Prescription drug options 2 and 3 are available for groups initially insuring three or more employees for coverage.

All three provisions noted above contain limitations for products, which are not in compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. Therefore, the provisions also violated R.C. 3901.21(M), because it discriminates among small groups. All products that are approved for sale in the small group market and the issuer is actively marketing, must be offered to all small employers applying for a small group product and accept any employer that applies for any of those products.

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 fourteen employees.
3. Discriminate between groups of fewer than fifteen eligible employees of essentially the same class and hazard in eligibility for maternity benefits.

Therefore, the two brochures were misleading in violation of R.C. 3923.16, and Ohio Adm.Code 3901-1-16(E)(2).

HCFA Bulletin, Transmittal No. 00-03, dated June, 2002, provides in part, “III . . . make clear that an issuer of coverage in the small group market generally must offer to each small employer . . . in the State each product that is approved for sale in the small group market and that is actively marketed by the issuer . . . . Example 1. A State law requires issuers to offer coverage for biologically-based mental illness to employers with more than 25 employees. However under the PHS Act’s all products requirement, if an issuer actively markets a product providing coverage for biologically-based mental illness to small employers with more than 25 employees, the issuer also must offer the product to all small employers with between 2 and 25 employees.”

**COMPANY RESPONSE:** The Company disagrees. As we noted in our response to FIC Inquiry #77, 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 in order to accommodate the federal requirement that groups employing more than 15 employees fails to meet the “All Products Guarantee”. However, **the Company respects Ohio’s position on this matter, and we have changed practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group. Moreover, we have changed our mental health/substance abuse and prescription drug options to be available to all small groups regardless of size.**

**EXAMINER RESPONSE:** Transmittal No. 00-03, dated June, 2002, clearly indicates that all products offered by an insurer must be made available with all options available to all small employers.

**Issue No. 5 – Small Group Marketing Materials (coverage options)**

The “John Alden Small Group - Agent’s Guide” (Guide), Form L-15049 (Rev.2/2004) and the “Small Employer Group Insurance Plans” brochure (Brochure), J4-1000 (Rev. 5/2003), contained similar provisions. Therefore, the two documents were combined for testing. The 16 violations and the Company’s responses are provided below:

1. The Guide and Brochure indicated that Maternity benefits are automatically included for small groups that provided medical coverage for ten or more employees, and not available for groups providing medical coverage for fewer than three employees. Groups initially providing medical coverage for three to nine employees have the option of maternity benefits for their group. Therefore, the materials excluded maternity for groups of two employees, and made it mandatory for groups of ten employees or greater; and allowed optional maternity benefits for groups of three to nine employees. The guaranteed availability requirements of R.C. 3924.03(E)(1),

Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and HCFA Bulletin, Transmittal No. 00-03, dated June, 2002, indicates that an issuer of coverage in the small group market generally must offer to each small employer . . . in the State each product that is approved for sale in the small group market and that is actively marketed by the issuer. In addition, the provisions also violate R.C. 3901.21(M), because the provisions unfairly discriminated among small groups. Therefore, the Guide and Brochure were deceptive, misleading and untrue in violation of R.C. 3923.16, R.C. 3901.21(B) and Ohio Adm.Code 3901-1-16(E)(2).

**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 as noted in our response . . . has changed its practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the number of employees in the group.*

**EXAMINER RESPONSE:** The Company disagrees. The HCFA Bulletin, Transmittal No. 00-03, dated June, 2002, clearly indicates that all options, for all plans, must be made available to all small employers that wish to apply for a small group plan. Therefore, the Guide and Brochure were misleading in violation of R.C. 3923.16, R.C. 3901.21(B) and Ohio Adm.Code 3901-1-16(E)(2).

2. The Guide and Brochure indicated that dental benefits are available as a complement to medical coverage or as a stand-alone product, and dental benefits are designed especially for small employers *with at least 3 covered employees*. If sold as a stand-alone product, there is no violation of law. However, when sold as additional coverage to the group plan, it limits access to only groups of 3 or more covered employees, it eliminates groups of 2 from the coverage which is a violation of guaranteed availability provisions at R.C. 3924.03(E)(1), Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150, and HCFA Bulletin, Transmittal No. 00-03, dated June, 2002. In addition, the Brochure stated in part, “Available to groups of at least 3 covered employees . . . . PPO plans may be selected for each area . . . .” This provision also violates the guaranteed availability provisions noted above. An insurer is never allowed to exclude groups of 2 from access to the same plans or options as is available for groups of 3 or more. Both provisions would also violate R.C. 3901.21(M), because they discriminate among small groups. Therefore, the Guide and Brochure were deceptive, misleading and untrue in violation of R.C. 3923.16, R.C. 3901.21(B) and Ohio Adm.Code 3901-1-16(E)(2).

**COMPANY RESPONSE:** The Company agrees. We will amend procedures and marketing material to ensure that dental is offered uniformly to all size groups when included as part of a health benefit plan offered to small employers.

3. The Guide and Brochure indicated that group life insurance and AD&D is automatically included in an employer's plan. An insurer is not allowed to make add on coverage's mandatory to small employer group health coverage. Issuance of a small employer group health plan cannot be contingent upon the purchase of any other product. The provision is a violation of the guaranteed availability provisions at R.C. 3924.03(E)(1), Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. In addition, to force the sale of Life and AD&D insurance upon a small employer group is an unfair device that may directly or indirectly, cause or result in the placing of coverage for adverse risks with another carrier in violation of R.C. 3901.21(V). Therefore, the Guide and Brochure were deceptive, misleading and untrue in violation of R.C. 3923.16, R.C. 3901.21(B) and Ohio Adm.Code 3901-1-16(E)(2).

**COMPANY RESPONSE:** The Company disagrees. Company actions taken in response to FIC . . . were taken by John Alden as well . . . . 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 has changed its practices and materials in such a way as to comport with the examiner's recommendations on this issue.**

**EXAMINER RESPONSE:** An insurer is not allowed to make add on coverage's mandatory for small employer group health coverage. Therefore, the Company procedures were a violation of R.C. 3901.21(V), and the Guide and Brochure were deceptive, misleading and untrue in violation of R.C. 3923.16, R.C. 3901.21(B) and Ohio Adm.Code 3901-1-16(E)(2).

4. The Brochure stated a small group could select a 30, 60 or 90 days waiting period. R.C. 3924.03 indicates that waiting periods are at the discretion of the employer, and the employer can select from a zero through a 90 days waiting period. Therefore, the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should allow an employer to choose a zero through 90 days waiting period in compliance with R.C. 3924.03.
5. The Brochure stated in part, “Effective Dates . . . future eligible employees may be required to furnish *satisfactory evidence of insurability*.” Health Status may not exclude coverage of an employee of any employer group. For compliance with R.C. 3924.03(C), Public Law 104-191, Part A – Group Market Reforms, Sec. 2702, and 45 CFR § 146.121, it is not permissible to indicate that an employee must furnish “*satisfactory evidence of insurability*.” Therefore, the Brochure was deceptive, misleading and untrue in violation of R.C. 3923.16, and Ohio Adm.Code 3901-1-16(E)(2).

**COMPANY RESPONSE:** The Company disagrees. While we agreed in our response to FIC . . . that use of the term may imply that health status information may have bearing on enrollment, both Company’s practices entailed gathering such information for rating purposes only. Other information on the enrollment form (e.g., hours worked, dependent status, etc.) establish pertinent non-medical eligibility information. As noted in our response to FIC Inquiry #61:

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.

**As with FIC, however, we are amending all materials to remove the term “Evidence of Insurability.”**

**EXAMINER RESPONSE:** The Company’s response, “that use of the term may imply that health status information may have bearing on enrollment,” indicates the Brochure was deceptive, misleading and untrue. Therefore, it was a violation of R.C. 3923.16, and Ohio Adm.Code 3901-1-16(E)(2).

6. The Brochure stated, “If an employee is not actively at work full time and performing all the duties of his or her regular job on the employee’s effective date of insurance, that employee’s coverage may be deferred until he or she returns to active, full-time work.” The Company has conditioned eligibility based on health status, which is a violation of R.C. 3924.03(C), Public Law 104-191, Part A – Group Market Reforms, Sec. 2702, and 45 CFR § 146.121. Therefore, the Brochure was deceptive, misleading and untrue in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2).

**COMPANY RESPONSE:** The Company disagrees. While we agreed to amend contract language in our response . . . we noted that Company practice does not entail deferment of effective dates for any health-status related reasons. As we stated: The Company does not administratively defer the effective date if the employee is absent from work due to illness or injury and otherwise meets the definition of an eligible full time employee.

**EXAMINER RESPONSE:** The Company should amend the Brochure as well, because it was misleading and deceptive in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2).

7. The Brochure stated in part, “In general, we have the right to terminate a company’s coverage when . . . . There has been fraud or misrepresentation by an insured person, the company or its representatives . . . . The company discontinues or suspends active business operations.” An insurer cannot terminate coverage for a misrepresentation; nor can it terminate coverage if an employer suspends business. An employer or an employee must provide an intentional misrepresentation of a material fact. In addition, some businesses go through shutdowns, which suspend business. Other businesses have operations suspended due to weather. The Brochure’s termination provisions would violate R.C. 3924.03(B)(1) and (2), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, and 45 CFR § 146.152. Therefore, the Brochure provided deceptive, misleading and untrue information in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2).

**COMPANY RESPONSE:** The Company disagrees. Please note that the product brochure provides general information and the phrase cited by the examiner begins with, “In general . . . .” Because the brochure is in use nationally, it is not designed, nor does it represent, that all the details of the requirements of state or federal law are summarized therein. Because the statement is qualified, we disagree that it is misleading.

With respect (sic) termination when an employer suspends business, please see our response to JALIC Inquiry #13, which stated: Disagree. We note that our administrative practice is in compliance with state and federal law. The language cited referring to discontinuation or suspension of active business operations is only applied when a group suspends business operations for an indefinite period of time. **It is not our practice to terminate all businesses, which temporarily suspend business activity; 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.**

**EXAMINER RESPONSE:** The federal termination provisions indicated above would be relevant for all states. Therefore, whether the guide was state specific, or provided on a national basis would not impact the applicability of misleading an individual about termination provisions. The Company’s second paragraph response did not address the Brochure. Both provisions were deceptive, misleading and untrue in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2).

8. The Guide indicated that an employer, to be able to submit an application for small group health coverage must provide the group's most current state wage and tax statement, and two life groups without a wage and tax statement must submit their most current business federal tax return. An employer cannot be declined for not supplying the information indicated above. The provisions make underwriting easier; however, an insurer cannot make the requirements mandatory of a small employer. To do so 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. Therefore, the Guide provided deceptive, untrue and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. Please see our responses to JALIC Inquiry #'s 14, 33, 57 and #74, pertinent parts of which are reproduced below:

As indicated by the examiner, the quarterly Wage & Tax statement is a valuable tool for verifying group and employee eligibility. However, with the elimination of the 6-month durational requirement, we will accept alternative means of establishing group and employee eligibility, consistent with Ohio and federal law. Employers unable to provide a quarterly Wage & Tax statement will be afforded the opportunity to submit alternative means of establishing eligibility.

In addition, please note that the requirement #6 from the Agent Checklist cited in the Inquiry was removed from the Employer Participation Agreement/Application, Form HC-1872-OH, effective February, 2005. **The form now contains the following statement:** “John Alden Life Insurance Company may request that the Employer provide documentation (i.e. Wage and Tax Form, Payroll Records, Business License, etc.) during the Underwriting process or at any time while coverage is provided by John Alden Life Insurance Company to support that eligibility and participation is being met.”

9. The Guide stated in part, “Employee Eligibility . . . . Eligible employee is a person who is regularly scheduled to work on a full-time basis year round (*at least 48 weeks per year*) . . . . *Employees must work at the firm’s usual place of business. Employees who travel outside the United States or Canada for more than 60 continuous days per year, whether for work or pleasure, are ineligible . . . .*” In addition, the Guide provides, “*Insured dependents that spend more than 60 consecutive days in any year outside the U.S. and Canada are not eligible.*” Many employees have earned 6 weeks of vacation per year. The Guide would eliminate these employees from health insurance coverage. If a personal employee is an employee of an employer, then they are eligible for health insurance coverage (work the necessary hours). The Company is not allowed to exclude coverage for officers, owners, or partners that do not draw a salary, when they are working more than 25 hours. Not earning income is not an allowable standard for determining who is an eligible employee. Employees may not work in the usual place of business, many employees now work from their home or other locations away from the “usual place of business” (an office building). The Company cannot restrict eligibility based on whether the employee travels for business or pleasure out of the country, or if a

dependent is out of the country for more than 60 consecutive days (the student may be going to college out of the country). All the noted provisions in the Guide restrict guaranteed availability to access of group health coverage for an employee in violation of R.C. 3924.01(G), R.C. 3924.03(E)(2), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. Therefore, the Guide provided deceptive, untrue and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company’s response stated,

“1. With respect to “regularly scheduled to work on a full-time basis year round (at least 48 weeks per year)”: **Agree:** As we noted in our response to Inquiry #1, we will remove from certificates the eligibility criterion specifying the employee (and/or dependent) may not reside outside the U.S. or Canada.

2. With respect to “Employees must work at the firm’s usual place of business. Employees who travel outside the United States or Canada for more than 60 continuous days per year, whether for work or pleasure, are ineligible . . .” and “Insured dependents that spend more than 60 consecutive days in any year outside the U.S. and Canada are not eligible.” **Agree:** As noted in our responses to JALIC Inquiries #1 and #2, “We will remove from certificates the eligibility criterion specifying the employee [dependent] may not reside outside the U.S. or Canada or spend more than 60 consecutive days per year outside the U.S. or Canada.””

10. The Guide stated in part, “Coverage for *employees and dependents added* after the group’s effective date will become effective . . . *on the 1<sup>st</sup> or the 15<sup>th</sup>* of the month following the later of the . . . *End of the groups waiting period.*” If the Company adds to the waiting period (after the end of the groups waiting period) by waiting until the next available 1<sup>st</sup> or 15<sup>th</sup> day of a month, it was a violation of R.C. 3924.03(E)(2). An employee is not allowed to be assessed a greater than 90 days waiting period, which would occur if the employer chose a 90 days waiting period. Therefore, the Guide provided deceptive, untrue and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. As noted in our response to JALIC Inquiry #5, however, we clarified that processes have been amended to ensure that new enrollees and dependents are not given effective dates that would exceed the 90 day waiting period.

11. The Guide stated in part, “John Alden does not consider union employees to be eligible, since health insurance is often a bargaining topic, and the nature of the John Alden Group Trust does not allow customizing benefits, guidelines or premiums for specific groups.” This restricts guaranteed issue provisions of R.C. 3924.03(E)(1), Public Law 104-191, Part A—Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. Whether the employees are unionized is not an allowable reason to not

issue small group coverage to an employer. Therefore, the Guide provided deceptive, untrue and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. We will amend procedures and marketing material to remove eligibility restrictions with respect to union membership.

**Issue No. 6 – Small Group Marketing Materials (special provisions)**

**I.** The JALIC “Special State Provisions Supplement for Ohio” (J4-1086 (OH) Rev. 4/02), stated in part, “This supplement describes special provisions applicable to John Alden Health group plans in Ohio . . . .

Mental Illness, Alcoholism, Drug Addiction and Chemical Dependency . . . charges incurred for mental illness consultation . . . . Treatment must be rendered by a hospital, or community mental health center or mental health clinic ***approved or licensed by the state of Ohio, or an Ohio-licensed*** psychologist or psychiatrist . . . .

diagnosis and/or treatment of alcoholism, drug addiction or chemical dependency as an outpatient. Treatment must be rendered by a hospital, or community mental health center or mental health clinic ***approved or licensed by the state of Ohio, or an Ohio-licensed psychologist or psychiatrist . . . .***”

Therefore, the marketing material did not provide the mandated benefits indicated at R.C. 3923.28 and R.C. 3923.29. Neither provision mandates an Ohio licensed provider. Therefore, the marketing material was deceptive, untrue and misleading in violation of R.C. 3901.21(B).

**II.** The JALIC “Special State Provisions Supplement for Ohio” (J4-1086 (OH) Rev. 4/02), stated in part, “This supplement describes special provisions applicable to John Alden Health group plans in Ohio . . . .

Pre-existing Condition Limitations

A pre-existing condition is any physical or mental illness or injury present during the six months prior to your enrollment date under this plan, ***whether or not medical advices, diagnosis, care, or treatment was recommended or received prior to enrollment.***”

The Company’s procedures for defining preexisting conditions in its contracts, and for claims was a violation of R.C. 3924.01, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, and 45 CFR § 146.111(a)(1)(i). R.C. 3924.01(L) provides in part, “Pre-existing conditions provisions means a policy provision that excludes or limits coverage for charges or expenses incurred during a specified period following the insured’s enrollment date as to ***a condition for which medical advice, diagnosis, care, or treatment was recommended or received*** during a specified period immediately preceding the enrollment date . . . .” Therefore, the marketing item was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company’s response stated:

“(I) Disagree: Please note that the language cited in both the JALIC Special State Provisions Supplement for Ohio and the Certificate J-4000 is intended to convey that services must be performed by a provider operating within the scope of their license. We administratively provide benefits for these services if the provider is licensed to provide the services, regardless of the state issuing the license. Therefore, benefits have not been denied based on the state in which the provider is licensed to practice. **We will, however, amend language in both forms to delete references to licensure in a particular state.**

(II) **Agree:** As noted in our response to JALIC Inquiry #22A, Certificate language will be amended to incorporate the provisions limiting pre-existing limitations to conditions for which “medical advice, diagnosis, care, or treatment was recommended or received for that Illness or Injury during the six months immediately preceding the enrollment date.” **We will further amend the Special State Provisions Supplement for Ohio accordingly.”**

**Issue No. 7 – Small Group Marketing Materials (disclosure of information)**

Public Law 104-191, Part A—Group Market Reforms, Sec. 2713, 45 CFR § 146.160, and R.C. 3924.033, all indicate that each carrier shall disclose to the employer as part of its solicitation and sales materials the following:

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

None of the Company’s materials defined pre-existing conditions in compliance with state and federal statutes; and the materials restricted the availability of all options within the only small group plan offered by the Company. In addition, none of the materials provided the required information indicated in (1) (2) and (4) above. Therefore, the Company’s solicitation process did not provide the mandated information in compliance with Public Law 104-191, Part A—Group Market Reforms, Sec. 2713, 45 CFR § 146.160, and R.C. 3924.033.

**COMPANY RESPONSE:** The Company’s initial response stated, “Disagree:

1. **John Alden Life’s Rate and Renewability Disclosure**, Form GD-1425-2 12/96, discloses the carriers right to change rates and the factors affecting rate changes in the section entitled “Rate Changes”;

2. **John Alden Life’s Rate and Renewability Disclosure**, Form GD-1425-2 12/96, discloses provisions relating to renewability of coverage in the section (obverse side of the form) entitled “Renewability of Coverage” and the Special State Provisions Supplement OHIO, form J4-1086(OH) Rev. 4/02, discloses renewability provisions on page 2 in the section entitled “Guaranteed Renewability”;

3. The Pre-Existing Condition Limitations provision is disclosed on page 3 of the Special State Provisions Supplement OHIO, Form J4-1086(OH) Rev. 4/02 [Note: The description replicates the definition of “pre-existing condition” found at 42 USC § 300gg(b)(1)(a) and 45 CFR 146.111(a)(1)(i). We will amend the form to more accurately describe the limiting of the application of pre-existing condition limitations to conditions “for which medical advice, diagnosis, care or treatment was received within the 6-month period ending on the enrollment date” as specified in 42 USC § 300gg(a)(1) and 45 CFR 146.111(a)(2)(A).]

4. The JALIC product brochure, John Alden Health: Small Employer Group Insurance Plans, form J4-1000 (Rev. 5/2003), provides the benefits available under all health plans underwritten by JALIC that are available to Ohio small employers. The John Alden Life’s Rate and Renewability Disclosure, Form GD-1425-2 12/96, discloses premiums available under the section entitled “Group Premium Rates.””

**COMPANY RESPONSE:** Later, the Company provided a supplemental response, which stated, “In the course of implementing HIPAA Rate & Renewability Disclosure requirements in connection with FIC Inquiry # 22, **it was discovered that the above referenced John Alden Life’s Rate and Renewability Disclosure, Form GD-1425-2 12/96, was not in use during the examination period.** The form was developed and used with Certificate Form J-3000, which was not issued during the exam period.

Consequently, we are withdrawing any reference to this form. **We therefore are amending our response to points 1 and 2, above to “agree” but would note that we are in the process of incorporating all of the information contained on Form GD-1425-2 12/96 into the “Special State Provisions Supplement” (Form J4-1086 OH) for use with all Ohio marketing and solicitation materials.** For point 4, we maintain that benefits available under all health plans underwritten by JALIC are available to small employers through The JALIC product brochure, John Alden Health: Small Employer Group Insurance Plans, form J4-1000 (Rev. 5/2003) and quotes provided at solicitation.”

**EXAMINER RESPONSE:** The Company did not comply with mandatory standards of 1, 2, 3 or 4 in Public Law 104-191, Part A—Group Market Reforms, Section 2713, 45 CFR § 146.160, and R.C. 3924.033. However, for “3,” it addressed pre-existing conditions, although its definition of a pre-existing condition was a violation of state and federal statutes.

## COMPLAINTS AND GRIEVANCES

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

The Company initially provided 47 Department complaint files. A comparison of the Department’s COSMOS listing of complaints indicated that there were other complaints than the 47 initially provided by the Company. After the Company compared its listing to the Department’s COSMOS listing, it provided 22 additional complaint files, which the Company failed to initially supply. Therefore, a total of 69 Department complaint files were tested.

The 69 Complaint files were tested, and the results of the testing are indicated in the table below:

Total # of Files	Failed WHCRA	Failed NMHPA	Failed HIPAA	Failed Ohio	WHCRA % Failed	HIPAA % Failed	Ohio % Failed
69	0	0	5	7	0%	7%	10%

**Issue No. 1 – Complaints and Grievances (maintenance of complaint files)**

For one Department complaint file the Company failed to retain its response to the Department in violation of Ohio Adm.Code 3901-1-60(H)(3), which provides in part, “Every third-party payer shall: . . . . Keep records of written complaints from and responses to beneficiaries and providers for three years.”

**Issue No. 2 – Complaints and Grievances (pre-existing condition)**

For one Department complaint file, the Company’s pre-authorization denial letter stated in part, “The Group Certificate . . . states that charges are covered for Reconstructive Surgery and related expenses when required as a result of a Congenital Defect, accidental injury, disease process or disease treatment. *The situation requiring the surgery must have occurred on or after the effective date of coverage, and continuous coverage must be maintained from the date of birth, accident or disease treatment.* Since the scar revision is the result of an accident which occurred prior to . . . effective date of June 1, 2002, we are unable to preauthorize the benefits.”

Every time the Company has eliminated coverage for a certificate holder based on this provision, it has acted in violation of R.C. 3924.03, Public Law 104-191, Part A-Group Market Reforms, Sec. 2701 and 45 CFR § 146.111. The Company has enacted a pre-existing condition(s) exclusionary provision for all certificate holders, which could limit some members to permanent pre-existing condition(s) exclusions. Certificate holders

would never receive coverage for conditions resulting from an accident prior to the effective date of this Company's group coverage.

The Company reversed its decision and allowed coverage for the condition. However, the insured had to complain to receive coverage. In addition, the denial of pre-authorization was also a violation of the statutes and regulation noted above.

**COMPANY RESPONSE:** The Company agrees. The certificate will be amended to remove limitations on coverage for reconstructive surgery to those resulting solely from injuries, which occurred while covered under the certificate.

**EXAMINER RESPONSE:** The Company's practices and procedures for group coverage should also be amended to eliminate all potential permanent pre-existing condition(s) limitations.

**Issue No. 3 – Complaints and Grievances (guaranteed renewability)**

For one Department complaint file, the Company performed two eligibility checks on the employer group to determine if the sole proprietor's spouse was an employee of the business. The search focused on determining if the spouse was paid minimum wage. The Company's small employer certificates allow the Company to determine employee eligibility based on earnings criteria (minimum wage). This is not a valid evaluation for determining if an individual is an employee of a small group. Many employers have spouses that work 40, 60, or 80 hours per week, and draw little or no wage. This is especially true in farming. However, for this farmer, his accountant had arranged for remuneration in an amount to cover his spouse's health insurance. Therefore, the employer still met the Company's participation guidelines.

1. Group Certificate (Edition 4/97), provides:

“Active Full-Time Employee” means a person employed by the Employer who is performing all of the customary duties of the job and *is paid a salary or wage by the Employer that meets or exceeds the minimum wage requirements of state or federal minimum wage law*. The person must work a minimum of 25 hours per week, 48 weeks a year at any of the Employer's business establishments within the United States or Canada. A partner, proprietor or corporate officer of the Employer, must be actively working in connection with conducting the Employer's business, as specified above.”

2. Group Certificate (Edition 9/97), has the same wording as above but with a variable 30 hours per week and 48 weeks per year work requirement.

The Company defined an eligible employee in a manner which is a violation of R.C. 3924.01, and has applied that provision to its certificate holders. An employee who is a proprietor, partner, or corporate officer may not be paid a salary or wage at all when the business is in the process of establishment or at other times depending on cash flow for the Company. Such persons may work well in excess of the 25 hours per week required.

The Company is not allowed to mandate that an employee must be paid minimum wage in order to qualify as an eligible employee.

After the employer provided adequate information to justify the employer was meeting participation guidelines, the Company sent another letter indicating that the farmer needed to provide his feed cost for animals, grain purchases, and indicate what type of farming he was performing. In addition, the Company only allowed the farmer two weeks to provide the information or it would terminate his coverage.

An insurer cannot terminate coverage for any of the reasons indicated in the letter. An employer does not have to provide his expenses to a health insurer for continuance of guaranteed renewability of group health insurance coverage. Feed and grain costs are not a determining factor for an employers' eligibility. In addition, the Company cannot justify the time frame indicated for the employer to provide the information. There is nothing in statutes, rules or regulations that support the Company assertion that two weeks is adequate time for a business to supply the requested information. Therefore, the requested information, and termination of the employer's coverage was a violation of R.C. 3924.03, Public Law 104-191, Part A-Group Market Reforms, Sec. 2712 and 45 CFR § 146.152, which would also be the case for every other employer that received a request/notice of this nature.

**COMPANY RESPONSE:** The Company disagrees. The insurance department complaint that is the subject of this Inquiry was regarding a scheduled renewal rate increase. This Inquiry is directed at eligibility checks, conducted to ensure compliance with employer participation rules that were referenced in the insured's letter to the Department. Please note that coverage remained in force and no action to terminate coverage was taken by the Company. Information provided by the employer established continued eligibility for coverage and compliance with the Company's participation requirements.

As was noted in Inquiry #16, we maintain that our practice of requesting minimum wage documentation is a valid method of determining eligibility and in compliance with §3924.01 of the Ohio Revised Code and 45 CFR §148.143. **However, as clarified in Inquiry #16, individuals who are exempt from the state and federal minimum wage requirements will not be found ineligible for failure to provide such documentation. Additional training has since taken place** to ensure that information requested in eligibility reviews is more targeted to the specific situation of the group.

With respect to our inquiry regarding the company's costs, though **we acknowledge that this letter was poorly drafted, we were seeking additional information in order to verify that this group continued to operate a viable business eligible for group health insurance as neither state nor federal law requires guaranteed renewal of ineligible groups.** Investigations into compliance with eligibility requirements necessarily must accommodate a wide range of means for the employer to establish compliance. **Thus, in the case of a farm operation, as presented in this instance, feed and grain purchases may establish that farming activities are on going and**

**indicative that viable business activity has occurred.** This may be particularly useful when other information (wage statements, time cards, or other common “employment” records) is not existent due to the nature of the business. Neither federal nor state laws require that persons that merely reside on a farm be considered an “employer” for the purposes of small employer guaranteed issue and renewability protections. While we recognize that a business may not be profitable, economic activity must take place to reasonably be considered a viable business. Therefore, we maintain that requesting evidence of such economic activity is within the purview of a carrier’s right to review continued eligibility for group insurance. As noted above, once the complainant established they were complying with these rules, coverage continued uninterrupted.

**EXAMINER RESPONSE:** Throughout the examination the Company has stated a small group employer has to be a “viable business,” as it did again in this response. The definition of a “Small Employer” at R.C. 3924.01(n)(1) provides, “Small Employer means, in connection with a group health benefit plan . . . an employer who employed two but no more than fifty eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.” Therefore, whether the business is viable is not a consideration in determining if the business is a small employer, and whether the farmer buys 500 pounds of grain or 50,000 pounds has nothing to do with determining if the farmer is a small employer for consideration of continued group health insurance. A small group employer does not have to produce a product or service to be considered a small employer for guaranteed availability or renewability of health insurance.

The farmer’s wife had autoimmune hepatitis. Therefore, the Company may have been attempting to avert an adverse risk in violation of R.C. 3901.21(V). The Company’s method of determining eligibility may be a 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.

**Issue No. 4 – Complaints and Grievances (waiting period)**

For one Department complaint file, the Company’s letter to the Department stated in part, “Since the form was not in our office until December 3, 2003, he was assigned the next available effective date of December 15, 2003.” Therefore, the Company imposed an additional 13 day wait period for the employee, which was greater than the 90 days waiting period elected by the employer. Therefore, the waiting period was greater than allowed by R.C. 3924.01(M) and R.C. 3924.03(E)(2). Due to this Company practice, the Company has acted in violation of R.C. 3924.03(E)(2) for every certificate holder that had his/her waiting period extended beyond the applicable (employer chosen) waiting period, which would have been a majority of the newly enrolled certificate holders.

The Company also indicated its employer group plans are only available on the 1<sup>st</sup> or the 15<sup>th</sup> day of any given month, which is a violation of guaranteed availability of coverage in the small employer group market. A small employer looking for its initial coverage, or a small employer that wants continuous coverage to its previous coverage is entitled to coverage on the date it selects. To limit coverage to the 1<sup>st</sup> or 15<sup>th</sup>, may leave a group

without coverage for 14 or 15 days, which would be a violation of the guaranteed availability of coverage requirements at R.C.3924.03 (E)(1), Public Law 104-191, Part A-Group Market Reforms, Sec. 2711, and 45 CFR § 146.150. A small group plan cannot be determined to be available if the plan is not available on the day an employer wants to begin coverage for his employees.

To limit coverage to the 1<sup>st</sup> and 15<sup>th</sup> may be an attempt by the Company to cause those employer's with an immediate need for health coverage due to illnesses, pregnancy, etc., to place coverage elsewhere in an attempt to avoid adverse risks in violation of R.C. 3901.21(V).

**COMPANY RESPONSE:** The Company agrees. As noted in our response to JALIC Inquiry #5, we have since amended administrative procedures to ensure that an employee's effective date of coverage falls not later than the 90<sup>th</sup> day following eligibility for enrollment. We further noted that we will amend certificate forms issued in Ohio accordingly.

Current underwriting guidelines with respect to the assignment of effective dates read as follows:

*For NC and OH groups with a 90 day waiting period, if the application is received on or before the 90<sup>th</sup> day of employment, we must assign effective dates on the 90th day. Effective dates for these two states with the 90 day waiting period will be any date. Additions for these states will have effective dates other than the 1<sup>st</sup> and 15<sup>th</sup>. The insured would be considered Timely.*

*Count out the exact number of days to determine the correct effective date.*

**Example:** *The application is date stamped on 3/25/05, and the 90 day waiting period ends on 4/16/05. The insured is considered Timely and their effective date would be 4/16/05.*

*The application is date stamped on 4/15/05, and the 90 day waiting period ends on 4/21/05. The insured is considered Timely and their effective date would be 4/21/05.*

### **Late Additions**

*If the enrollment form is received after the 90 day waiting period then their effective date would be the next 1<sup>st</sup> or 15<sup>th</sup> of the month and the insured would be considered Late. The 30 day grace period would not apply. The insured would be considered Late.*

**Example:** *The application is date stamped on 6/25/05 and the 90 day waiting period ends on 4/16/05. The insured is considered Late and their effective date would be 7/1/05.*

*The application is date stamped on 7/15/05 and the 90 day waiting periods on 6/25/05. The insured is considered Late and their effective date would be 7/15/05.*

*Later Effective Dates (The insured is Timely or Late and requests a later effective date than they are eligible for):*

*If the insured does have other medical coverage in effect they may have the later effective date to avoid duplicative coverage.*

*If the insured does not have other medical coverage in effect they can only have what they are eligible for as described above.*

**EXAMINER RESPONSE:** The Company's amendments to its certificates and procedures for "Late Additions" (late enrollees), would limit employees in a manner where some would be considered a late enrollee in violation of R.C. 3924.03, Public Law 104-191, Part A-Group Market Reforms, Sec. 2701, and 45 CFR § 146.111. An employee must enroll timely with "the plan." When the Company receives the employee enrollment form is irrelevant to determining if the employee is a late addition. If the Company receives the enrollment form late, and the employer indicates it received the enrollment form timely, then the employee is *not* a late enrollee. However, for protection of the insurer, it is allowed to bill for the premium it would have received if the enrollment form had been provided timely by the employer (the plan).

The Company did not agree that making small employer coverage available only on the 1<sup>st</sup> or 15<sup>th</sup> day of a month is a violation of guaranteed availability requirements.

**Issue No. 5 – Complaints and Grievances (certificate of creditable coverage)**

The certificate holder indicated that she had attempted for six months to try to get a certificate of creditable coverage. Nothing in the file indicates that the Company was willing to assist the insured in gathering proof of her previous creditable coverage. In a letter to the Department, the insured wrote in part, "First you wanted a Certificate of Coverage from United Healthcare which took me 6 months to accomplish. In spite of . . . who already had that information." Therefore, the agent had the information, and thus the Company already had the information. When the Company insisted on a certificate of creditable coverage (CCC), it was a violation of 45 CFR 146.115(c).

The insured clearly was cooperating; she indicated she had provided a certificate to her agent. Therefore, the Company already had access to the CCC. The insured was with the same employer group that had her previous coverage. Therefore, her previous coverage was available with one phone call to the employer group plan, which is also where the Company could have been informed of the previous carrier, which it could have called for verification. The Company's actions were a violation of 45 CFR § 146.115, Public Law 104-191, Part B - "Individual Market Rules, Sec. 2701(e) and R.C. 3924.03.

**COMPANY RESPONSE:** The Company agrees. There was an error when the group was activated on the system and claims staff did not have access to information regarding prior coverage for this individual.

**Issue No. 6 – Complaints and Grievances (waiting period)**

The employer group elected a 90 days waiting period. An employee enrolled in the plan prior to the end of the waiting period. The employee's coverage should have been effective on April 1, 2003 (the application only allows for the 1<sup>st</sup> & 15<sup>th</sup> as a start date) in accordance with the Company's guidelines. However, the Company provision extends the waiting period for a period of greater than 90 days in violation of R.C. 3924.03(E)(2). R.C. 3924.03(E)(2) provides in part, ". . . *waiting periods shall not be greater than ninety days.*"

The letter to the insured and the Department stated in part, "a Certificate of Creditable coverage was provided to our office indicating coverage was effective from April 18, 2002 through December 20, 2002 with Fortis Insurance Company . . . . *The Pre-existing Conditions provision of the (sic) your Certificate of Insurance was applicable since there was a coverage lapse from December 20, 2002 to May 1, 2003, a period greater than 63 days. The pre-existing elimination period will end on November 1, 2004.*" Therefore, the Company's stated method of counting for creditable coverage violated Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03, because the waiting period days are not counted.

During the examination it was indicated to the Company that the employee only had a gap in coverage of 32 days (December 20, 2002 through the employee's start date of January 21, 2003). Therefore, the Company applied a pre-existing conditions limitation for the employee in violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03.

In addition, the Company has a legal obligation to assist the insured with finding out if they have creditable coverage to reduce or eliminate their pre-existing condition(s) period. The Company's letter to the insured and Department stated in part "In order to review the Medicare coverage for pre-existing elimination period credit, please submit a *Certificate of Creditable coverage* from your Medicare carrier for our review." A CCC is not the only way to provide sufficient evidence of other coverage, and the Company indicated that the insured must submit a CCC. The Company failed to assist the insured in determining if she had other creditable coverage, which is a violation of 45 CFR § 146.115.

During a conversation with the employee's wife and the EIC, she indicated that she and her husband had group coverage continuously for years prior to the FIC coverage with the current employer, and prior to the current employer. Therefore, none of the insured's claims should have been denied as pre-existing, and now the Company should credit all the applicable creditable coverage, eliminating the pre-ex period, and pay all the claims denied as pre-existing conditions with interest. Every claim for this certificate holder that was denied for a pre-existing condition was denied in violation of Public Law 104-191,

Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115, and R.C. 3924.03, R.C. 3801.381, R.C. 3801.385 (unnecessary delays) and R.C. 3801.389 (Company should now pay the claims plus interest for late payment of claims). The Company actions also were a violation of Ohio Adm.Code 3901-1-07(C)(1) and (C)(6).

**COMPANY RESPONSE:** The Company disagrees. We note no violation of either 45 CFR § 146.113 (nor 45 CFR §146.115 concerning issuance of certificates of creditable coverage) or R.C. §3924.03. As noted in the correspondence in the file to the Department, the applicant was assessed an 18 month pre-existing period rather than a 12 month pre-existing period because he was a late enrollee.

29 CFR § 2590.701-3(3)(iii) states that if an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. The applicant signed the enrollment form on 3/4/03. His date of hire was 12/21/02. Because the group selected a 90 day waiting period, the Company needed to receive the enrollment form within 90 days (3/21/03) of the date of hire, when the applicant first became eligible to enroll. Our records reflect that we received the enrollment form on 4/11/03. Therefore, the enrollee was deemed a late enrollee with a greater than 63-day gap in coverage.

Because the enrollment form was received on 4/11/03, he was offered the next available effective date of 4/15/03. The employer subsequently requested a change in the effective date to 5/1/03 and the request was honored.

Please note that the proof of prior coverage referenced by the examiner as obtained directly from the complainant consisted of payroll records from a prior employer reflecting health insurance contributions from January of 2002. The documentation provided established coverage was in effect for that month only rather than 7 years as stated. Because the enrollee had a greater than 63-day gap in coverage (from 12/20/02 to 4/11/03), the information obtained by the examiner does not impact the imposition of the pre-existing condition limitation period.

*There was no violation of R.C. 3924.03(E)(2) because, as noted above, no waiting period was applied. The enrollee was offered an effective date 4 days following receipt of the enrollment form, which was received 20 days following the expiration of a 90-day waiting period from the date of hire. The employer-requested effective date of 5/1/03 was honored . . . . We respectfully note no violation of P.L. 104-191, Section 2701, CFR § 146.115, 3924.03, R.C. 3801.381, R.C. 3801.385 (unnecessary delays) and R.C. 3801.389 because the enrollee did not timely enroll for coverage. Therefore, there was a greater than 63 day gap in coverage and the enrollee did not have prior creditable coverage . . . . The enrollee’s status as a late enrollee rendered any investigation into prior coverage moot.*

**EXAMINER RESPONSE:** The Company told the Department that the reason the claims were denied was because the insured had a greater than 63 day gap in coverage. The Company’s first response indicated that the insured was a “late enrollee.” Therefore, it

applied an 18 month pre-existing conditions limitation for the employee and dependents from the date requested by the employer.

However, the employee was not a “late enrollee” either, because the employee enrolled in the plan within the timeframe allowed by Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.111 and R.C. 3924.03. An employee enrolls with the employer group plan, not with an insurance company.

Therefore, the employee could enroll with the plan during the 90 days waiting period, which he did, and he also had an additional 30 days after the end of the waiting period to enroll with the plan (certificate provides a 30 days period for an employee to enroll in the plan), during which time he could not be determined to be a late enrollee.

The employee’s wife provided proof that the employee had 7 years of previous coverage without a gap in coverage.

The treatment of this employee and dependent noted the following violations:

1. The Company assessed a pre-existing conditions exclusionary period when the employee was cooperating and had indicated there was previous coverage. To not assist the employee in gathering previous creditable coverage is a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03. To “pend” claims, when the insured is cooperating is a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115, and R.C. 3924.03, R.C. 3801.381, R.C. 3801.385 (unnecessary delays) and R.C. 3801.389 (Company should now pay the claims plus interest for late payment of claims).
2. The Company indicated the employee was a late enrollee. However, the enrollee enrolled timely. The Company’s procedures for determining who is a “late enrollee” are predicated on the employee’s enrolling date with the Company. However, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.111 and R.C. 3924.03 indicate that the employee enrolls with the plan (the employer’s plan). Therefore, the Company’s procedures and its actions for this insured were a violation of the statutes and regulation noted above.
3. The Company should not have provided an 18 month pre-existing conditions exclusionary period when the employee was not a “late enrollee.” The assessment of the pre-existing conditions exclusionary period for this employee and his dependents was a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03.
4. The Company should pay claims it denied as pre-existing conditions. The Company was not allowed to assess a pre-existing conditions exclusionary period for compliance with Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03. Therefore, the claims were denied in violation of and Ohio Adm.Code 3901-1-07(C)(1) and (C)(6).

5. The Company should not have enrolled the individual for a period greater than the 90 days waiting period. This was a violation of R.C. 3924.03. In addition, an employer cannot request a date of greater than law allows. The Company should not have allowed the employer to choose a waiting period for this employee which was greater than allowed by R.C. 3924.03(E)(2).

6. The Company did not assist the insured in gathering previous creditable coverage. The insured had continuous previous coverage in effect since February 1, 2002. Therefore, the Company procedures were a violation of Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.115 and R.C. 3924.03.

**COMPANY RESPONSE:** The Company's response to the six violations stated:

*1. Disagree: As noted below, we continue to maintain that this participant was appropriately determined to be a late enrollee, as detailed below.*

*2. Disagree: We respectfully maintain that the date of plan enrollment is the date that the signed, completed enrollment form is received in our underwriting office rather than the date that it is received by the employer. Accepting back-dated enrollment forms heightens the risk of an insured not enrolling during the enrollment period, becoming ill, and then backdating the enrollment form claiming that the employer didn't send in the form. Moreover, we believe that the definitions of late enrollee and waiting period indicate that the enrollment period may run concurrent with the waiting period. The distinction between the two definitions is when the individual is eligible to enroll versus when the individual is eligible for coverage.*

*Company practice with respect to determination of timely enrollment entails receipt of enrollment within the 30 days of the end of the waiting period or, in the case of an Ohio employer that has elected a 90 day waiting period, within the waiting period. This procedure is in place in order to comply with R.C. 3924.03(E)(2). In addition, these procedures have been established as permitted by 45 CFR 146.150(b)(2):*

*(b) Eligible individual defined. For purposes of this section, the term "eligible individual" means an individual who is eligible —*

*(2) For coverage under the rules of the health insurance issuer which are uniformly applicable in the State to small employers in the small group market;*

*Our rules, uniformly applicable to all small employers in Ohio, require that we receive enrollment prior to the expiration of 30 days following a waiting period or the expiration of the waiting period in the case of an employer that elects a 90-day waiting period.*

*In order to comply with R.C. 3924.03(E)(2) while using the formulation described by the examiner, it would be allowable for an enrollee to elect retroactive enrollment (i.e.,*

where an enrollee elects to enroll after the 90 waiting period but within 31 days after the end of the waiting period). In such an instance, we would be either required to:

- a) impose a greater than 90 day waiting period by issuing coverage with an effective date after the 90 day waiting period in violation of R.C. 3924.03(E)(2); or,
- b) retroactively issue coverage effective at the end of the 90 day waiting period but before the enrollee actually elects coverage.

Furthermore, we respectfully maintain that our process is not discriminatory because the deadline for timely enrollment when an employer has selected a 90 day waiting period is in excess of that for employers electing a 0-day waiting period. In either case, the time-frame for timely enrollment is uniformly made based on the employer's election of waiting periods and in compliance with R.C. 3924.03(E)(2). Contrary to the examiner's assertion, it would seem arbitrarily discriminatory to grant an eligible employee a greater time to enroll because his/her employer elected a waiting period as opposed to an eligible employee whose employer elected 0-waiting days waiting period.

3. *Disagree:* As noted above, we respectfully maintain that this enrollee was appropriately deemed a late enrollee and that the 18 month pre-existing condition limitation is therefore permissible under applicable state and federal law.

4. *Disagree:* We respectfully decline to re-process claims denied as pre-existing because, as noted above, we maintain that the enrollee was a late enrollee without prior creditable coverage.

5. *Disagree:* Because the enrollee was a late enrollee, no waiting period was applied and we complied with the employer's request for a specific enrollment date.

6. *Disagree:* As noted in #4 above, we maintain that the enrollee was a late enrollee without prior creditable coverage. No investigation of prior coverage was warranted in this instance.

**EXAMINER RESPONSE:** None of the Company's responses are valid because its method of determining who is a late enrollee violates Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, 45 CFR § 146.111 and R.C. 3924.03. The Company's method of determining who is a late enrollee, allowed the Company to eliminate coverage for the employee and his dependents for all pre-existing conditions for 18 months.

The employee's wife had a great need for coverage because she was partially disabled, has rheumatoid arthritis and colon problems.

***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 DOI Complaints (69) and Grievances (35), the Internal Complaints/Appeals were not sampled or requested for testing. It was determined that the testing of DOI Complaints and Grievances would provide a sufficient population for determining if the Company’s complaint and grievance procedures and practices resulted in compliance with HIPAA, WHCRA, NMHPA, and Ohio Statutes and Regulations.

***Complaints and Grievances Standard #3*** – *Sample grievance/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 provided a listing of 35 policy/certificate holders that took an issue to grievance during the period under examination. All the files were sampled for testing.

The 35 grievance 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
35	0	1	0%	3%

**Issue No. 1 – Complaints and Grievances (maintenance of records)**

The Company failed to locate and provide one of the grievance files. The Company stated, “Documentation for the appeal file was either not filed or filmed under an incorrect number, resulting in our inability to recover the documentation for review.” Therefore, the Company failed to maintain records in compliance with Ohio Adm.Code 3901-1-60(H)(3), which provides in part, “Every third-party payer shall: . . . Keep records of written complaints from and responses to beneficiaries and providers for three years.”

**CONTRACT/POLICY LANGUAGE**

**Contract/Policy Language Standard #1** – *Test all contracts/policies, applications, riders and endorsements to determine if the contractual language is in compliance with HIPAA, WHCRA, NMHPA and Ohio Statutes and Rules, i.e. benefits, pre-ex, guaranteed issue, guaranteed renewable, etc.*

During the entrance conference the Examiner-in-Charge (EIC) provided the Company with a document (Potential Common Ground Issues), which indicated that some of the inquiries referencing Fortis Insurance Company (FIC) operations in the individual market could be equally applicable to JALIC. To save time and expense, the Company was offered the opportunity to sign an agreement indicating that the Company’s responses to

inquiries for the FIC examination, in relation to its operations in the individual market could also be used for the JALIC examination.

Prior to the inception of fieldwork, the Company was asked if it would stipulate that the *underwriting process* for individual JALIC products was identical to that for individual FIC products, e.g., that underwriting, termination and rescission guidelines were identical, notices of adverse underwriting decisions and certificates of creditable coverage (CCCs) were issued in the same manner and from the same systems as FIC, and that claims administration and all other practices relating to its individual products were provided in the same manner for both companies. The Company signed a document entitled “Examination reciprocal agreement concerning the JALIC examination, in correlation with FIC and JALIC operations in the individual market” (Reciprocal Agreement) indicating that its plans were identical as those offered by FIC, except for Fortis’ student select plan. JALIC did not issue a student select plan.

JALIC indicated that FIC certificate 225 was identical to JALIC certificate 390, and FIC certificate 227 was identical to JALIC certificate 397. The FIC responses provided for the FIC examination, referred to certificates 225 and 227. Therefore, for all the FIC/JALIC responses below, certificate 225 would be in reference to JALIC certificate 390, and certificate 227 would be in reference to JALIC certificate 397. Therefore, the JALIC individual market certificates 390 and 397 were not tested for policy certificate language.

JALIC plan J-1110, was the only plan offered for conversion coverage during the period under examination. By signing the Reciprocal Agreement, the Company agreed that it was the same conversion plan offered by FIC. However, because the certificate was a JALIC plan, the contract language was not tested during the FIC examination. Therefore, the contract language for J-1110 was tested, and the results are indicated below.

In addition, it was subsequently found that another individual product (Form J-1080), which had not been filed in Ohio, was in force during the period under examination. The Company stated by e-mail on October 7, 2005, “Upon investigation, I have determined there was a total of 97 of the older ‘Jalicare’ individual market products in force during the exam period. The last of these was terminated or rolled to form 397 by 7/1/04.” Therefore, the J-1080 certificate was tested, and the results are indicated below.

**Issue No. 1 – All certificates and riders must be filed in compliance with R.C. 3923.02**

The Company has issued (during the entire period under examination), and continues to issue certificates 390 and 397. Certificate J-1110 (JALIC conversion plan) was made available for issue during the examination period and remains available for issue. None of these certificates were filed with the Department prior to use, in violation of R.C. 3923.02.

A response from the Company stated in part:

1. *“Please note that our response to . . . did not specify that the approval referenced was in the situs state. **We regret the oversight.** In order to avoid replicating errors, our current plan is . . . resolution of our filing of Certificate Forms 225 and 227. . . .*
  
3. *Certificate Form J-1110 was **filed by John Alden Life Insurance Company in Tennessee**, the state in which the master policy was issued, and approved on 1/4/89.”*

Another Company response stated in part, “. . . **consequently, the riders associated with it, were not filed with the Ohio Department of Insurance.** Our plans include filing these forms upon satisfactory resolution of the filing of Certificate Forms 225 and 227 in order to avoid replicating objections from the Department.” Therefore, none of the riders associated with the plans above were filed with the Department.

In addition, the Company stated, “This form (J-1080-C; et al.) is a Certificate of Insurance that provides coverage under a master policy issued to the AHRA Group Trust in the State of Tennessee.”

Therefore, the Company failed to file certificates (390, 397, J-1110 and J-1080) and the associated riders in violation of R.C. 3923.02.

**COMPANY RESPONSE:** The company notes that under 3923.02 the general filing requirement broadly outlines the filing procedure for policies and certificates delivered and issued within the state. However, the Department’s position does not properly take into account the second paragraph of 3923.02, which directly addresses the form of certificate the Company used in Ohio. The second paragraph of 3923.02 provides in relevant part: “The form of any certificate furnished by an insurer to a resident of this state in connection with, or pursuant to any provisions of, any group sickness and accident insurance policy which policy is not delivered, issued for delivery, or used in this state but which insures residents of this state shall, upon request of the superintendent, be filed with the superintendent.” The master group policies, pursuant to which certificates are issued to Ohio residents, are not delivered, issued for delivery or used in this state. The Superintendent has not requested that the Company file the form of certificates which insures residents of Ohio. Bulletin 14, Section 6 fully supports this reading of 3923.02. Bulletin 14, Section 6 state: “The certificates referred to in the last sentence of the second paragraph of Section 3923.02 are those which are used in the State of Ohio in connection with or pursuant to the provisions of any group sickness and accident insurance policy which is not delivered or issued in the State of Ohio but which insures residents of Ohio. The purpose of such sentence is to provide a method whereby the Superintendent of Insurance may request the filing of a particular form of certificate for informational purposes. When the Superintendent desires such information he will request it.”

Since the company acknowledges that certain benefit mandates applicable to policies (defined to include certificates) delivered in the state do impact certificate forms under

out-of-state master policies, the company of its own accord now files all certificate forms for review by the Office of the Superintendent as a way of ensuring benefit mandates are in compliance with state interpretation. However, we respectfully note this is not required under Ohio law under the specific provision of 3923.02.

1. Individual market group certificates 390 and 397 were accepted as “FILED” by the Ohio Department of Insurance on February 22, 2006 and February 27, 2006 respectively. These forms are no longer offered for sale in Ohio.

2. Conversion certificate Form J-1110, a certificate delivered under an out-of-state discretionary trust, was filed by John Alden Life Insurance Company in Tennessee, the state in which the master policy was issued, and approved on 1/4/89. Form J-1110 is no longer offered in Ohio. John Alden Life Insurance Company Basic and Standard plans were accepted as “FILED” on October 22, 2000. John Alden Life Insurance Company has filed updated Basic plan (form 209-OH Rev. 2/2008) and updated Standard plan (form 208-OH Rev. 2/2008) for use as conversion plans and as Basic and Standard required offers. John Alden Life Insurance Company updated Basic and Standard plans were accepted as “FILED” on 5/5/2008 and 5/2/2008 respectively.

#### **Issue No. 2 – Coordination of benefits**

The following individual market certificates and policies allow for a carve-out of Medicare benefits regardless of a person’s entitlement to Medicare. This is a violation of HIPAA, as indicated in the Federal Register Preamble.

“Supplementary Information:

II. Provisions of This Interim Final Rule,

C. Guaranteed Renewability (page 16989)

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

Exclusions within certificates 390 and 397 state, “Charges that are payable or reimbursable by: Medicare Part A or Part B (where permitted by law). *If you do not enroll in Medicare we will estimate benefits.*”

The Ohio Basic (208) and Standard Plans (209), both stated, “Exclusions . . . For covered persons who are eligible for Medicare, that part of any charge for **which a benefit would be paid under Medicare** to a person enrolled under Parts A and B of Medicare, regardless of whether such person actually was enrolled. This does not apply when the

benefits of this plan are, by law, primary to those of Medicare.” This provision is not in the Department’s *current* version of the Standard and Basic plans.

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

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

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

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

**Issue No. 3 – Maternity benefits**

The maternity rider (Form 2804) for the 390 and 397 plans did not indicate that postpartum care was a covered benefit. To not provide, or limit follow-up (postpartum) care to two visits is a violation of R.C. 3923.63. Therefore, rider language was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company filed rider 2804, and it was approved for use on February 17, 2006.

**Issue No. 4 – Maternity benefits**

The Company’s maternity rider (rider 2804 for certificates 390 and 397) stated in part:

“Maternity benefits will be paid for Covered Charges incurred due to an Insured’s pregnancy which:

- *A health care Practitioner determines began more than 270 days after the effective date of this rider; and . . .”*

R.C. 3901.21(O), provides:

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

The statute allows for a benefit waiting period of 270 days. The statute does not allow for denial of coverage when an insured conceives after the inception of coverage, and the delivery is greater than 270 days after the inception date of coverage. Under the Company’s maternity rider, an insured would have to pay maternity coverage premiums for 270 days before maternity coverage became available, and then pay premiums again for 9 months (normal delivery) if the insured conceived on the 271<sup>st</sup> day after the inception date of coverage. Therefore, the Company’s maternity rider was not, and is not providing maternity coverage in compliance with R.C. 3901.21(O). Therefore, the rider language was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

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

**COMPANY RESPONSE:** The Company filed rider 2804, and it was approved for use on February 17, 2006.

**Issue No. 5 – Prosthetic device coverage**

Certificates 390 and 397 contained identical language for prosthetic devices, reconstructive services, and the exclusion of cosmetic services. The certificates state there is coverage for basic prosthetic devices and repair, but replacement or duplicates are not covered. The certificate reference to prosthetic devices included breast prosthesis. The Company is not allowed to determine the best prosthetic device for the patient, and it

may have to replace and/or repair breast prosthesis to comply with the mandated benefits of WHCRA. In addition, the certificates state they cover the *initial reconstructive surgery* after mastectomy for cancer including surgery on the unaffected breast to achieve symmetry. An insurer cannot restrict itself to the initial surgery. The policy excludes all other cosmetic services. Therefore, the mandated benefits of WHCRA are not provided by these two certificates.

**COMPANY RESPONSE:** The Company disagrees. The Company is currently administratively complying with the WHCRA mandate to provide breast prostheses at all stages of mastectomy. The plan is currently administered such that medically necessary benefits are allowed for a person with a history of mastectomy regardless of when that experience occurred. This benefit was addressed in the revision filing of forms 225 and 227 (originally submitted on March 10, 2004). Once the revised contracts are approved by the Department, the forms will also reflect the properly administered benefit. Other recent form filings have addressed this language properly, such as form 244, approved April 8, 2004, which reads in part:

*Reconstructive surgery after a mastectomy includes:*

*reconstruction of the breast on which the mastectomy was performed;*

*surgery and reconstruction of the other breast to produce a symmetrical appearance; and*

*prosthesis and treatment for physical complications at all stages of mastectomy, including lymphedemas.*

**EXAMINER RESPONSE:** The certificate language used during the period under examination is failed as indicated above. In addition, the language indicated above, which the Company stated has been approved for FIC Form 244, and is attempting to have approved for certificates 390 and 397 does not provide the mandated benefits of breast reconstruction, “*completed in the manner determined in consultation with the attending physician and the patient.*” Therefore, the Company’s suggested correction for its filing of certificates 390 and 397 would not be in compliance with WHCRA or Bulletin 2001-1. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**Issue No. 6 – WHCRA benefits**

The individual market certificates and policies (Forms #390, 397, 208 and 209), under “Rental and Purchase of Durable Medical Equipment and Supplies,” or “Supplies and Durable Medical Equipment,” all contain similar contractual language. The language stated that the *initial* external breast prosthesis needed because of the Medically Necessary surgical removal of all or part of the breast was covered, *provided the surgical removal was done while the Covered Person was covered under this plan. Charges for repairs to, or replacement of, maintenance or enhancement of the whole parts of such items are NOT covered.*

The Company's individual certificates, which were issued during the period under examination and are currently issued, were not provided in compliance with WHCRA and Bulletin 2001-1. The policies and certificates limit mandated breast prostheses benefits in a manner less favorable than the law allows. The surgical removal of the breast does not dictate when or how breast reconstruction is provided as a benefit in accordance with WHCRA. The Company did not allow for maintenance, repair, modification, enhancement, replacements or duplicate breast prosthesis, which is a violation of WHCRA. People lose weight, or gain weight, and therefore, the breast prostheses may no longer fit properly. People may lose, misplace, or 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 covered mastectomy. 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 should be the restricting factor in determining if the patient's request for an additional breast prosthesis is warranted, not the Company or any other insurer.

The Department's versions of the Standard and Basic plans provide the complete language of WHCRA (Section 2753 and 2701 of the PHS Act). Therefore, if the Company had incorporated the language indicated by the Department, it would not have limited breast prosthesis in a manner less favorable than allowed by WHCRA and Bulletin 2001-1. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**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 . . . 185, 186 . . . 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:** The Company's proposed language does not provide the mandated benefits of WHCRA. It still excludes the language "**coverage provided in consultation with the attending physician and the patient,**" and JALIC did not indicate it will eliminate the restrictions noted above for breast prosthetic devices (breast prostheses), and mastectomy bras.

**Issue No. 7 – Adding newborn and adopted children**

The Company's certificate 397 and rider B021, (provided with certificate 390), are not issued in compliance with R.C. 3923.26 and R.C. 3923.40. The statutes indicate a certificate or policy may require notification of birth for a newly born child and payment of the required premium to be furnished to the insurer *within thirty-one days after the date of birth* to have coverage continue beyond such period. Therefore, the language in

the certificate and the rider was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

Certificate 397 and rider B021 stated in part, “. . . Adding Newborn and Adopted children . . . we receive any required premium within *30 days* of birth or adoption. This is one day less, than is allowed.

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

**EXAMINER RESPONSE:** The certificate provided language that was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**Issue No. 8 – FEI determination**

The Company’s practices and procedures for certificate 390 and 397 did not allow JALIC to determine who is a federally eligible individual (FEI) at the time of application. The application can be filled out correctly by the applicant, but would not allow the Company to determine if the applicant was an eligible individual in some situations. The JALIC application did not request enough information to determine who was an FEI. The application only requested if any of the proposed insureds had existing health coverage, and if the applicant answers “no,” then the Company interpreted this to mean the applicant could not be an eligible individual (indicated by the Company during testing of complaint files). In addition, even when the insured provided adequate information (determined to be a FEI), the Company did not offer the Ohio Standard and Basic plans. During testing of underwriting and complaint files, every FEI who received an Ohio Standard or Basic plan had to request that plan.

Therefore, the Company was asked six questions:

1. Will the Company agree that it does not determine who is an eligible individual in Ohio at the time of application and this has been true for the entire period under examination and has continued to date?
2. If so, it is anticipated that several of the 50 files, which were issued during the period under examination and have been sampled, will have similar situations to this file, and therefore, an Inquiry will be written for each if the Company does not agree to #1 above.
3. The review of these files will be withheld until the Company makes such a determination.

4. Would the Company agree that Form 25238 should be provided to every applicant?
5. Would the Company agree Form 25238 should be filed, and become a document incorporated into the application process in the State of Ohio?
6. The Company, if it agrees to #1 above, should provide a written summation of the underwriting process it intends to implement to indicate it will determine who is a federally eligible individual, and indicate how it will guarantee that every federally eligible individual is offered the Ohio Standard and Basic plans.

The Company's response to the six questions stated:

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

The Company's response indicated that the Company did not consistently determine the federal eligibility status of all applicants during the examination period. However, during testing of all files, the Company never determined an individual's FEI status unless the individual requested an Ohio Basic or Standard plan. Therefore, the Company's practices and procedures were a violation of R.C. 3923.581.

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

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

*To qualify as an Eligible Individual, you/your:*

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

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

**EXAMINER RESPONSE:** The Company’s proposal does not indicate that an applicant has up to a 63 day gap in coverage to be a FEI. In addition, the Company still failed to provide a method of determining eligibility at the time of application; instead it has placed that requirement with the applicant. Therefore, the Company’s method of correction would not be in compliance with R.C. 3923.581(B), (C) and (D). The Company must provide an application in a format that allows “JALIC” to determine who is an FEI at the time of application, and offer the Ohio Standard and Basic plans to all who are eligible, at the same time it offers certificate 390 or 397.

**Testing of JALIC Conversion Plan (Form J-1110) and JALICARE (Form J-1080)**

**Issue No. 1 – Child health supervision services**

Conversion certificate J-1110, failed to include child health supervision services required to be provided under R.C. 3923.55. Therefore, the certificate provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. The Company will take the appropriate steps to ensure compliance with R.C. 3923.55. We would note, however, that no coverage under this plan was in-force during the examination period and therefore there were no violations of R.C. 3923.55.

**EXAMINER RESPONSE:** Because of the Company’s response, it should be noted that the J-1110 was the only plan offered for conversion by JALIC, which was a violation of R.C. 3923.122, and its conversion practices and procedures were also a violation of R.C. 3923.581, as noted during testing of underwriting.

**Issue No. 2 – Complications of pregnancy**

Conversion certificate J-1110, failed to provide coverage for all complications of pregnancy and did not state that emergency services would be covered for any pregnant woman insured under the certificate.

The certificate stated:

“Definitions

Complications of Pregnancy means:

1. when pregnancy is not terminated; conditions which require hospital confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as:
  - a. acute nephritis, or
  - b. nephrosis; or
  - c. cardiac decompensation; or
  - d. missed abortion; and
  
2. when pregnancy is terminated:
  - a. non-elective cesarean section; or
  - b. ectopic pregnancy which is terminated; or
  - c. spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include:

1. false labor;
2. occasional spotting;
3. physician prescribed rest during the period of pregnancy;
4. morning sickness;
5. hyperemesis gravidarum.

Regardless of whether the complication is included or excluded in its list of covered complications of pregnancy, or whether the insured has elected coverage for maternity services, complications of pregnancy must be covered if the complication results in an emergency medical condition. In the case of an insured that has not elected maternity coverage, coverage must be provided until the patient's medical condition is stabilized. R.C. 3923.65, specifically references a pregnant woman when defining an "emergency medical condition." Therefore, the certificate provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

In addition, the certificate also unfairly discriminated between women needing emergency services who have pregnancy coverage and those who do not, in contravention of R.C. 3901.21(M).

**COMPANY RESPONSE:** The Company agrees. We will remove or qualify any statement that only charges listed under the Certificate Definition of Complications of Pregnancy will be covered.

**Issue No. 3 – Pregnancy Coverage**

Conversion certificate J-1110, failed to provide pregnancy coverage that was in compliance with R.C. 3923.122. Therefore, the certificate provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

The certificate either did not offer pregnancy coverage, or did not cover any pregnancy coverage other than a pregnancy existing *at the time of conversion*. Certificates 390 and 397 were offered in the open market with an optional maternity rider. Therefore, the Company's practices and procedures were not in compliance with R.C. 3923.122.

The conversion certificate was sold with one of two Benefit Summaries, as follows:

**“Benefit Summary**

Provisions with Respect to Pregnancy

- (1) THE TERM ‘ILLNESS’, AS USED HEREIN, **SHALL** INCLUDE PREGNANCY, RESULTING CHILDBIRTH, NON-ELECTIVE ABORTION (AS WELL AS COMPLICATIONS OF PREGNANCY, AS DEFINED IN THE DEFINITIONS SECTION).

COVERED MEDICAL CHARGES IN CONNECTION WITH A NORMAL PREGNANCY WHICH BEGAN BEFORE THE EFFECTIVE DATE OF THIS BENEFIT SUMMARY AS WELL AS COMPLICATIONS OF PREGNANCY WILL BE PAYABLE ON THE SAME BASIS AS FOR ANY OTHER ILLNESS. **NO BENEFITS WILL BE PAYABLE FOR CHARGES DUE TO A NORMAL PREGNANCY WHICH BEGAN AFTER THE EFFECTIVE DATE OF THIS BENEFIT SUMMARY.**

**OR**

(2) THE TERM 'ILLNESS', AS USED HEREIN, **SHALL NOT** INCLUDE PREGNANCY, RESULTING CHILDBIRTH, NON-ELECTIVE ABORTION (AS WELL AS COMPLICATIONS OF PREGNANCY AS DEFINED IN THE DEFINITIONS SECTION).”

R.C. 3923.122 requires an insurer to offer any of the policies then being issued by the insurer for conversion coverage for all insureds who are *not* federally eligible individuals (FEI), which would include the Ohio Basic and Standard plans. Or, an insurer may offer a substantially similar plan. For FEIs, the Company must offer the Ohio Basic or Standard plans, or a substantially similar plan.

The Company currently makes only the J-1110 certificate available to conversion eligible individuals. The Company stated it had not offered the Ohio Basic and Standard plans to any individuals. If the Company had offered the Ohio Basic and Standard plans, a conversion eligible individual would have had the option of pregnancy coverage on an *ongoing* basis under the Standard plan.

**COMPANY RESPONSE:** The Company’s response stated, “As noted in our response to FIC Inquiry #48, **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. Further, as we also noted in that response, Section 3923.122(1) requires that a carrier offer its regular commercial plans to conversion eligible individuals. Section 3923.122(2) establishes a higher standard and requires a carrier to offer the Basic and Standard plans or their substantial equivalent, for federally eligible individuals. The Company believes that the J-1110 qualifies as substantially equivalent to the Basic and Standard plans, and offers this higher standard to all conversion eligible individuals under Section 3923.122, not just the federally eligible individuals.

JALIC forms 208 and 209 are the JALIC Ohio Basic and Standard plans. Although the Company believes that offering of the substantially similar certificate form J-1110 meets the statute’s requirements, the Company would also be willing to offer these JALIC forms 208 and 209 to all conversion eligible individuals.”

**COMPANY RESPONSE:** The Company’s response concerning FEIs stated in part, “. . . *Please see our response in #1 above wherein we note that the Basic and Standard plans will be offered to all converttees. With respect to b), please see our response to FIC Inquiry #45, which noted: ‘. . . [the Company] will develop processes that will . . . provide for the offer of Basic and Standard plans to HIPAA eligible individuals.’”*

**EXAMINER RESPONSE:** The Department indicated that an insurer should offer the Ohio Basic and Standard plans to all conversion eligible individuals, whether federally eligible or not. In addition, the J-1110 is not substantially similar to the Ohio Basic and Standard plans.

The Company procedures failed to offer either the Ohio Basic or Standard plans or a substantially similar plan to FEIs who were converting their coverage, and failed to offer certificates 390 and 397, and the Ohio Basic and Standard plans to non-FEIs in violation of R.C. 3923.122. Pregnancy coverage was not offered in compliance with R.C. 3923.122. Therefore, the certificate provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

**Issue No. 4 – Mental health and alcoholism coverage**

Conversion certificate rider J-1110-R (OH) 5/2000, restricted the providers of mental health, alcoholism, chemical dependency and drug addiction, to those providers licensed in the State of Ohio. To restrict an insured’s access to benefits by covering only those services provided by Ohio licensed providers would be a violation of R.C. 3923.28 and R.C. 3923.29. Insureds that access care in another state may have their claims unfairly denied under such provisions. Therefore, the provision was untrue, misleading and deceptive in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 3901.21(M).

Form J-1110-R (OH) 5/2000, stated:

“This Rider applies to Ohio Resident Only

- A. The ‘Covered Medical Charges’ in the Major Medical section of this Certificate are expanded to include outpatient charges incurred for mental or nervous disorder consultation, diagnosis, and treatment by: (1) a Hospital; or (2) a community mental health center or mental health clinic approved or licensed by the *State of Ohio*; or (3) an *Ohio licensed psychologist or psychiatrist*. Benefits payable for such outpatient charges shall not exceed \$550 in any one year.
  
- B. The ‘Covered Medical Charges’ in the Major Medical section of this Certificate are expanded to include outpatient charges incurred for alcoholism treatment by a Hospital; and outpatient, inpatient, and intermediate primary care charges incurred for alcoholism treatment by: (1) a community mental health center or alcoholism treatment facility

approved or licensed by the *State of Ohio*; or (2) an *Ohio licensed psychologist or psychiatrist*. Benefits payable for such charges shall not exceed \$550 in any one year.”

**COMPANY RESPONSE:** The Company’s response stated, “**We will take the necessary steps** to ensure that conversion coverage offered and issued in Ohio provides the coverage required without respect to the state of licensure of the facility or provider.”

**EXAMINER RESPONSE:** The Company did not elaborate on how it would correct the provision.

**Issue No. 5 – Renewal provisions**

Conversion certificate J-1110, failed to provide for renewal if the insured was eligible for Medicare, had other coverage similar to this certificate, or failed to respond to a request for information. The provisions were not in compliance with the guaranteed renewability provisions of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742(b) and 45 CFR § 148.122(c). Therefore, the certificate provided language that was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“Information About Other Insurance

We may request, before any premium due date, information about whether any insured person is eligible for Medicare or covered for benefits similar to those provided by this plan. *Failure to respond to such a request may result in non-renewal of this insurance coverage.*

Renewal of Coverage

*You may renew this insurance, except as provided below, until the premium due date next following the date you become eligible for Medicare . . . .*

We can refuse to renew your insurance or the Insurance of any insured person if . . .

*2. you or an insured person become eligible for coverage under Medicare or become covered under any other group, individual, state or federal medical expense benefit plan which, when combined with the benefits of this insurance, results in over-insurance as determined by us; or . . . .”*

R.C. 3923.57, HCFA Bulletin, Transmittal No. 01-01, dated March 2001, and the Federal Register Preamble, Supplementary Information, II., page 16989, do not permit the Company to:

1. Non-renew a conversion certificate because a person becomes eligible for, or entitled to, Medicare.

**COMPANY RESPONSE:** The Company agrees. We will amend the certificate to remove references to non-renewal for Medicare eligibility or entitlement.

2. Non-renew a conversion certificate because a person becomes covered under any other group, individual, state, or federal medical expense benefit plan, whether or not the combined benefits result in overinsurance. However, the Company may coordinate benefits to the extent permitted by R.C. 3923.122.

**COMPANY RESPONSE:** The Company agrees. *We will amend the certificate to remove references to non-renewal upon coverage under any other health insurance.*

3. Non-renew a conversion certificate because an insured failed to respond to a request for information about other coverage. Failure to respond to the Company's request is not one of the reasons included in Ohio statutes and HIPAA's list of permissible reasons for nonrenewal.

**COMPANY RESPONSE:** The Company agrees. We will amend the certificate to reflect that failure to respond to a request for information about other coverage may result in claim denial.

**Issue No. 6 – Coverage denial**

Conversion certificate J-1110, failed to cover injuries that were not repaired within twelve months, thus unfairly discriminating against insureds that could not, or had not, had their injuries repaired within the Company's time frame.

The certificate stated:

“Exclusions

Covered Medical Charges do not include any charges:

11. for any medical or hospital care in connection with orthodontics (or braces) or any other dental services, treatments or supplies unless:
  - a. required for repair or replacement of sound natural teeth damaged by an accidental injury sustained while insured under this plan and performed while so insured and *within 12 months following such injury*; or . . . .”

The Company's certificate denies coverage because an injury was not repaired within 12 months following the date of its occurrence. To do so is unfairly discriminatory in violation of R.C. 3901.21(M), because it imposes a permanent pre-existing conditions exclusion on the injuries of some insureds whose injuries were not or could not be

repaired within 12 months, while for other insureds, the charges are covered because the injury was repaired within that time frame. In addition, repair of the injury may not be possible within a specific time period, for example, in the case of injury to a child before full growth is attained. Therefore, the certificate's language was untrue, misleading, and deceptive in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. We will amend the certificate exclusions that limit coverage to treatment of injuries sustained will (sic) covered under the plan or within 12 months following the injury.

**Issue No. 7 – WHCRA benefits**

Conversion certificate J-1110, failed to provide coverage for reconstructive breast surgery on the affected breast and surgery on the unaffected breast, following a mastectomy. If the Company denied coverage for these services, it would have been a violation of Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificate's language was untrue, misleading, and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“Definitions

Cosmetic means surgery or other treatment to improve a person's appearance (except in connection with a congenital defect or malformation of [*sic*] birth abnormality of a newborn child).

Exclusions

Covered Medical Charges *do not include any charges:*

12. *for cosmetic treatment or surgery*, including treatment of complications of such treatment or surgery, except:

- a. for correction of damage caused by accidental injury sustained while insured under this plan if such treatment or surgery is also performed while so insured; or
- b. in connection with the following conditions of a newborn child; congenital defect; malformation or birth abnormality.”

**COMPANY RESPONSE:** The Company agrees. Form J-1110 will be amended to provide coverage for reconstructive surgery following a mastectomy.

The above mentioned provisions would be another reason why conversion plan J-1110 was not substantially similar to the Ohio Basic and Standard plans.

**Issue No. 8 – WHCRA benefits**

Conversion certificate J-1110, failed to provide coverage for treatment of the *physical complications of reconstructive surgery*, including lymphedemas. If the Company denied charges for these services, it would have been a violation of Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificate’s language was untrue, misleading, and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“Exclusions

Covered Medical Charges *do not include any charges:*

12. *for cosmetic treatment or surgery*, including treatment of complications of such treatment or surgery, except:

- a. for correction of damage caused by accidental injury sustained while insured under this plan if such treatment or surgery is also performed while so insured; or
- b. in connection with the following conditions of a newborn child; congenital defect; malformation or birth abnormality.”

**COMPANY RESPONSE:** The Company agrees. Form J-1110 will be amended to provide coverage for complications arising from prosthetic surgery.

**EXAMINER RESPONSE:** The above mentioned provisions would be another reason why conversion plan J-1110 is not substantially similar to the Ohio Basic and Standard plans.

**Issue No. 9 – WHCRA benefits**

Conversion certificate J-1110, failed to provide the required benefits for prostheses following reconstructive breast surgery by imposing limits on such coverage beyond those provided for in Ohio Bulletin 2001-1 and WHCRA. Neither Ohio Bulletin 2001-1, nor WHCRA restrict coverage for the provision of prosthetic devices following reconstructive surgery other than by the prescription of a physician. Breast prostheses must be covered *without regard to when the mastectomy was performed or the length of time between replacements*. Therefore, the certificate’s language was untrue, misleading, and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“Major Medical Benefits for You

Covered Medical Charges

Subject to the Exclusions and Limitations Sections which follow, Covered Medical Charges include only the charges described below that are Medically Necessary and incurred by a person while insured (a charge is deemed incurred as of the date of the service, treatment or purchase giving rise to the charge): . . . .

12. Charges for the *first purchase and first fitting* of artificial limbs, larynx, eyes or *other prosthetic appliances*, but only if required for replacement of natural parts of the body *lost while you are insured.*”

**COMPANY RESPONSE:** The Company agrees. Form J-1110 will be amended to remove the exclusion that requires the insured to have been covered under the plan when a mastectomy is performed in order for the plan to provide coverage for prostheses. In addition, the limit on the number of covered prostheses will be removed.

**EXAMINER RESPONSE:** The above mentioned provisions would be another reason why conversion plan J-1110 was not substantially similar to the Ohio Basic and Standard plans.

**Issue No. 10 – Renewal provisions**

Conversion certificate J-1110, provided for refusal to renew the certificate for *misrepresentation* in *applying for* renewal. Non-renewal of a conversion plan for any “misrepresentation” would be a violation of R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742 and 45 CFR § 148.122. Therefore, the certificate provided language that was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“Terms of Coverage

Renewal of Coverage

We can refuse to renew your insurance or the Insurance of any insured person if: . . .

3. we establish that you used fraud or *misrepresentation in applying for renewal* or any benefit of this plan.”

1. The Company may only non-renew the certificate for an *intentional* misrepresentation of material fact, not for a “misrepresentation,” that is neither intentional nor of material fact.

**COMPANY RESPONSE:** The Company disagrees. As noted in our response to Inquiry #3 in the FIC examination:

*‘With respect to examiner remarks regarding termination language for ‘fraud or intentional misrepresentation’, 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 not have issued the policy. The process is designed to preclude any consideration of any misrepresentations, intentional or otherwise, that are not factually material to our issuance of coverage.*

*While we maintain that we are in compliance, in an effort to amicably resolve this matter, we will modify the language to include the phrase ‘of a material fact’.*

*Because there is very little underwriting involved with conversion coverage, the only potential intentional misrepresentation that would result in cancellation or non-renewal would involve willful, intentional misrepresentation involving employment status (i.e., eligibility) prior to applying for the conversion plan. Such a circumstance would necessarily be fraudulent in nature.*

The provision addressed *renewability*, not initial eligibility, and therefore employment status should not be at issue.

2. The Company may not require an insured under a conversion certificate to *apply for* renewal. Renewal is guaranteed except in the limited circumstances described in R.C. 3923.57, Public Law 104-191, Part B – Individual Market Rules, Sec. 2742(b) and 45 CFR § 148.122(c).

**COMPANY RESPONSE:** The Company disagrees. We do not administratively require submission of requests to renew conversion coverage. We renew coverage upon receipt of premium due, which constitutes the insured exercising the option to renew conversion coverage. Therefore, we note no violation of R.C. 3923.57(C)(1). **We will, however, amend certificate language to comport with administrative practice and the requirements of state and federal law.**

**EXAMINER RESPONSE:** The certificate language allowed the Company the right to mandate an insured to apply for renewal. Therefore, the certificate provided language that was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**Issue No. 11 – Hearing screening benefits**

Rider J-1080-R (OH) 12/97, for certificate J-1080, failed to include coverage for hearing screening required to be included as a child health supervision service under R.C. 3923.55. In addition, if the Company failed to pay claims for hearing screening it would have been a violation of R.C. 3923.55. Therefore, the rider provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

The rider stated:

“C.1. The following benefits are added to Covered Medical Charges provision

Charges for child health supervision service for a covered Dependent for periodic review of a child’s physical and emotional status performed by a Physician or by a health care professional under the supervision of a Physician which include:

- a. a complete history
- b. complete physical examination
- c. developmental assessment
- d. anticipation (*sic*) guidance
- e. appropriate immunization;
- f. laboratory tests.

The benefits provided shall include benefits provided to a child during the period from birth to age one (1) shall not exceed a maximum limit of \$500. Benefits provided to a child during any year thereafter shall not exceed a maximum limit of \$150 per year.”

**COMPANY RESPONSE:** The Company disagrees. We note no violation of Oh. Stat. 3923.55. Please note that benefits for hearing screening coverage are included under the "complete physical examination" or "laboratory testing" provisions, subject to the \$500 annual limit.

Please also note that, as previously stated, no JALICARE coverage is marketed and no Certificate J-1080 forms remain in force in Ohio as of 7/1/04. Therefore, we respectfully decline to amend the rider.

**EXAMINER RESPONSE:** R.C. 3923.55 requires the certificate to provide coverage for hearing screening with a \$75 limit on benefits for that service. Parents in doubt about their child’s hearing status may have been deterred from seeking medical advice because they believed the charges would not have been reimbursable.

**Issue No. 12 – WHCRA benefits**

Certificate J-1080, failed to provide benefits for the reconstructive breast surgery, prostheses and physical complications of mastectomy required to be covered under Ohio Bulletin 2001-1 and WHCRA. If the Company denied these mandated benefits, it would have been a violation of Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificate provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

The certificate stated in part:

“Definitions

*Cosmetic means surgery or other treatment to improve a person's appearance (except in connection with a congenital defect or malformation or birth abnormality of a newborn child).*

*Elective treatment or surgery means any care, treatment, or surgery for which there is no medical necessity and/or which does not treat an illness or injury (such as care provided primarily as a convenience or to improve or preserve appearance, etc.).*

#### Major Medical Benefits

#### Covered Medical Charges

Subject to the Charges Not Covered section which follows, Covered Medical Charges include only the charges described below that are medically necessary and incurred by you, or your insured dependents, while insured, . . .

12. For the *first* purchase and *first* fitting of . . . *prosthetic appliances, but only if required for replacement of natural parts of the body lost while insured.*

#### Charges Not Covered

13. *For Cosmetic treatment or surgery, or any complication therefrom, except for correction of damage caused by accidental Injury sustained while insured under this plan if such treatment or surgery is also performed while so insured."*

1. The certificate denied benefits required to be provided by WHCRA by *denying coverage for:*
  - (a) *Elective surgery for which there is no medical necessity and/or which does not treat an illness or injury; and*
  - (b) *Cosmetic surgery (surgery to improve a person's appearance).*

Reconstructive surgery is an elective surgery performed to cosmetically restore a part of the body and is not treatment of an illness or injury. The certificate defines an "Injury" as "an accidental bodily injury which is caused . . . by an accident." While a mastectomy may be required due to an accident, this is not usually the case. Reconstructive surgery on both the affected breast and the unaffected breast must be covered when the insured had a covered mastectomy.

**COMPANY RESPONSE:** The Company disagrees. We note no violation of the requirements outlined in WHCRA or Ohio Bulletin 2001-1. Please note, we administratively comply with WHCRA and the Ohio Bulletin 2001-1. Our compliance guidelines provide coverage for reconstructive surgery following mastectomy on both the affected breast and the unaffected breast in order to achieve symmetry. As reflected in

our response to FIC Inquiry #27, our compliance guidelines are consistent with the requirements of WHCRA and Ohio Bulletin 2001-1.

**EXAMINER RESPONSE:** Administrative compliance does not inform an insured, who reviews the certificate and believes that reconstructive surgery following a mastectomy is not a covered expense, and therefore does not attempt to seek such services. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

2. The certificate excludes coverage for external prostheses, except for the initial fitting and first purchase. The certificate also requires that the prosthesis be necessitated due to an event that occurred while the woman was insured. Ohio Bulletin 2001-1 and WHCRA mandates coverage of *prostheses*:
  - When prescribed by a physician, including replacement prostheses; and
  - Regardless of whether the woman was insured under the certificate at the time of the event causing the necessity for the prostheses, i.e. regardless of when the mastectomy was performed.

The Company may not refuse benefits for replacement of external breast prostheses when prescribed by a physician. The only limit provided by WHCRA, is that a physician must prescribe the breast prostheses.

**COMPANY RESPONSE:** The Company disagrees. The Company is administratively complying with the WHCRA mandate to provide breast prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Medically necessary benefits are allowed for a person with a history of mastectomy regardless of when the mastectomy was performed.

**EXAMINER RESPONSE:** It is deceptive and misleading to state that a service or supply is not covered when it is mandated to be covered. Such statements may deter an insured from seeking or making claim for a service or supply. Administrative compliance does not inform an insured, who reviews the certificate, that replacement prostheses are a covered expense when there is a history of a covered mastectomy. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

3. The certificate allows for denial of coverage for physical complications of a mastectomy, including lymphedemas, by denying coverage for complications from cosmetic surgery. For compliance with WHCRA, coverage must be provided for physical complications of all stages of mastectomy, including lymphedemas.

**COMPANY RESPONSE:** The Company disagrees. The Company is administratively complying with the WHCRA mandates to provide breast prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. Medically

necessary benefits are allowed for a person with a history of mastectomy regardless of when the mastectomy was performed.

**EXAMINER RESPONSE:** The certificate should contain factual statements concerning coverage. It is deceptive, untrue and misleading to state that a service or supply is not covered when it is mandated to be covered. Administrative compliance does not inform an insured, who reviews the certificate and believes that physical complications of a mastectomy, including lymphedemas are not a covered expense. Therefore, the certificate language was a violation of R.C. 3901.21(B).

**Issue No. 13 – WHCRA Notice**

Certificates J-1110 and J-1080, failed to satisfy the requirements for WHCRA enrollment notices. The enrollment notice did not state that for an insured who is receiving benefits in connection with a mastectomy, coverage will be provided *in a manner determined in consultation with the attending physician and the patient*. Therefore, the notice was not provided in compliance with Ohio Bulletin 2001-1 and WHCRA.

**COMPANY RESPONSE:** The Company disagrees. As we noted in our response to FIC Inquiry #12, the language of both the enrollment and annual WHCRA notices (identical to language in current use) were reviewed without comment by CMS as of March 27, 2002. The resulting Report may be viewed at <http://63.241.27.79/hipaa/hipaa1/content/enforcement.asp>. This review was conducted after the issuance of Bulletin 2001-1, which the examiner references in the Inquiry. In addition, it has come to our attention that a separate review of Fortis Benefits Insurance Company forms used in Massachusetts and Colorado, utilizing the same language for WHCRA annual notices, was completed and the forms were accepted by CMS in a letter dated July 29, 2002.

We are unable to find any regulatory mandate in statute or regulation requiring that the phrase “coverage will be provided in a manner determined in consultation with the attending physician and the patient” be included with either the enrollment or annual WHCRA notice. The Inquiry points only to a Q&A document posted on the internet by CMS. It is unclear when this language first appeared and it is impossible to determine when or if CMS made inclusion of this language an enforceable requirement. In the absence of such information, carriers can only rely on such information as may be found in the published statutes and regulations or gleaned from direct communication from the regulatory agency. As note (sic) above, documentation from CMS indicates that the language currently in use is acceptable.

**EXAMINER RESPONSE:** CMS’ “Consumer Q & A’s about the Women’s Health and Cancer Rights Act Notice Requirements” Update of *January 28, 2000*, provides in part, “The enrollment notice shall describe the benefits that group health plans and insurance issuers must cover under WHCRA. *The enrollment notice must* indicate that, in the case of a participant, policyholder, or beneficiary who is receiving benefits in connection with a mastectomy, coverage will be provided *in a manner determined in consultation with the attending physician and the patient, for . . . .*”

The enrollment notices failed to provide the CMS mandated language in violation of WHCRA and Ohio Bulletin 2001-1. Therefore, the language in the notices was deceptive, untrue and misleading in violation of R.C. 3901.21(B).

**Issue No. 14 – Complaint procedures**

Certificates J-1080 and J-1110, failed to include the Company’s “Complaint Procedures” in violation of Ohio Adm.Code 3901-1-60(H)(1). The Company must adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances received from insureds or claimants. *These complaint procedures must be included in the certificate.*

**COMPANY RESPONSE:** The Company agrees. Certificate Form J-1080 and Certificate Form J-1110 do not explicitly contain the complaint procedures available to insureds. However, we would note that neither of these forms was issued in Ohio during the examination period and there are currently none in force in Ohio. Consequently, no consumers were harmed.

**EXAMINER RESPONSE:** The Company’s response was not completely accurate. Consumers may have been harmed, because there were certificate holders of the J-1080 with *coverage in force* during the period under examination. That is the reason why the certificate was tested. In addition, there may have been J-1110 certificates in force during the period under examination. The Company only stated that no J-1110 certificates were *issued*. Therefore, insureds whose certificates were in force during that period under examination were not provided with the required information in violation of Ohio Adm.Code 3901-1-60(H)(1). Therefore, failure to provide the language in the certificate was deceptive and misleading in violation of R.C. 3901.21(B).

***Testing of Small Group Plans (Form J-3000) and (Form J-4000)***

**Issue No. 1 – Form of policy filed with superintendent**

The Company failed to file its employer applications and enrollment forms that were in use during the period under examination. Failure to file applications is a violation of R.C. 3923.02.

The Company stated that employer application HC-1078-0 (Rev. 1/2002) and employee enrollment form HC-1002-3 (Rev. 8/2001) were in use for the period under examination. The form the Company later stated was in use during the examination period (Form HC-1078 (OH) RFP (1-2002)), was not found in any of the files tested. In addition, during the review of Small Groups Issued, the following forms were also found to be in use during the examination period: employer application HC-1078-0 (Revs. 6/99, 7/99, 8/99 and 8/01), HC-1001-3 (Rev. 8/2001) and J4-1863; and employee enrollment form HC-1002-3 (Rev. 8/99) and J4-1864.

**COMPANY RESPONSE:** The Company’s response stated, “*We are unable to locate any information indicating the above referenced forms were filed with the Ohio Department of Insurance. Please note that the currently used Employer Participation*

*Agreement (form HC-18720-OH) and Employee Enrollment Form (form HC-1871) were filed and approved on 4/27/05 (see attached)."*

**EXAMINER RESPONSE:** Neither of the forms the Company stated it filed on 4/27/05 were in use during the period under examination.

**Issue No. 2 – Guaranteed availability of coverage**

The employer applications and certificate J-4000 permitted discrimination between employees of the same class on the basis of travel and could be used to deny a small group a guaranteed available small group health plan.

The applications asked:

“6. Do any employees travel outside the United States or Canada, for business or pleasure, for more than 60 consecutive days a year?”

The question in the applications may be used to deny eligibility of a group or an otherwise eligible employee by requesting information from the small employer that is irrelevant to issue and more restrictive than permitted under R.C. 3924.03(E)(1) and 3924.01(N)(1). Any refusal of an agent to accept an application from an employer who answered in the affirmative or any denial of coverage by the Company to a small group or specific employee based on this qualification would be in contravention of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1).

**COMPANY RESPONSE:** The Company disagrees. Responses to the question do not impact the acceptance of small employers applying for coverage. The question is reasonable because extensive foreign travel could result in substantially increased claim adjudication costs (e.g., currency conversion, non-standard claim submissions, etc.). The information may be valuable for a number of resource planning perspectives. Moreover, we are unable to identify any rules or statutes that would prohibit such an inquiry.

**EXAMINER RESPONSE:** The Company stated that the question concerning travel outside the U.S. or Canada does not affect the acceptance of small employers for coverage but could *substantially increase claim adjudication costs (e.g., currency conversion, non-standard claim submissions, etc.)* The Company’s response is not valid because certificate J-4000 specifically excludes coverage for employees (and thereby their dependents) in these circumstances, stating:

“‘Active Full-Time Employee’ *does not include* any person who resides outside the U.S. or Canada, or who spends more than [60 consecutive] days in any Year, outside the U.S. or Canada, whether for work or for pleasure; . . . .”

If the Company denied eligibility of either a group or an individual on the basis of foreign travel, it was a violation of R.C. 3924.03(E)(2), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(B) and 45 CFR § 146.150(a)(2). Therefore, the

provision was misleading and deceptive in violation of R.C. 3901.21(B). The provision is also unfairly discriminatory in violation of R.C. 3901.21(M).

**COMPANY RESPONSE:** The Company’s response to the certificate language stated, “**Agree:** We will remove from certificates the eligibility criterion specifying the employee may not reside outside the U.S. or Canada or spend more than 60 consecutive days per year outside the U.S. or Canada.”

**Issue No. 3 – Agent of the insurer**

The Company’s (1) employer applications (other than employer application J4-1863); and (2) employee enrollment forms HC-1002-3 (Revs. 8/99 and 8/2001) and J4-1864; stated that the agent represents the employer and the employees, not the Company. R.C. 3923.141 provides that the agent represents the insurer, not the insured. Therefore, the forms were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The employer applications stated in part:

“Agreement

I understand the agent submitting this request for participation represents my interests, not those of John Alden Life Insurance Company, . . .”

The employee enrollment forms stated:

“I understand that the agent submitting this enrollment form represents my interests, not those of John Alden Life Insurance Company.”

The agent represents and solicits business for the Company. The agent represents the Company’s interests. Therefore, the application/enrollment forms’ statements were untrue, misleading and deceptive in violation of R.C. 3901.21(B). If refusal to sign such a statement resulted in the declination of an application from either the employer or employee, it would also have been a violation of R.C. 3924.03(E), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1) and 45 CFR § 146.150(a).

**COMPANY RESPONSE:** The Company agrees. We will amend the **enrollment form** to clarify that the agent may represent the interests of both the insured and the insurer.

As noted in our response to Inquiry No. 35, we will amend the any currently used [sic] **enrollment form** to clarify that the agent may represent the interests of both the insured and the insurer.

**EXAMINER RESPONSE:** The Company’s responses did not address the statement in the *employer* applications. The correction for the *employee* enrollment forms would not be in compliance with R.C. 3923.141. The Company indicated it will revise the enrollment form to state that the agent may represent the interests of *both the insured and*

*the insurer.* R.C. 3923.141 clearly provides that the agent represents the insurer, not the insured.

**Issue No. 4 – Guaranteed availability**

The Company *required* certain tax forms as a condition of issuance of a small group health plan. The guaranteed availability requirements of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1) do not require the employer to provide tax forms. Therefore, the Company practice violated the statutes and regulation noted above. In addition, the applications provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

The “Agents Checklist,” which formed part of the small employer applications, stated in part:

(1) HC-1078-0, Revisions 6/99, 7/99:

“6. Groups of three employees or more (not health insurance lives) *must submit* most current state-required Employer Wage & Contribution report . . . .”

(2) HC-1078-0, Revision 8/2001 and 1/2002:

“Please submit the following . . .

6. Groups of three employees or more (not health insurance lives) *must* submit most current Employer Wage & Contribution Report filed with State Unemployment Department. Groups of fewer than three employees without Employer Wage & Contribution Report, *must* submit their most current business federal tax return.”

(3) HC-1001-3 (Rev. 8/2001):

“Complete copies of the following forms *must be submitted*:

6. Most current employer wage and contribution report filed with state unemployment department.

7. Groups of fewer than three employees without employer wage & contribution report, *must* submit their most current business federal tax return.” For example:

- a) If a sole proprietor, Form 1040 & schedule C.
- b) If a farmer, Form 1040 and schedule F.
- c) If a corporation, Form 1120.

- d) If an S corporation, Form 1120S with schedule K-1 for each shareholder.
- e) If a partnership, Form 1065 with schedule K-1 for each partner.”

(4) J4-1863:

“ Groups not required to file a state quarterly wage and tax statement *must provide* a copy of their most current business federal tax return and associated schedules

Sole Proprietors – Form 1040 & Schedule C (farms use Schedule F)  
C-Corporations – Form 1120  
S-Corporations – Form 1120S and Schedule K-1  
Partnerships – Form 1065 and Schedule K-1”

An employer that is unable to provide the tax form(s) (e.g., a start-up business, or for any other valid reason), must be permitted to provide other valid proof of the legitimacy of the business and be issued coverage on that basis.

The checklist for four of the forms stated “*not health insurance lives.*” However, the small group health products are tied to the purchase of life insurance. Therefore, an employer that does not provide the required documentation for life insurance is barred from the guaranteed issue of a small group health plan.

**COMPANY RESPONSE:** The Company’s response concerning employer application HC-1078-0 (Rev. 1/2002), stated, “**Agree:** Please see our response to JALIC Inquiry #14, which contained the following remarks:

As indicated by the examiner, the quarterly Wage & Tax statement is a valuable tool for verifying group and employee eligibility. However, with the elimination of the 6-month durational requirement, we will accept alternative means of establishing group and employee eligibility, consistent with Ohio and federal law. Employers unable to provide a quarterly Wage & Tax statement will be afforded the opportunity to submit alternative means of establishing eligibility.

In addition, please note that the requirement #6 from the Agent Checklist cited in the Inquiry was removed from the Employer Participation Agreement/ (sic) Application, Form HC-1872-OH, effective February, 2005. The form now contains the following statement:

*“John Alden Life Insurance Company may request that the Employer provide documentation (i.e. Wage and Tax From, Payroll Records, Business License, etc.) during the Underwriting process or at any time while coverage is provided by John Alden Life Insurance Company to support that eligibility and participation is being met.”*

**EXAMINER RESPONSE:** When the same requirements were found in other employer applications located in the small groups issued files; the Company indicated it agreed with the violation.

**Issue No. 5 – Evidence of insurability**

The employer *application* and employee *enrollment forms* specified below, failed to eliminate health status as a factor in eligibility for coverage. To condition eligibility based on any health status-related factor would be a violation of R.C. 3901.21(T)(1) and 3924.03(C), Public Law 104-191, Part A, Sec. 2702 and 45 CFR § 146.121. Therefore, the language in the forms is untrue, deceptive and misleading in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 3901.21(M).

The employer applications stated in part:

HC-1001-3 (Rev. 8/2001):

“A. Enclosed are . . . (3) any initially required *evidence of insurability*.”

J4-1863:

“It is further understood and agreed that (3) those subject to *evidence of insurability* must receive prior approval by John Alden Life Insurance Company at its home office *before coverage becomes effective*, . . . .”

The employee enrollment form J4-1864 stated in part:

“Authorization and Signature

I understand . . . (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* . . . Information regarding *your insurability* will be treated as confidential.”

Evidence of insurability for coverage under a small group health plan may not be required either initially or at any other time. An employer or employee reading the form(s) may be misled into believing that a particular applicant (for instance a disabled spouse or dependent child) is not eligible due to his or her health status and may therefore fail to submit an enrollment form from that person until such time as he or she is no longer sick or disabled, by which time the person may have become a late enrollee. Such a person would then be subject to a pre-existing conditions limitation. No reference to insurability should appear in *any of the Company’s forms* relating to a group health plan.

**COMPANY RESPONSE:** The Company agrees. The noted representations in any forms currently in use are being revised to remove references to ‘Evidence of Insurability’. 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. In addition, we would note that the enrollment and employer Request for Participation forms referenced here are no longer in use.

**Issue No. 6 – Prohibited discrimination**

Certificates J-3000 and J-4000, failed to comply with the prohibition against any requirement for proof of insurability in a small group plan. To require proof of insurability would contravene R.C. 3901.21(T) and 3924.03(C), Public Law 104-191, Part A – Group Market Reforms, Sections. 2702(a)(1) and 2711(a)(1)(B) and 45 CFR § 146.121(a). Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 3901.21(M).

Certificate J-3000, stated:

“General Provisions

Effective Dates for Adding Dependents

Insurance for such Dependent will become effective on the 1<sup>st</sup> or 15<sup>th</sup> of the month next after the date We approve Your request, except as stated under ‘Newborn Children.’ *We may ask for proof of good health.* This must be given at no cost to Us.

Newborn Children

Insurance for a newborn child born while Your insurance is in effect, who is an Eligible *Dependent* at birth, will become effective on the child's date of birth if You request insurance for the child within the first 31 days after the child's date of birth. Any later request will require *Our approval of a statement of health* for the child before he or she may become insured.”

Certificate J-4000, stated in part:

“Section VIII: Eligibility for Coverage

When is Insurance Effective?

. . . The enrollment form must be received by Us before coverage is effective.

Otherwise, Your coverage will be effective on Your Employer's next premium due date following the later of:

1. the date You enroll if You enroll within 30 days of satisfying the Employer's eligibility waiting period; or
2. *the date You meet satisfactory evidence of insurability/eligibility requirements, when required or as permitted by law.*

Each Dependent's insurance will be effective the later of:

3. the next premium due date following the date Your Dependent meets *satisfactory evidence of insurability/eligibility*, if required, if You enroll a Dependent more than 30 days after the date he or she became your Dependent, . . .

Evidence of Insurability/Eligibility means *proof of good health* or eligibility will be required before Your insurance, or the insurance for Your Dependent(s) is effective. The type and form of required proof will be determined by Us in compliance with state and federal requirements in effect on the date this proof is required."

The prohibition against proof of insurability applies whether the applicant is timely or late. The Company may impose a pre-existing conditions limitation on a late applicant, but may not require proof of insurability for coverage. The certificate requirements may deter an unhealthy individual from applying for coverage for him or herself and/or for a dependent spouse or child who is sick or disabled.

**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. 7 – Prohibited discrimination**

Rider J-3000 11/97, for certificate J-3000, included a statement that proof of good health may be requested from employees applying for *special enrollment* for themselves or their dependents under a *Large Employer's* group health plan.

The rider stated in part:

"D. The GENERAL PROVISIONS section of the Certificate is changed as follows: . . .

3. The 'EFFECTIVE DATE FOR ADDING DEPENDENTS' has been changed to read:

## Effective Dates for Adding Dependents

A new Eligible Dependent may become insured only if You

1. request insurance for such Dependent; and
2. agree to any required increase in Your premium contribution

Insurance for such Dependent will become effective on the 1<sup>st</sup> or 15<sup>th</sup> of the month next after the date We approve Your request, except as stated under ‘Newborn Children’ or ‘Special Enrollment Periods.’ *We may ask for proof of good health for coverage other than Major medical Benefits if you are employed by a Small Employer or for all coverages if You are employed by a Large Employer.* This must be given at no cost to Us.

4. Insurance for a newborn child born while Your insurance is in effect, who is an Eligible Dependent at birth, will become effective on the child’s date of birth if You request insurance for the child within the first 30 days after the child’s date of birth. *Any later request will require Our approval of a statement of good health (for coverages other than Major Medical Benefits if You are employed by a Small Employer or for all coverages if You are employed by a Large Employer)) before he or she may become insured.”*

Proof of good health may *not* be required as a condition of eligibility for coverage under *any* employer-sponsored group health plan, whether for timely, late, or special enrollees. If the Company imposed a requirement for proof of good health it would contravene R.C. 3901.21(T)(1)(b), Public Law 104-191, Title XXVII, Part A – Group Market Reforms, Sec. 2702(a), and 45 CFR § 146.121(a). Therefore, the rider language was untrue, deceptive and misleading in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 3901.21(M).

**COMPANY RESPONSE:** The Company agrees. As we stated in our response to Inquiry #4, the noted representations in the contract have been 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.

The Rider was filed and deemed approved by the Ohio Department of Insurance on 12/19/97. A copy of the stamped letter was provided on 7/21/05.

**Issue No. 8 – Employee eligibility requirements**

Employer application H-1001-3 (Rev. 8/2001), and certificate J-4000 failed to comply with the hourly work requirement for eligibility specified in R.C. 3924.01(G). Therefore, the application and the certificate were untrue, misleading and deceptive in violation of R.C. 3901.21(B).

(1) The application stated:

“2 A. How many are full-time/eligible (regularly scheduled to work 30 hours per week) and on your payroll?”

This application was found in the files of four small groups issued. R.C. 3924.01(G) provides that an employee who works 25 hours per week is eligible for coverage under a small employer plan.

**COMPANY RESPONSE:** The Company disagrees. The Request for Participation form in use in Ohio during the examination period was Form HC-1078 (OH) RFP (1-2002). The question on that form relative to the number of full- and part-time employees reads:

1. How many people, including yourself, are currently employed by your business? \_\_\_\_\_
2. How many are full-time (regularly scheduled to work at least 25 hours per week)? \_\_\_\_\_
3. How many are part-time (regularly scheduled to work less than 25 hours per week)? \_\_\_\_\_

In the cases cited above, the submitting agent provided the employer with a Request for Participation form designed for use in states other than Ohio. However, in each case, the Request for Participation form was accompanied by a business census that listed each employee and the number of hours per week those employees were scheduled to work. In order to underwrite the group submission in a timely fashion, the forms incorrectly noting a 30 hour per week full-time standard were accepted because the information needed to determine full or part time status of the employees was provided with the Census.

The “Request for Participation” (HC-1078 (OH) RFP (1-2002)), which the Company referred, was not found in any of the 50 files tested.

(2) Certificate J-4000 stated in part:

“Section VIII: Eligibility for Coverage

Who is Eligible to Become Insured by this Certificate?

... The person must work a minimum of 30 hours per week, ...”

**COMPANY RESPONSE:** The Company’s initial response to the certificate stated, “Disagree: The certificates provided for review were filing copies, as submitted to the Ohio Department of Insurance. The 30 hours per week reflected as variable language is included as sample text only that would (or may) vary from text appearing in issued

copies. The certificate forms as issued in Ohio comply with the 25 hour criteria specified in § 3924.01(G) of the Ohio Revised Code.”

**EXAMINER RESPONSE:** During testing of issued small groups it was found that certificate J-4000 was uniformly *issued* with a 30 hour work requirement.

**COMPANY RESPONSE:** The Company’s second response stated, “**Agree:** The Company will correct the certificate issue system so that certificates issued reflect that 25 hours per week is the full-time standard in Ohio.

We would note, however, that we have administratively complied with this requirement. Underwriting guidelines as well as instructions to agents have been correct. Please see the ‘Special State Provisions Supplement – OHIO’ [Form J4-1086(OH) Rev. 4/02] included with the marketing materials provided on 9/15/05.”

When the 30 hour requirement was also found in certificate J-4000 edition 9/97, the Company’s response stated, “With respect to comments regarding the variable 30 hours per week in edition 9/97, please see our response to Inquiry #1A. We noted that we have administratively complied with the 25 hour standard. Underwriting guidelines as well as instructions to agents have been correct. Please see the ‘Special State Provisions Supplement – OHIO’ [Form J4-1086(OH) Rev. 4/02] included with the marketing materials provided on 9/15/05.”

**EXAMINER RESPONSE:** Administrative compliance does not avoid the requirement that the certificates contain correct information. The application and certificates noted above contained a provision that was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

**Issue No. 9 – Guaranteed availability**

The Company failed to comply with the guaranteed availability requirements for small group health plans by forcing the sale of life and AD&D insurance upon a small employer as a condition for the purchase of a small group health benefit plan.

The Sales Brochure “Small Employer Group Insurance Plans,” stated in part:

“Additional Coverage

Group Life Insurance

Basic life insurance is automatically included in your plan in the amounts shown in the chart below: . . . .”

The Company’s practice of not permitting the sale of a small group health benefit plan without life and AD&D insurance violated R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a), 45 CFR § 146.150(a), R.C. 3901.21(V) and

Public Law 104-191, Part C, Sec. 2791(e). Neither life nor AD&D insurance should be a required part of the sale of a small group health insurance plan.

- (1) A review of the fifty (50) small groups issued files revealed that all fifty were sold on this combined basis. Issue of a small group health plan (without the compulsory purchase of any other coverage) is guaranteed by the statutes and regulation noted above.
- (2) The forced purchase of life and AD&D insurance avoids adverse risk by deterring an unhealthy small employer group from buying coverage under its small group health/life product, due to the added cost of life insurance. This cost increases commensurately with the unhealthiness of the group, and, therefore, adverse risks stand a high chance of being averted and placed with another carrier, while healthy groups may be attracted to the combined product. For instance, during the testing of small groups issued, it was found that the increase in premium by the addition of life insurance for one unhealthy group with three covered medical employees was \$99.45 per month. Such an increase may be substantial to a small group and may deter the sale of the small group health plan. The sale of life insurance resulted in this case in an approximate 12% increase in the premium above the cost of the medical insurance.

One file reflected a group that was quoted a small group health product without life insurance. The Company advised the agent that the group would have to “resign a complete new quote that includes the LIFE benefit.” The e-mail correspondence concluded with the Company stating, “Please let me know if they are going to accept with the life or *withdraw*.” Therefore, the Company’s procedures and practices were a direct violation of the mandated guaranteed availability of small group health plans.

**COMPANY RESPONSE:** As we noted in response to FIC Inquiry #'s 68 and 75, we disagree that these practices serve either to discourage the acceptance of adverse risks or to contravene Ohio and federal guaranteed issue requirements. **Nonetheless, 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. 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 denial of life coverage to an individual within such a group would result directly or indirectly in the carrier avoiding adverse risk.

The Company would also submit that the added cost of life coverage does not deter the guaranteed issuance of health 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. Moreover, we disagree with the assertion that the overall premium cost for health and life to a group increases commensurately with the unhealthiness of the group. In fact, the addition of premium costs due to life coverage for a group with adverse risks would actually be lower than the added costs to a healthy group since the high risk individuals would be declined for the basic life coverage. Therefore, while 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.***

**Issue No. 10 – Discrimination based on a health factor**

Certificates J-3000 and J-4000, failed to eliminate health status as a factor in enrollment by deferring: (1) coverage for an employee who was not actively-at-work, and therefore coverage also for any dependents; and/or (2) an increase in benefits for a confined dependent, on the date coverage or any increase in benefits would otherwise become effective.

Certificate J-4000 stated in part:

“When is Insurance Effective?

. . . However, your effective date *may be delayed* in accordance with the Deferred Effective Date provision *if You are not at work on the date Your insurance would otherwise be effective . . . .*

Deferred Effective Date

If You are not at work as an Active Full-Time Employee on the effective date shown on the Benefit Summary, or on the effective date of any increase in benefits, *Your insurance, or any increase in benefits, will not become effective until the date You return to work as an Active Full-Time Employee . . . .*”

Rider J-3000-RR 11/97 contained a “Deferred Effective Dates” section for dependents, which stated:

“With respect to Major Medical Benefits only, if one of Your Dependents is confined in any institution because of an Illness or Injury on the date any increase in that Dependent’s benefits would become effective, the increase in benefits with respect to that Dependent *will not become effective until the date after his or her discharge from the confinement.*”

Certificate J-4000 certificate continued the Deferred Effective Date section stating:

*“With respect to Medical Benefits only, if one of Your Eligible Dependents is confined in any institution because of an Illness, Injury on the date any increase in that dependent’s benefit would become effective, the increase in benefits, with respect to that dependent will not become effective until the date after his or her discharge from the confinement.”*

Denial of eligibility for benefits, or an increase in benefits based on health status is a violation of R.C. 3924.03(C), 3901.21(T)(1)(b)(3), Public Law 104-191 Part A – Group Market Reforms, Sections. 2702(a)(1)(A) and 2711(a)(1)(B), 45 CFR § 146.121(a)(1) and HCFA Bulletins, Transmittal Nos. 00-01 and 00-04. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 3901.21(M).

The deferment was not modified by an exception for cases where the health of the employee was the reason for the failure to be actively-at-work. In failing to include such an exception, the certificate permits denial of eligibility on the basis of health status. In the case of a dependent, the provision specifically excludes the increase in benefits on the basis of the dependent’s health status.

**COMPANY RESPONSE:** The Company’s response to the “Deferred Effective Date” for employees stated, “**Agree.** We will amend contract language to comport with Company practice. The Company does not administratively defer the effective date if the employee is absent from work due to illness or injury and otherwise meets the definition of an eligible full time employee.”

**COMPANY RESPONSE:** The Company’s response to the deferment of (1) a dependent’s effective date of coverage; and (2) an increase in benefits; due to the dependent’s confinement stated respectively:

- (1) “**Agree:** We will amend contract language to comport with Company practice. It is the company’s administrative practice regarding the above referenced forms not to defer an effective date due to confinement to an institution due to illness or injury so long as the dependent is eligible for coverage and otherwise meets the definition of a dependent.”
- (2) “**Agree:** We will amend contract language to comport with Company practice. It is the company’s administrative practice not to defer a dependent’s effective date for an increase in benefits due to confinement to an institution due to illness or injury.”

**EXAMINER RESPONSE:** The Company may not defer the effective date of a dependent’s insurance or increase in benefits due to his or her confinement in an institution on the date that person’s coverage would otherwise become effective.

**Issue No. 11 – Eligible employee**

Certificate J-4000 failed to comply with R.C. 3924.01(G) by requiring the employee to work a minimum of 48 weeks a year for eligibility. Therefore, the certificate’s eligibility requirement was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

The certificate stated in part:

“The term ‘Active Full-Time Employee’ does not include: . . . .

2. Any ‘seasonal’ or ‘temporary’ Employees who *work less than 48 weeks a Year.*”

The law does not require an employee to work 48 weeks a year in order to be considered a full-time employee and does not define a seasonal or temporary employee as one who works less than 48 weeks a year. Such a requirement contravenes R.C. 3924.01(G). The certificate definition could provide an opportunity for the Company or an employer to deny coverage to an employee until he or she had completed 48 weeks of service with the employer.

**COMPANY RESPONSE:** The Company agrees. We will remove and amend the language in the certificate specifying the employee must work 48 weeks per year to be considered an “Active Full-Time Employee.

**Issue No. 12 – Participation requirements**

The employer applications imposed a 100% participation requirement for employees in non-contributory groups (the employer pays 100% of the premium), but failed to non-discriminately impose that requirement.

Discriminating between 100% non-contributory groups by allowing some employers to cover fewer than 100% of their employees, while requiring other employers to cover 100% of their eligible employees was unfairly discriminatory in violation of R.C. 3901.21(M).

The employer application HC-1078-0 (Rev. 1/2002), stated:

“If employer pays 100% of premium, all eligible employees must enroll.”

In the review of Small Groups Issued, it was found that in seven of the twelve files reflecting non-contributory groups, employees were permitted to waive coverage.

**COMPANY RESPONSE:** The Company’s response concerning one file stated, “It is our guideline that at 100% employer contribution level, that 100% of the full-time employee’s must enroll. **It appears that the Underwriter inadvertently overlooked the 100% contribution and allowed the employee to waive coverage.** The employer should have been advised that the employee must enroll or the employer would have to

select a contribution percentage less than 100%. We have reminded staff of the requirement and the importance of adhering to established guidelines.”

**COMPANY RESPONSE:** The Company response concerning another file stated, “participation requirements for this case was 100% of all eligible employees, including employees with valid waivers. Please see the waivers included in the file for employees (names of two employees), both of which report coverage under a spouse’s plan. **This appears to be an audit error on the part of the underwriter.** In such situations, employers are ordinarily informed that either the employees with valid waivers must enroll or the employer must modify his premium contribution level to less than 100%.”

**EXAMINER RESPONSE:** The Company failed to follow the language in its applications and unfairly discriminated among its non-contributory small groups in violation of R.C. 3901.21(M).

**Issue No. 13 – Dependent eligibility**

Certificates J-3000 and J-4000 contained requirements for dependent eligibility that were not in compliance with R.C. 3924.46(B)(3), 3924.47(B), 3924.51(A)(3) and 45 CFR § 146.143(a) and 146.150(b)(3). The certificates provided information to the employer and employees that was untrue, deceptive, and misleading in violation of R.C. 3901.21(B).

Rider J-3000-RR 11/97 to certificate J-3000 stated in part:

“A. The DEFINITIONS section of the Certificate is changed as follows:

“‘Child’ means Your natural child, Your legally adopted child upon *placement in Your home*, Your step-child *who resides in Your household*, and any other child who is supported solely by You and *permanently residing in Your household*.”

. . . The term ‘Dependent’ does not include any spouse or child who resides outside of the United States or Canada or *who spends more than 90 consecutive days in any year outside the U.S. or Canada*, whether for work or pleasure; or . . . .”

Certificate J-4000, stated in part:

“Section VIII: Eligibility for Coverage

. . . ‘Child’ means:

2. A child placed *in Your home* for adoption provided proof of intended adoption is presented to Us within 31 days of placement *in Your home* . . .

4. any other child who is supported *solely* by You and who permanently *resides in Your household* in a regular parent-child relationship.

A Dependent DOES NOT INCLUDE a person who:

- b. resides outside the U S or *Canada* or *who spends more than 60 consecutive days in any Year outside the U.S. or Canada; . . . .*”

The certificate provisions provide the Company and/or an employer with an opportunity to deny coverage to otherwise eligible dependent children.

(1) R.C. 3924.46(B)(3), R.C. 3924.47(B), and R.C. 3924.51 do *not* provide for an adoptive child to be *in the employee’s home* in order for that child to be eligible for coverage. The above laws are specific in that an adoptive child must be covered as soon as the employee assumes a legal obligation for total or *partial support* of a child in anticipation of the adoption.

**COMPANY RESPONSE:** The Company agrees. The Company will amend the Certificate(s) to reflect the requirements of §3924.51(B) of the Ohio Revised Code. Please note, however, that current administrative practices comply. Current guidelines provide that insurance for a newborn or adopted child will become effective on the child's date of birth, adoption or placement, without any review of Health History provided we receive an enrollment request (or call to Customer Service) within 31 days of birth, adoption or placement.

(2) R.C. 3924.46(B)(3), R.C. 3924.47(B), and R.C. 3924.51 do not provide for eligibility of an adoptive child only if the employee is *solely* supporting the child. R.C. 3924.51(A)(3) and (B) require the child to be enrolled even if the adopting employee is providing only *partial* support of the child.

**COMPANY RESPONSE:** The Company agrees. The Company will amend the Certificate(s) to reflect the requirements of §3924.51(A)(3) of the Ohio Revised Code by removing references to sole support and residence. Please note, however, that current administrative practices comply. Current guidelines provide that insurance for a newborn or adopted child will become effective on the child's date of birth, adoption or placement, without any review of Health History, provided we receive an enrollment request (or call to Customer Service) within 31 days of birth, adoption or placement.

(3) R.C. 3924.46(B)(3), R.C. 3924.47(B) and R.C. 3924.51 do not provide for eligibility of a child *other than* an adoptive child only if the employee is *solely* supporting that child. Form J-3000, which was in force during the examination period, did not provide an exception for a child subject to a Qualified Medical Child Support Order (QMCSO). R.C. 3924.49 requires the Company to treat any child covered by a Qualified Medical Child Support Order (QMCSO) as a Dependent under the plan and cannot deny coverage to any such child on the grounds that the employee is not providing the sole support for that child.

**COMPANY RESPONSE:** The Company agrees. Please see prior response above.

(4) R.C. 3924.46(B)(3), R.C. 3924.47(B) and R.C. 3924.51 do not provide for eligibility of a child who is not the subject of a QMCSO. If the child’s health coverage is provided through the non-custodial employee parent and that parent provides only part of the support for the child, R.C. 3924.47 requires the Company to cover the child.

**COMPANY RESPONSE:** The Company agrees. Please see prior response above.

(5) R.C. 3924.46(B)(3), R.C. 3924.47(B) and R.C. 3924.51 do not provide for eligibility of a child to be restricted to a child who resides *in the employee’s household, permanently or otherwise*. R.C. 3924.46 specifically provides that an insurer may not deny coverage to a child who does not reside in the household of the employee. This applies to a child whose health coverage is provided through the non-custodial employee parent.

**COMPANY RESPONSE:** The Company agrees. The Company will amend the Certificate(s) to reflect the requirements of 3924.46(3) of the Ohio Revised Code prohibiting limiting eligibility for dependents on the basis of non-residence with the covered employee.

(6) R.C. 3924.46(B)(3), R.C. 3924.47(B) and R.C. 3924.51 do not provide for eligibility of a child of a non-custodial parent only if that child does not spend more than 60 days in any year outside the U.S. or Canada, or who does not reside in the service area of the insurer. R.C. 3924.46 specifically provides that the child does not have to live in the service area of the parent.

**COMPANY RESPONSE:** The Company agrees. As we noted in our response to Inquiry #1, we will remove from certificates the eligibility criterion specifying the employee (and/or dependent) may not reside outside the U.S. or Canada.

**Issue No. 14 – Waiting period**

Certificate J-4000 and the Company’s administrative practices failed to comply with the 90 days waiting period limitation in violation of R.C. 3924.03(E)(2).

The certificate stated in part:

“Section VIII: Eligibility for Coverage

When is Insurance Effective?

. . . *Your coverage will be effective on Your Employer’s next premium due date following the later of:*

- The date you enroll if You enroll within [30/31] days of satisfying the Employer's eligibility waiting period;
- The date You meet satisfactory . . . .”

The employee enrollment form HC-1002-3 (Rev. 8/2001), gave the employee a choice of effective date of either the first or fifteenth of the month, regardless of the length of the waiting period.

When an employer chooses an eligibility waiting period of 90 days, and the Company does not make a new enrollee's coverage effective until the employer's next premium due date after the end of the waiting period, the employee's waiting period is extended beyond 90 days and may be up to 120 days in length, if for instance employment starts on the second day of the month and the employer's premium due date is the first of the month.

**COMPANY RESPONSE:** The Company agrees. We will amend certificate forms issued in Ohio accordingly. **Please note, however, that our administrative practices are in compliance with § 3924.03 of the Ohio Revised Code.** Current underwriting guidelines with respect to the assignment of effective dates read as follows:

For **NC** and **OH** groups with a 90 day waiting period, if the application is received on or before the 90<sup>th</sup> day of employment, we must assign effective dates on the 90<sup>th</sup> day. Effective dates for these two states with the 90 day waiting period will be any date. Additions for these states will have effective dates other than the 1<sup>st</sup> and 15<sup>th</sup>. The insured would be considered Timely.

Count out the exact number of days to determine the correct effective date.

**Example:** The application is date stamped on 3/25/05, and the 90 day waiting period ends on 4/16/05. The insured is considered Timely and their effective date would be 4/16/05.

The application is date stamped on 4/15/05, and the 90 day waiting period ends on 4/21/05. The insured is considered Timely and their effective date would be 4/21/05.

### **Late Additions**

If the enrollment form is received after the 90 day waiting period then their effective date would be the next 1<sup>st</sup> or 15<sup>th</sup> of the month and the insured would be considered Late. The 30 day grace period would not apply. The insured would be considered Late.

**Example:** The application is date stamped on 6/25/05 and the 90 day waiting period ends on 4/16/05. The insured is considered Late and their effective date would be 7/1/05.

The application is date stamped on 7/15/05 and the 90 day waiting periods on 6/25/05. The insured is considered Late and their effective date would be 7/15/05.

**Later Effective Dates (The insured is Timely or Late and requests a later effective date than they are eligible for):**

If the insured does have other medical coverage in effect they may have the later effective date to avoid duplicative coverage.

If the insured does not have other medical coverage in effect they can only have what they are eligible for as described above.

**EXAMINER RESPONSE:** In one Small Group Terminations file, an employee was subject to a 100 days waiting period. This occurred because of the Company's procedure of assigning an effective date of either the 1<sup>st</sup> or 15<sup>th</sup> of the month.

**COMPANY RESPONSE:** The Company's response to this violation stated, "**Agree:** As noted in our responses to JALIC Inquiry #5 and JALIC Inquiry #18, we have since amended administrative procedures to ensure that an employee's effective date of coverage falls not later than the 90<sup>th</sup> day following eligibility for enrollment. We further noted that we will amend certificate forms issued in Ohio accordingly . . . ."

**EXAMINER RESPONSE:** Testing of complaint files indicated that another employee had a waiting period greater than 90 days. Coverage was effective 103 days after his enrollment date. This also occurred because of the Company's procedure of assigning an effective date of either the 1<sup>st</sup> or 15<sup>th</sup> of the month.

**Issue No. 15 – Newly born children and congenital defects**

Certificate J-4000 failed to provide the benefits mandated for dental congenital defects by placing a \$2,000 cap on such benefits.

The certificate stated:

“Section I: Definitions

Congenital Defect

An Illness, disorder, malformation or abnormality that was present from the moment of birth, or which has been diagnosed or treated during the growth and developmental process before five years of age.

Benefit Schedule

Dental Congenital Defects, dental treatment, tooth problems or tooth loss, including orthodontics: Subject to all other provisions of this Certificate, treatment for Dental Congenital Defects, dental treatment, tooth problems or tooth loss, including orthodontics, is covered *up to a maximum benefit of \$2,000 per lifetime for all services combined*. Benefits are limited to conditions present at birth or diagnosed before age 5.”

R.C. 3923.26 does not place any dollar limit on services required for dental congenital defects. Placing a dollar cap on such services contravenes R.C. 3923.26. Therefore, the provision was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

The certificate exclusion could severely impact the provision of services for congenital defects such as cleft lip and cleft palate, which require services such as those described in the provision.

**COMPANY RESPONSE:** The Company agrees. We will amend the certificate to remove caps on benefits for congenital defects of a newborn . . . We will amend the certificate to provide coverage for congenital defects of a newborn, consistent with the requirements of § 3923.26 of the Ohio Revised Code.

**Issue No. 16 – Continuation of coverage**

Certificates J-3000 and J-4000, failed to comply with the continuation of coverage provisions of R.C. 3923.38, by requiring payment for three months’ coverage in advance and/or by limiting coverage to the remainder of the month plus three months. Therefore, the certificate language provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

(1) Certificate J-4000 stated in part:

“Continuation Rights

You may be eligible to have Your Major Medical coverage continued under this plan, for You and Your then insured Dependents for the rest of the month in which that insurance stops, plus *3 more months . . .*”

**COMPANY RESPONSE:** The Company disagrees. Please note that we administratively provide six months of continuation coverage as required by R.S. (sic) 3923.38.

**EXAMINER RESPONSE:** The certificate language contradicts what the Company states are its administrative procedures.

(2) Rider J-3000-RR 11/97 and certificate J-3000, stated in part:

“Continuation Rights

*. . . the Employer must be paid in advance for the full cost of coverage including any portion usually paid by the Employer, but for no more than 3 months of coverage at a time . . .*”

The certificate provisions would violate R.C. 3923.38. By failing to comply with the requirements of R.C. 3923.38, the certificates are untrue, deceptive and misleading in violation of R.C. 3901.21(B).

R.C. 3923.38 requires the Company to continue coverage for *six months and to require no more than one month's coverage* to be paid in advance. An employee reading the certificate may be deterred from applying for coverage if (s)he believes that three months' premium must be provided at the time of application.

**COMPANY RESPONSE:** The Company disagrees. As we noted in our response to JALIC Inquiry #29, the phrase 'entire cost of coverage' conveys that the insured is responsible for the entire premium and that there is no employer's share. Because billings are monthly and subject to change upon renewal, change in benefits, or change in age, the 'entire cost' for the full period of continuation eligibility could not be reliably determined. Please note Company practice requires the payment of premium in advance of each of the employer's premium due date (monthly). Please see attached documentation in use by our Premium Services department. We would note in particular that Company practice is less stringent than permitted by law under R.C. 3923.38(C)(3)(b) and (c).

**We will, however, take the necessary steps to ensure that in-force certificates reflect the requirements of R.C. 3923.38.**

**EXAMINER RESPONSE:** The Company provided a sample of the letter it sends to prospective continuation enrollees. That letter did not state that continuation coverage was available for six months. Therefore, the Company was asked to provide a copy of an issued letter. The Company was unable to provide a copy of any letter it actually issued.

**Issue No. 17 – Group Certificate and COBRA Coverage**

Certificate J-4000 denied COBRA continuation rights to individuals who were *entitled to Medicare*.

The certificate stated in part, in Section V:

“State and Federal Continuation Rights

IMPORTANT NOTE: There are no Continuation Rights available to any Insured Person when:

1. such person is entitled to Medicare coverage; . . . .”

While this statement is true concerning 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.

Failure to provide COBRA continuation rights to Medicare entitled insureds contravenes COBRA. A Medicare entitled insured's right to elect COBRA continuation was confirmed by the U.S. Supreme Court in *Geissal v. Moore* on June 8, 1998. Therefore,

the certificate language provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. We will amend the certificate language to comply with federal guidelines regarding COBRA eligibility.

**Issue No. 18 – Continuation of coverage for reservist**

Certificates J-3000 and J-4000, failed to comply with R.C. 3923.381, concerning the rights of reservists called or ordered to active duty. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

Certificate J-3000, *did not provide the required notice* of continuation for reservists called or ordered to active duty.

Certificate J-4000 stated:

“State Continuation Rights

Employees on Military Leave.

Employees going to or returning from military service will have plan rights mandated by the Uniformed Service Employment and Reemployment Rights Act. These rights include *up to 18 months* of extended health care coverage *upon payment of the entire cost of coverage plus a reasonable administration fee . . . .*”

**COMPANY RESPONSE:** The Company agrees. We will take the necessary steps to ensure that in-force certificates in Ohio provide notice of the continuation rights as required by §3923.381. In addition to the J-4000-CB (OH), this would necessarily include the J-3000-MM 7/96.

**Issue No. 19 – Maternity benefits**

Certificate J-3000 offered a mother a financial incentive to forgo the inpatient care required to be provided under R.C. 3923.63. Such financial incentives are prohibited under R.C. 3923.63, and are considered an unfair and deceptive act or practice in the business of insurance under R.C. 3901.19 through 3901.26. Therefore, the certificate provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

The certificate stated:

“Benefit Summary

Special Provisions for Major Medical Benefits:

Pregnancy Benefits:

Covered Medical Charges in connection with pregnancy (including resulting childbirth, non-elective abortion and complications of pregnancy) *are paid subject to all of the same benefits and provisions as for any other illness.*

For a newborn child, Covered Medical Charges include Hospital charges for the newborn's routine nursery and pediatric care subject to all benefits and provisions, *including a separate deductible for the newborn.*

Covered Medical Charges of a Nurse Midwife will be paid at 100%, without application of the deductible, for a covered pregnancy.

Covered Medical Charges of a Birth Center or Hospital will be paid at 100% without application of the deductible, *for one day Hospital Confinements."*

While the Company added rider J-3000-RR 11/97 to the certificate to provide the 48/96 hours inpatient care required by R.C. 3923.63, the rider was silent as to the copayment percentage and deductible. Therefore, the insured may assume that the copayment percentage and deductible are those that apply to the certificate generally.

The wording of the certificate in the section entitled "Special Provisions for Major Medical Benefits: Pregnancy benefits," results in:

- (1) Payment at 100% without imposition of a deductible *if the mother and newborn are discharged after a one day stay.*
- (2) Two deductibles to be imposed (one for the mother and one for the newborn) if the mother and newborn are not discharged within 24 hours.
- (3) The standard copayment percentage to apply if the mother and newborn are not discharged within 24 hours.

The certificate provision established and offered monetary incentives for a mother to decline the inpatient care required to be covered by R.C. 3923.63. The certificate provided for payment of the second and subsequent days' hospital stay in a manner less favorable than that of the preceding portion of the stay by imposing deductibles and the standard copayment percentage after 24 hours of stay. This also results in unfair discrimination between a mother and child who stay one day and a mother and child who stay for 48 or 96 hours. All mothers are entitled to the same conditions of payment under R.C. 3923.63 and R.C. 3901.21(M).

**COMPANY RESPONSE:** The Company disagrees. Please note that benefits are administered in compliance with federal and state requirements for maternity stays and, therefore, there are no violations of § 3923.63 of the Ohio Revised Code. The claims system is programmed to automatically provide coverage based on the standard deductible, co-pay and coinsurance provisions selected by the employer for the first 48 hours in the case of a vaginal birth and 96 hours in the case of a birth by cesarean section.

**However, we note that the Certificate for J-3000-S requires additional clarification beyond that currently provided in Rider J-3000-RR 7/86 – Spectrum (OH) 3/95 and we will take the necessary steps to assure the certificate language reflects the requirements of § 3923.63 of the Ohio Revised Code.**

**EXAMINER RESPONSE:** The Company responded to the issue of the incentive to a mother to forgo hospital care after the first 24 hours by stating, “*As noted above, we do not provide financial incentives to forego benefits, however, we will take necessary steps to [sic] the certificate language reflects the requirements of § 3923.63 of the Ohio Revised Code.*”

Only WHCRA claims were tested. Therefore, administrative compliance could not be determined. The certificate wording could result in a mother foregoing the care to which she and her baby were entitled. The certificate wording did not comply with R.C. 3923.63, by discriminating in the payment of benefits between mothers who stay for 48/96 hours and those who are discharged within 24 hours, and therefore also violated R.C. 3901.21(M).

**Issue No. 20 – Mental health and alcoholism coverage**

Certificates J-3000 and J-4000, failed to provide the mandated benefits for mental health services and alcoholism, chemical dependency and drug addiction services, by restricting coverage to the services of *Ohio licensed* providers. Neither R.C. 3923.28 nor 3923.29 contain any such restriction. Therefore, the certificates provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B).

Rider J-3000-RR 11/97 to certificate J-3000 stated in part:

“B. The MAJOR MEDICAL BENEFITS part of the Certificate is changed as follows:

1. The “Benefits for Mental Illness, Alcoholism, Chemical Dependency, Drug Addiction” . . . for Covered Medical Charges as follows.
  - a. For outpatient charges incurred for a mental or nervous disorder consultation, diagnosis, and treatment by: . . . (3) *an Ohio licensed psychologist or psychiatrist . . .*
  - b. For outpatient charges incurred for alcoholism treatment by a Hospital; and outpatient, inpatient, and intermediate primary care charges incurred for alcoholism treatment by: . . . (2) *an Ohio licensed psychologist or psychiatrist . . .*”

Certificate J-4000 stated in part:

“IV. Mental Illness, Alcoholism, Drug Addiction, Chemical Dependency

We will cover charges . . . .

3. For outpatient charge incurred for a mental or nervous disorder consultation, diagnosis, and treatment by: (1) a Hospital; or (2) a community mental health center or mental health clinic *approved or licensed by the State of Ohio*; or (3) an *Ohio licensed* psychologist or psychiatrist . . . .
4. For outpatient charges incurred for alcoholism treatment by a Hospital; and outpatient, inpatient, and intermediate primary care charges incurred for alcoholism treatment by: (1) a community mental health center or alcoholism treatment facility *approved or licensed by the State of Ohio*; or (2) an *Ohio licensed* psychologist or psychiatrist . . . .”

**COMPANY RESPONSE:** The Company disagrees. Our remarks as noted in our response to Inquiry #44 also apply to Rider J-3000-RR(11/97):

Please note that the language cited in both the JALIC Special State Provisions Supplement for Ohio and the Certificate J-4000 is intended to convey that services must be performed by a provider operating within the scope of their license. We administratively provide benefits for these services if the provider is licensed to provide the services, regardless of the state issuing the license. Therefore, benefits have not been denied based on the state in which the provider is licensed to practice.

**We will, however, amend language in both forms to delete references to licensure in a particular state.**

**EXAMINER RESPONSE:** In the testing of marketing and sales materials, the JALIC “Special State Provisions Supplement for Ohio” contained the same invalid restriction. The certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

**Issue No. 21 – Pre-existing conditions**

The wording in certificates J-3000 and J-4000, failed to comply with the limitations applicable to pre-existing conditions set forth in R.C. 3924.01 and 3924.03. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

Certificate J-3000 stated in part:

“Charges Not Covered

Covered Medical Charges do not include any charges: . . . .

6. For any services, treatment or supplies furnished *in* connection with a Pre-existing Condition; except as stated in this section.”

Rider J-3000-RR 11/97, which amended the J-3000, stated in part:

“Pre-existing Conditions Limitation

. . . Covered Medical Charges do not include any charges incurred in connection with a pre-existing condition *whether or not* any medical advice, diagnosis, care or treatment was recommended or received before the Enrollment Date, except those charges incurred 12 months after You or Your Dependent’s Enrollment Date, or in the case of a Late Enrollee, 18 months after the Enrollment Date . . . .

The Pre-Existing Condition Limitation does not apply to . . . .

3. an adopted Dependent child under the age of 18 who, as of the last day of the 30 day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage. *This does not apply to coverage the adopted child may have had before such adoption or placement for adoption . . . .”*
- A. The certificates exclude as a pre-existing condition any condition *whether or not* any medical advice, diagnosis, care or treatment was recommended or received (i.e. *was present*) during the six months just before the insured’s enrollment date. The certificate wording does not comply with R.C. 3923.571, R.C. 3924.03 and Public Law 104-191, Part A – Group Market Reforms, Sec. 2701. The Company cannot deny covered medical charges incurred in connection with a pre-existing condition *in the absence of* medical advice, diagnosis, care, or treatment being recommended or received during that six month period. Therefore, the certificates provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company disagrees. The complete language cited by the examiner from page 5 of the Rider reads as follows:

*4. The Pre-Existing Condition Limitation is replaced with the following:*

*Pre-existing Conditions Limitation*

*A pre-existing condition is any Illness (whether physical or mental) or Injury, regardless of the cause of the Illness or Injury, for which an insured person received any diagnosis, medical advice, care or treatment, during the 6 months just before his or her Enrollment Date of Major Medical coverage. Genetic information in the absence of a diagnosis of a condition related to such information will not be considered a pre-existing condition.*

*Covered Medical Charges do not include any charges incurred in connection with a preexisting condition whether or not any medical advice, diagnosis, care or treatment was recommended or received before the Enrollment Date, except those charges incurred 12 months after You or Your Dependent's Enrollment Date, or in the case of a Late Enrollee, 18 months after the Enrollment Date.*

*The final sentence in the above is a holdover from previous Certificate versions that quoted the definition of pre-existing condition found in 42 USC 300gg(b)(1)(A). Company practice throughout the examination period has been consistent with the definition contained in the first sentence of the above, which includes the test that "medical advice, care or treatment" has been recommended or received.*

***We will, however, amend certificate language to comport with company practice.***

**B.** The Company may not deny the total waiver of the pre-existing conditions limitation for an adoptive child on the basis of coverage the adoptive child may have had before the placement for adoption. A pre-existing conditions limitation is *always* totally waived for a timely enrolled adoptive child.

**COMPANY RESPONSE:** The Company disagrees. Company practice throughout the examination period has been to provide a complete waiver for the pre-existing condition exclusion for adoptees if they are enrolled within 30 days from adoption or placement for adoption.

**EXAMINER RESPONSE:** The certificate language is not in compliance with R.C. 3923.40 or R.C. 3924.51. Any coverage an adoptive child may have had prior to adoption is irrelevant to coverage under the adopting parent's certificate. For example, if an adoptive child had creditable coverage of six months under the birth mother's plan, the Company may not require the child to complete a further six months of coverage for the pre-existing conditions limitation to be met. The provision was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

**C.** Certificate J-4000 stated in part:

"IX. General Medical Charges

***We will not cover charges: . . . .***

7. For any services, treatments or supplies furnished in connection with a Pre-existing Condition.

Section I. Definitions

Pre-Existing Condition (applies to Medical Benefits only)

Any Illness (whether physical or mental) or Injury *present* during the six (6) months just before You or Your Dependent’s enrollment for medical benefits under this certificate whether or not any medical advice, diagnosis, care or treatment was recommended or received before the Enrollment Date . . . .”

The Company’s definition of “Pre-existing Condition” does not conform with R.C. 3924.01(L), 3924.03(A)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701, or 45 CFR § 146.111 when used as the basis for a limitation or exclusion of benefits. The *presence* of an illness or injury during the six months before enrollment is irrelevant to receipt of benefits unless medical advice, diagnosis, care, or treatment was recommended or received for that Illness or injury during the six months immediately preceding the enrollment date. The Company may not deny “*Covered Medical Charges incurred in connection with a pre-existing condition*” in the absence of medical advice, diagnosis, care, or treatment being recommended or received during that six month period. Therefore, the language provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

**COMPANY RESPONSE:** The Company agrees. Certificate language will be amended to incorporate the provisions limiting pre-existing limitations to conditions for which “medical advice, diagnosis, care, or treatment was recommended or received for that Illness or Injury during the six months immediately preceding the enrollment date.

**EXAMINER RESPONSE:** Similar wording was also found in the “Special State Provisions Supplement for Ohio,” during the testing of Marketing and Sales.

**Issue No. 22 – Pre-existing conditions limitations**

Certificates J-3000 and J-4000, failed to comply with the required pre-existing conditions limitation of 12 or 18 months. If the Company imposed the restrictions in the certificates, it would have been a violation of R.C. 3901.21(M), 3924.03(A)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701(a)(2), 45 CFR 146.150(a)(2) and 45 CFR § 146.111(a). Therefore, the certificates provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

Certificate J-3000 stated in part:

“Benefit Summary

**Covered Medical Charges**

. . . Covered Medical Charges include charges:

11. For the first purchase and first fitting of artificial limbs, larynx, eyes or other prosthetic appliances, but only if required for replacement of natural parts of the body *lost while insured* . . . .

## Charges Not Covered

13. For orthodontics (or braces) or any other dental services, treatments or supplies unless.
  - a. required for repair or replacement of sound natural teeth damaged by an accidental Injury *sustained while insured under this plan* and performed while so insured and within 12 months following such Injury; . . . .
15. For Cosmetic treatment or surgery, or any complication therefrom, except for the following: (a) correction of damage caused by accidental Injury *sustained while insured under this plan* if such treatment or surgery is also performed while so insured; or (b) in connection with congenital defects, malformations or abnormalities present at birth.
19. For eye refractions, or examinations, in connection with corrective lenses or hearing aids (except when necessary because of accidental Injury to a natural eye or ear, *sustained while insured under this plan* if such eye refraction or examination is also performed while so insured) or for the purchase of corrective lenses or hearing aids; or for radial keratotomy or any other surgical procedure performed to correct myopia or hyperopia.”

Certificate J-4000 stated in part:

### “VI. Medical Equipment, Supplies and Prostheses

***We will cover charges . . . .***

2. For the first temporary fitting and first permanent purchase of artificial limbs, larynx, eyes or other Prostheses, but only if required for replacement of natural parts of the body *lost while insured . . . .*

### VIII. Cosmetic Treatment or Surgery/Dental and Vision Related Benefits

***We will cover charges:***

1. For Cosmetic treatment or surgery for the following only:
  - a. correction of damage caused by Accidental Injury *sustained while insured under this plan*, if such treatment or surgery is also performed while so insured; or
  - b. in connection with Congenital Defects present at birth, but only if the insured person was *covered under this plan at birth* or if the condition was diagnosed and documented prior to age 5.

2. For Reconstructive Surgery and related expenses when required as a result of a Congenital Defect, Accidental Injury, disease process or disease treatment. *The situation requiring the surgery must have occurred on or after Your original effective date of coverage, and continuous coverage must be maintained from the date of birth, accident or disease treatment. NOTE: This criteria applies regardless of any Pre-Existing Condition limitation or waiver thereof.* With regard to Reconstructive Surgery following a mastectomy, such Reconstructive Surgery must be performed within five (5) years of initial surgery. The requirement that such initial surgery must occur while insured under this plan is not applicable to Reconstructive Surgery due to a mastectomy . . . .
  
5. For dental treatment, services or supplies (including orthodontics or braces) or surgery, but only if . . . .
  - b. required for repair or replacement of sound natural teeth damaged by an Accidental Injury sustained *while insured under this plan and performed while so insured* and within 12 months following such Injury;
  - c. required for repair or replacement of sound natural teeth damaged during a course of treatment related to a disease process *which occurs and is treated while so insured*; or . . . .
  
7. For eye refractions or examinations in connection with corrective lenses or hearing aids, but only when necessary because of Accidental Injury to a natural eye or ear, *sustained while insured under such plan*, and if such eye refraction or examination is also performed while so insured and within 12 months of the Injury.”

The certificates *permanently* excluded coverage for some insureds whose illness or injury was pre-existing, although it provided coverage for those same conditions for insureds whose illness or injury occurred *while they were covered under the plan*. Examples 1 and 2 of 45 CFR § 146.111(a) and CMS Bulletin, Transmittal No. 05-02, June 2002, clarify the prohibition on restriction of coverage to accidental injuries that occur *while the insured is covered under the plan*. The certificate did not provide for a pre-existing conditions limitation to be imposed and reduced by creditable coverage. To exclude coverage for some insureds, while providing it for other similarly situated insureds, is unfairly discriminatory and therefore, also a violation of R.C. 3901.21(M).

**COMPANY RESPONSE:** The Company agrees. As to Forms J-3000 and J-4000: We will amend certificate language and take the necessary steps to provide coverage consistent with permissible pre-existing condition limitations. We note, however, that there were no instances during the examination period in which a covered person was

denied reconstructive breast surgery following a mastectomy because the mastectomy was performed more than five years prior to the proposed reconstructive surgery.

**Issue No. 23 – Coverage denial**

Certificates J-3000 and J-4000, failed to cover services for some accidental injuries if receipt of health care was not provided within a specific time frame after the injury. If the Company imposed this restriction it would have been a violation of R.C. 3901.21(M), R.C. 3901.21(T)(1)(b) and 3924.03(C), Public Law 104-191, Part A – Group Market Reforms, Sec. 2702(a)(1)(D) and (2)(B), and 45 CFR § 146.121(a) and (a)(iv). Therefore, the certificates provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

Certificate J-3000 stated in part in the Benefit Summary:

“Dental Benefits

**Charges Not Covered**

Covered Medical Charges do not include any charges: . . . .

13. For orthodontics (or braces) or any other dental services, treatments or supplies unless.
  - a. required for repair or replacement of sound natural teeth damaged by an accidental Injury sustained while insured under this plan and performed while so insured and *within 12 months following such Injury*; . . . .”

Certificate J-4000 stated in part:

“VIII. Cosmetic Treatment or Surgery/Dental and Vision Related Benefits

**We will cover charges: . . . .**

2. For Reconstructive Surgery and related expenses when required as a result of a Congenital Defect, Accidental Injury, disease process or disease treatment. The situation requiring the surgery must have occurred on or after Your original effective date of coverage, and continuous coverage must be maintained from the date of birth, accident or disease treatment. NOTE: This criteria applies regardless of any Pre-Existing Condition limitation or waiver thereof. With regard to Reconstructive Surgery following a mastectomy, such Reconstructive Surgery *must be performed within five (5) years of initial surgery*. The requirement that such initial surgery must occur while insured under this plan is not applicable to Reconstructive Surgery due to a mastectomy.”

5. For dental treatment, services or supplies (including orthodontics or braces) or surgery, but only if:
  - b. required for repair or replacement of sound natural teeth damaged by an Accidental Injury sustained while insured under this plan and performed *within 12 months following such Injury; . . . .*”
7. For eye refractions or examinations in connection with corrective lenses or hearing aids, but only when necessary because of Accidental Injury to a natural eye or ear, sustained while insured under such plan, and if such eye refraction or examination is also performed while so insured and *within 12 months of the Injury*.

***We will not cover charges:***

6. For any medical or Hospital care in connection with dental treatment not otherwise listed above as covered, when:
  - c. such care is not directly related to an accidental Injury sustained while insured under this plan, performed while so insured and *within 12 months following such Injury.*”

By requiring receipt of health care services to be provided within a specific period of time, the Company is avoiding its responsibility to some insureds for services that are otherwise covered under the policy. The Company’s obligation to cover services is not removed just because complications of an injury were not manifested or the injury was not treated or not able to be treated, within the time frame set forth by the Company. For example, delay in *receipt of health care* may be medically necessary when a child is injured, and due to growth it is inadvisable to treat the condition within the specified time frame. However, regardless of the reason for non-treatment of the injury within the specified time, a health benefit plan should not unfairly discriminate between similarly situated insureds by imposing a time frame for repair, which will adversely impact insureds that have not, or cannot, have the repair performed within that period. No such limitations should appear in a group health benefit plan.

**COMPANY RESPONSE:** The Company agrees. As to Forms J-3000 and J-4000: We will amend certificate language and take the necessary steps to provide coverage consistent with permissible pre-existing condition limitations. We note, however, that there were no instances during the examination period in which a covered person was denied reconstructive breast surgery following a mastectomy because the mastectomy was performed more than five years prior to the proposed reconstructive surgery.

**Issue No. 24 – Coverage denial**

Certificate J-4000, failed to provide credit for prior coverage by imposing a requirement for *continuous coverage under the Plan* before benefits were payable for some services. When the Company followed its certificate language and denied credit for prior coverage, it would have been a violation of R.C. 3924.03(A), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701(a), and 45 CFR § 146.111(a). If the Company discriminated in payment of benefits between similarly situated enrollees according to the certificate requirement for continuous coverage under the plan, it would also have been a violation of R.C. 3901.21(M) and (T)(1)(b), Public Law 104-191, Part A – Group Market Reforms, Sec. 2702(a)(1)(D) and (2)(B) and 45 CFR § 146.121(a). Therefore, the certificate language provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

Certificate J-4000, stated in part:

“VI. Medical Equipment, Supplies and Prostheses

***We will cover charges: . . . .***

3. For the replacement of Prostheses that have been outgrown due to normal skeletal growth and/or wear and tear, but only after the insured has had the Prostheses for at least 5 years, *has been continuously covered under this plan for at least 5 years*, and only on a 5 year replacement basis thereafter . . . .

VIII. Cosmetic Treatment or Surgery/Dental and Vision Related Benefits

***We will cover charges:***

2. For Reconstructive Surgery and related expenses when required as a result of a Congenital Defect, Accidental Injury, disease process or disease treatment. The situation requiring the surgery must have occurred on or after Your original effective date of coverage, and *continuous coverage must be maintained from the date of birth, accident or disease treatment. NOTE: This criteria applies regardless of any Pre-Existing Condition limitation or waiver thereof.* With regard to Reconstructive Surgery following a mastectomy, such Reconstructive Surgery *must be performed within five (5) years of initial surgery.* The requirement that such initial surgery must occur while insured under this plan is not applicable to Reconstructive Surgery due to a mastectomy.”

The provision would result in either a pre-existing conditions limitation that exceeds 12/18 months, or in a denial of benefits to some insureds. For example, the certificate provides for replacement prostheses every five years but also imposes a five year *continuous coverage* requirement under the certificate before a replacement will be covered. A new enrollee who had sufficient creditable coverage to eliminate the pre-

existing conditions limitation and who had had a prosthesis for three years while covered under a prior plan would be subject to an eight year gap between replacements, whereas a new employee with a new prosthesis would wait for only five years before being eligible for a replacement.

45 CFR § 146.111, in Example 8, provides an example of an attempt to circumvent the pre-existing conditions limitation and confirms that such provisions are not permissible under law. The regulation is applicable to all the certificate provisions cited because all the charges listed are for services for pre-existing conditions.

**COMPANY RESPONSE:** The Company agrees. We will amend certificate language and take the necessary steps to provide coverage consistent with permissible pre-existing condition limitations.

**Issue No. 25 – Certificates of creditable coverage**

Rider J-3000-RR 11/97, for certificate J-3000, failed to comply with the requirements for automatic issuance of certificates of creditable coverage (CCCs) upon termination of employment. Failure to provide automatic issuance of CCCs contravenes R.C. 3924.03(A), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701 and 45 CFR § 146.115. Therefore, the rider language provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B).

The rider stated in part:

“7. The following provisions are added:

Certification of Periods of Prior Creditable Coverage Upon Termination .

...

This certification will be provided:

1. at the time You or Your Eligible Dependent cease to be covered under this plan *or otherwise become covered under a COBRA continuation provision*”

In an earlier response the Company indicated that the rider quotes 45 CFR § 146.115. However, it quoted only half a sentence, and by omitting the second half of the sentence, the certificate failed to comply with the above stated statutes and regulation.

The certificate provided for the Company to choose to issue a CCC at the time of termination from the group “*or*” when covered under COBRA. As indicated in the statutes and regulation noted above, an insurer “*must*” provide an automatic issue CCC at the time of termination of employment and again at the time of discontinuance of COBRA, or other continuation coverage.

**COMPANY RESPONSE:** The Company disagrees. The first phrase of the sentence covers both contingencies ('cease to be covered under this plan' may be read to apply to both the employer-sponsored coverage or the continuation coverage). In actual practice, a CCC is issued any time an enrollee is terminated from the administrative system. This includes termination from either group coverage or subsequent termination from COBRA or state continuation coverage.

**We have, however, identified contingencies where the enrollee would not be issued a CCC upon termination from the employer-sponsored coverage.** If the notice of termination from the group is received simultaneously with the request for continuation coverage, current processes allow us to issue the continuation coverage without terminating the employer-sponsored coverage under the group. In such instances, since no system termination has occurred, no CCC is sent. **We will amend procedures to ensure that a CCC is provided to enrollees at termination from the employer-sponsored coverage, when issued continuation coverage, and when the continuation coverage is exhausted or otherwise terminates.**

**Issue No. 26 – WHCRA benefits**

Certificates J-3000 and J-4000, failed to provide coverage for reconstructive breast surgery on the affected breast and surgery on the unaffected breast, following a mastectomy. If the Company failed to provide coverage for these services, it would have been a violation of Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificates provided untrue, deceptive and misleading information in violation of R.C. 3901.21(B).

Certificate J-3000 stated in part:

“Major Medical Benefits

**Charges Not Covered . . . .**

15. For Cosmetic treatment or surgery, or any complication therefrom except for the following: (a) correction of damage caused by accidental Injury sustained while insured under this plan if such treatment or surgery is also performed while so insured; or (b) in connection with congenital defects, malformations or abnormalities present at birth.”

Certificate J-4000 stated:

“Section I: Definitions

Prosthesis/Protheses

Any device that replaces all or part of a missing body organ or body member

Reconstructive Surgery

Surgery that is Restorative or improves bodily function to the level experienced before the event which necessitated the surgery or, in the case of a Congenital Defect, to a level considered normal. Such surgery may have a coincidental Cosmetic effect, but *the Cosmetic effect must not be the reason for the surgery.*”

**COMPANY RESPONSE:** The Company disagrees. The contract language cited above is outdated. However, we note no violation of the requirements outlined in WHCRA or Ohio Bulletin 2001-1. Benefits are provided consistent with the claims documentation used below. Benefits are processed under the plan benefits (deductible/coinsurance/copayments) consistent with the plan selected by the employer/employee. **Contract language will be amended to comport with actual company practice**, which is compliant with the Compliance documentation below.

The documentation which the Company referred, stated:

*Women’s Health and Cancer Rights Act: The following services are eligible under normal plan benefits after mastectomy:*

- a. Reconstructive surgery on the breast on which the mastectomy was performed.*
- b. Surgery & reconstruction of the other breast to produce a symmetrical appearance; and*
- c. Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.*

**EXAMINER RESPONSE:** The Company’s compliance documentation is not in the certificate. The Company agreed to amend the certificate. However, the Company’s reformation again avoided the mandated language of “*coverage will be provided in a manner determined in consultation with the attending physician and the patient.*” Therefore, the suggested correction would still *not* be in compliance with Ohio Bulletin 2001-1 and WHCRA.

**Issue No. 27 – WHCRA benefits**

Certificate J-4000 failed to provide the coverage required for reconstructive breast surgery and related expenses by imposing restrictions on coverage that did not comply with Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificates provided information that was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

The certificate provided coverage only if:

- (1) The situation resulting in the need for surgery occurred on or after the *effective date* of coverage; and
- (2) Continuous coverage was *maintained from the date of the accident or disease treatment, regardless of the Pre-existing Condition limitation*; and

(3) The reconstructive surgery is performed *within five years of the initial surgery*.

Ohio Bulletin 2001-1 and WHCRA require coverage for reconstructive surgery without any of the limitations described in (1) through (3) above.

The certificate stated in part:

“VIII. Cosmetic Treatment or Surgery/Dental and vision related benefits

We will cover charges: . . . .

2. For Reconstructive Surgery and related expenses when required as a result of Congenital Defect, Accidental Injury, disease process or disease treatment. The situation requiring the surgery must have occurred on or after Your original effective date of coverage, and *continuous coverage must be maintained from the date of birth, accident or disease treatment*. NOTE This criteria applies regardless of any Pre-Existing Condition limitation or waiver thereof. *With regard to Reconstructive Surgery following a mastectomy, such Reconstructive Surgery must be performed within five (5) years of initial surgery*. The requirement that such initial surgery must occur while insured under this plan is not applicable to Reconstructive Surgery due to a mastectomy.”

**COMPANY RESPONSE:** The Company disagrees. We note, that we administratively comply with the requirement to provide coverage required by WHCRA as noted in the above claims documentation. **We will amend the certificate language accordingly.**

**EXAMINER RESPONSE:** The certificate language did not address the Company’s internal compliance documentation. The certificate language, upon which insureds rely, should not be deceptive, untrue or misleading.

**Issue No. 28 – WHCRA benefits**

Certificates J-3000 and J-4000, failed to provide the required benefits for prostheses following reconstructive breast surgery by imposing limits on such coverage more restrictive than permitted by Ohio Bulletin 2001-1 and WHCRA. Neither Ohio Bulletin 2001-1 nor WHCRA, restrict coverage for the provision of prosthetic devices following reconstructive surgery other than by the prescription of a physician. If the Company failed to provide coverage for prostheses that are prescribed by a physician following reconstructive breast surgery, it would have been a violation of Ohio Bulletin 2001-1 and WHCRA. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

- (1) Certificate J-3000, stated in part:

“Major Medical Benefits

Covered Medical Charges

Charges must be Medically Necessary and incurred by You, or Your insured Dependent, while insured . . . Covered Medical Charges include charges:

11. For the first purchase and first fitting of . . . other *prosthetic appliances, but only if required for replacement of natural parts of the body lost while insured.*”

(2) Certificate J-4000, stated in part:

“VI. Medical Equipment, supplies and prostheses

We will cover charges:

3. For the replacement of Prostheses that *have been outgrown* due to normal skeletal growth and/or wear and tear, but *only after the insured has had the Prostheses for at least [5] years, has been continuously covered under this plan for at least [5] years, and only on a [5] year replacement basis thereafter.*”

The certificate(s) restricted coverage to:

1. The *first* purchase and first fitting of the prosthesis;
2. Prostheses required as a result of the *loss while insured, of a body part*;
3. Replacement of prostheses that have been *outgrown*;
4. Replacement only after the insured has had the prosthesis for a *specified period of time and has been continuously insured under the health benefit plan*;
5. Replacement *only on a specified interval basis*.

Breast prostheses and replacement breast prostheses must be covered *when prescribed by a physician*, without regard to when the mastectomy was performed or the length of time between replacements.

**COMPANY RESPONSE:** The Company disagrees. We note that we administratively comply with the requirement to provide ‘Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas’ as noted above. **We will amend the certificate language accordingly.**

**Issue No. 29 – Termination provisions**

Certificates J-3000 and J-4000 provided for termination of a small group plan in the event of the employer’s suspension of business operations or a change in the nature of the

business. Failure to guarantee the renewal of a small group health plan would be a violation of R.C. 3924.03, Public Law 104-191, Part A — Group Market Reforms, Sec. 2712 and CFR § 146.152. A carrier must *renew or continue the plan in force* at the option of the plan sponsor. Therefore, the certificate language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

Certificate J-3000 stated in part:

“Termination of Insurance

Your insurance will automatically stop on the earliest of the: . . . .

6. Date the Employer discontinues or *suspends active business operations; or changes the nature of business;* or no longer exists because of dissolution, merger or otherwise.”

Certificate J-4000 stated in part:

“Section IX: Termination Provisions

Employee Insurance

Your insurance will automatically terminate on the earliest of the: . . . .

8. end of the premium month in which the Employer discontinues or *suspends active business operations; or changes the nature of the business;* or no longer exists because of dissolution, merger or otherwise; or . . . .”

1. A small group health plan may *not* be terminated because the employer suspended business operation.

**COMPANY RESPONSE:** The Company disagrees. We note that our administrative practice is in compliance with state and federal law. The language cited referring to discontinuation or suspension of active business operations is only applied when a group suspends business operations for an indefinite period of time. It is not our practice to terminate all businesses, which temporarily suspend business activity; 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.**

**EXAMINER RESPONSE:** The Company must continue the small group plan in force while premiums continue to be paid. Suspension of business operations is not one of the reasons provided for in either state or federal law for termination of the plan. The Company also refers to the viability of a business. Many small businesses go through periods when they are not financially viable. This is particularly true of start-up businesses, which may not be “viable” for a considerable period.

The Company did not provide its proposed modification of the language. If the proposed modification predicates guaranteed renewability on the Company's determination of the viability of the business, it would continue to act in violation of the guaranteed renewability for small group health plans.

2. A small group health plan may *not* be terminated because the employer changes the nature of the business.

**COMPANY RESPONSE:** The Company disagrees. The language cited is intended to apply to a business that ceases to operate as the business that originally applied to participate in John Alden Life Insurance Company's group health plans. For example, a business that changes its tax identification number and name, or that reincorporates as a different business, dramatically alters the business and is fundamentally different from that in which we originally issued coverage to at initial underwriting. The information obtained in the initial underwriting process may be inaccurate and not even closely reflect the composition of the original business. This is distinct from normal business transitions involving staff changes, expansion/growth, new location, new product or service offerings, etc.

In such an instance, where the original business no longer exists, it is our position that the new entity replacing the business may be eligible to apply for coverage if the new entity qualifies as a small employer under Ohio and federal law.

**EXAMINER RESPONSE:** The certificate wording is sufficiently broad to incorporate the smallest of changes in the nature of a business, such as the addition of a gift section to a florist shop. It does not reflect what the Company describes in its response as the circumstances in which the provision would be enforced. The violation did not address the wording "no longer exists because of dissolution, merger *or otherwise*," *rather it was* to the wording "*changes the nature of the business.*" Therefore, the language was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

## 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 population of 676 small group issued files was sampled by use of the Excel Random Number Generator. A sample of 50 files was obtained for testing.

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

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

**Issue No. 1 – Form of policy filed with superintendent**

All fifty files were failed because the Company failed to file with the Department any of the six employer applications or three employee enrollment forms found in the files. Failure to file employer applications and employee enrollment forms was a violation of R.C. 3923.02.

**COMPANY RESPONSE:** The Company’s response stated, “We are unable to locate any information indicating the above referenced forms were filed with the Ohio Department of Insurance. Please note that the currently used Employer Participation Agreement (form HC-18720-OH) and Employee Enrollment Form (form HC-1871) were filed and approved on **4/27/05** (see attached).”

**EXAMINER RESPONSE:** The forms referenced in the Company’s response were filed with the Department after the period under examination.

**Issue No. 2 – Employee enrollment forms (evidence of insurability)**

Rules for eligibility that require evidence of insurability are prohibited under R.C. 3901.21(T)(1)(b)(3)(g), R.C. 3924.03(C), Public Law 104-191, Part A – Group Market Reforms, Sec. 2702(a)(1)(G) and 45 CFR § 146.121(a)(1)(vii).

Employer application HC-1001-3 stated in part:

“Enclosed are . . . the necessary enrollment forms, and (3) any initially required *evidence of insurability*.”

Employer application J4-1863 stated in part:

“It is further understood and agreed that: . . . (3) those subject to *evidence of insurability* must receive prior approval by John Alden Life Insurance Company at its home office *before coverage becomes effective*;”

Employee enrollment form J4-1864 stated in part:

“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 applications HC-1001-3 (Rev. 8/2001) (found in three files), J4-1863 (found in six files), and the employee enrollment form J4-1864 (found in five files) were

failed for containing statements that *evidence of insurability* may be required. However, five of the files contained both an employer application and employee enrollment form referenced above. Therefore, nine files contained language which was untrue, misleading and deceptive in violation of R.C. 3901.21(B).

In addition, group certificate J-3000, which was in force during the period under examination, contained a requirement for “evidence of insurability” in large group health plans for the addition of new dependents and for newborn children not timely enrolled.

**COMPANY RESPONSE:** The Company agrees. The noted representations in any forms currently in use are being revised to remove references to ‘Evidence of Insurability’. 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. In addition, we would note that the enrollment and employer Request for Participation forms referenced here are no longer in use.

### **Issue No. 3 – Guaranteed availability**

The employer applications required the employer to provide its state quarterly wage and tax statement or a copy of its most current business federal tax return and associated schedules *when applying* for a small group health plan.

All 50 files were failed for inclusion of this requirement, as follows: form J4-1863 (6 files); form HC-1078-0 (41 files); form HC-1001-3 (3 files). To *require* certain tax forms when a small employer is applying for a health plan would be a violation of the guaranteed availability requirements of R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711 and 45 CFR § 146.150. These statutes and regulation do not require the employer to submit the forms the Company states the employer must provide.

An employer that is unable to provide the form (for example, a start-up business) must be permitted to provide other valid proof of the legitimacy of the business. The wording in the application would enable the Company to deny or delay issue to a small group that was not able to provide a tax form at the time of application for coverage.

The employer application:

J4-1863 stated in part:

“Copy of the most current state quarterly wage and tax statement (state quarterly unemployment withholding form), including notation as to current status and hours worked/wk of all employees listed

Groups not *required* to file a state quarterly wage and tax statement *must* provide a copy of their most current business federal tax return and associated schedules

Sole Proprietors – Form 1040 & Schedule C (farms use Schedule F)  
C-Corporations – Form 1120  
S-Corporations – Forms 1120S and Schedule K-1  
Partnerships – Form 1065 and Schedule K-1”

HC-1078-0 (all versions) stated in part:

“6. Groups of three employees or more (not health insurance lives) *must submit* most current state-required Employer Wage & Contribution report . . . .”

HC-1001-3 (Rev. 8/2001) stated in part:

“Complete copies of the following forms *must* be submitted: . . . .

6. Most current employer wage and contribution report filed with state unemployment department.
7. Groups of fewer than three employees without an employer wage & contribution report, *must* submit their most current business federal tax return. For example:
  - a) If a sole proprietor, Form 1040 & Schedule C.
  - b) If a farmer, Form 1040 and schedule F.
  - c) If a corporation, Form 1120.
  - d) If an S corporation, Form 1120S with schedule K-1 for each shareholder.
  - e) If a partnership, Form 1065 with schedule K-1 for each partner.”

**COMPANY RESPONSE:** The Company agrees. As noted in our response to JALIC Inquiry #33 and JALIC Inquiry #14:

As indicated by the examiner, the quarterly Wage & Tax statement is a valuable tool for verifying group and employee eligibility. However, with the elimination of the 6-month durational requirement, we will accept alternative means of establishing group and employee eligibility, consistent with Ohio and federal law. Employers unable to provide a quarterly Wage & Tax statement will be afforded the opportunity to submit alternative means of establishing eligibility.

In addition, please note that the requirement #6 from the Agent Checklist cited in the Inquiry was removed from the Employer Participation Agreement/Application (sic), Form HC-1872-OH, effective February, 2005. The form now contains the following statement:

John Alden Life Insurance Company may request that the Employer provide documentation (i.e. Wage and Tax From, Payroll Records, Business License, etc.) during the Underwriting process or at any time while coverage is provided by John Alden Life Insurance Company to support that eligibility and participation is being met.

**Issue No. 4 – Guaranteed renewability**

The Company failed to guarantee *renewability* of small group plans unless certain tax forms were provided by the employer. The files contained letters used by the Company to require both tax forms *and* a completed business census.

Rather than *requesting* the group to provide tax forms, the Company *required* the forms. In a letter, in a file, the Company stated in part, “*Please be advised that if all of the information is not received by the requested date, your small group contract will be terminated.*” A follow-up letter stated in part, “If we have not received this information confirming your group’s eligibility by . . . your coverage will be discontinued effective with the premium paid-to-date or . . . whichever is earlier . . . . *Please be advised that if all of the information is not received by the requested date, your small group contract will be terminated.*”

Failure to provide tax forms is not a valid reason for terminating a small group health plan. To *require* certain tax forms would violate the guaranteed renewability requirements of R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. While tax forms are a valid form of documentation and may be requested, a completed business census or other valid documentation may also be used to provide the information necessary to confirm participation requirements.

**COMPANY RESPONSE:** The Company agrees. Please see our responses to Inquiry #'s 14, 33, and 57, pertinent parts of which are reproduced below:

As indicated by the examiner, the quarterly Wage & Tax statement is a valuable tool for verifying group and employee eligibility. However, with the elimination of the 6-month durational requirement, we will accept alternative means of establishing group and employee eligibility, consistent with Ohio and federal law. Employers unable to provide a quarterly Wage & Tax statement will be afforded the opportunity to submit alternative means of establishing eligibility.

In addition, please note that the requirement #6 from the Agent Checklist cited in the Inquiry was removed from the Employer Participation Agreement/Application (sic), Form HC-1872-OH, effective February, 2005. The form now contains the following statement:

John Alden Life Insurance Company may request that the Employer provide documentation (i.e. Wage and Tax From, Payroll Records, Business License, etc.) during the Underwriting process or at any time while coverage is provided by John Alden Life Insurance Company to support that eligibility and participation is being met.

**Issue No. 5 – Agent of the insurer**

All fifty files were failed for containing forms that required the applicant to sign a statement that the agent represented their interests, not those of the Company. The statements violate R.C. 3923.141 and 3905.20(A). Therefore, the language within the forms was untrue, deceptive and misleading in violation of R.C. 3901.21(B).

The employer applications HC-1001-3 (three files) and HC-1078-0 (all versions) (41 files), and employee enrollment forms HC-1002-3 (both versions) (46 files) and J4-1864 (five files), all required the applicant to sign the statement concerning agent representation. One file contained both the employee enrollment form HC-1002-3 and J4-1864.

Employer applications HC-1001-3 (both versions) and HC-1078-0 (all versions) stated in part:

“B. I understand the agent submitting this application *represents my interests*, not those of John Alden Life Insurance Company, . . . .”

Employee enrollment forms HC-1002-3 (both versions) and J4-1864 stated in part:

“. . . I understand that the agent submitting this enrollment form *represents my interests*, not those of John Alden Life Insurance Company.”

**COMPANY RESPONSE:** The Company agrees. As noted in our response to Inquiry #35, we will amend the any (sic) currently used enrollment forms to **clarify that the agent may represent the interests of both the insured and the insurer.**

**EXAMINER RESPONSE:** The Company’s proposed amendment does not comply with R.C. 3923.141 or 3905.20(A). Therefore, the proposed language would still be untrue, deceptive and misleading in violation of 3901.21(B). The statutes state that ***the agent represents the insurer*** and not the employer or insureds. Furthermore, the Company response only addressed the statement in the enrollment forms. It did not address the statement in the employer applications.

**Issue No. 6 – Employer contribution percentage requirements**

The Company failed to consistently enforce its requirement for 100% participation in groups with 100% non-contributory coverage. When coverage is 100% non-contributory, permitting one group to cover fewer than 100% of its employees while requiring another group to cover all employees is unfairly discriminatory, and thus contravenes R.C. 3901.21(M). Seven files were failed for this reason.

**COMPANY RESPONSE:** Two of the Company’s responses addressing two of the files stated respectively:

(1) “*It is our guideline that at 100% employer contribution level, that 100% of the full-time employee’s (sic) must enroll. It appears that the Underwriter inadvertently overlooked the 100% contribution and*

*allowed the employee to waive coverage. The employer should have been advised that the employee must enroll or the employer would have to select a contribution percentage less than 100%. We have reminded staff of the requirement and the importance of adhering to established guidelines.”*

- (2) *“Participation requirements for this case was 100% of all eligible employees, including employees with valid waivers. Please see the waivers included in the file for employees (names of two employees), both of which report coverage under a spouse’s plan.*

***This appears to be an audit error on the part of the underwriter. In such situations, employers are ordinarily informed that either the employees with valid waivers must enroll or the employer must modify his premium contribution level to less than 100%.”***

**EXAMINER RESPONSE:** Testing of the file addressed in the Company’s response for “(1),” indicated the group met the Company’s standard by modifying its premium contribution level to 99% from 100% to accommodate employee waivers. Therefore, the Company’s actions were unfairly discriminatory.

Testing of the file addressed in the Company’s response for “(2),” indicated the underwriter was aware that the group was 100% non-contributory. The underwriter classed the group as “high risk” on the group underwriting worksheet, noting on the form that the group was 100% non-contributory. An e-mail dated 12/19/02, from the underwriter stated in part, “I was going over the census & I think . . . should be life only. Which would cause the prem. amount to go down & the rating to go up. Help!” Therefore, the underwriter was aware that this high risk group was a non-contributory group, yet the employee who was the subject of the e-mails, and one other employee were allowed to waive coverage. Therefore, the Company’s actions were unfairly discriminatory.

**Issue No. 7 – Additional coverages**

The Company failed to sell small group health plans to small groups without the additional purchase of life insurance. Failure to sell small group health plans on a stand-alone basis was a violation of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1). An insurer is required to make its small group health plans available to all qualifying small employer groups. In addition, the use of this practice would result in the placing of adverse risks with another insurer in violation of R.C. 3901.21(V). Therefore, all 50 files were failed.

- (1) The Company issued only a combined group health/life insurance product. A review of the fifty (50) issued groups’ files revealed that all fifty were sold on this combined basis.

(2) The Company's practice of tying its life product to its small group health product avoids adverse risks by deterring an unhealthy small employer group from buying coverage due to the added cost of life insurance.

Testing of one file indicated that a group had been offered coverage without life insurance. When the error was discovered, the underwriter noted that the group must submit a new application with life insurance or withdraw its application.

In addition, the Company's Sales Brochure "Small Employer Group Insurance Plans," stated in part:

"Basic life insurance is automatically included in your plan in the amounts shown in the chart below: . . . ."

**COMPANY RESPONSE:** The Company's response stated, "As we noted in response to FIC Inquiry #'s 68 and 75, we disagree that these practices serve either to discourage the acceptance of adverse risks or to contravene Ohio and federal guaranteed issue requirements. Nonetheless, **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. 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 denial of life coverage to an individual within such a group would result directly or indirectly in the carrier avoiding adverse risk.

The Company would also submit that the added cost of life coverage does not deter the guaranteed issuance of health 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. Moreover, we disagree with the assertion that the overall premium cost for health and life to a group increases commensurately with the unhealthiness of the group. In fact, the addition of premium costs due to life coverage for a group with adverse risks would actually be lower than the added costs to a healthy group since the high risk individuals would be declined for the basic life coverage. Therefore, while 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:** In one file, an e-mail from a JALIC employee stated in part, “Hi guys, This group was quoted without life. Per (employee’s name), this group *must take life* as the agent is not a *Western Southern* agent. *Please obtain a new, signed quote that includes life coverage. . . .*” Another e-mail from a JALIC employee stated in part, “I have reviewed your request to waive the life on this product. OH is a mandatory life state unless the agent is a Western/Southern agency. Other than Western/Southern cases, all OH groups quoted should include the life benefit . . . . Please let me know if they are going to accept with the life or *withdraw . . . .*”

The Company’s response concerning the role of Western-Southern agents, stated, “***Although life was not optional in Ohio, Western-Southern (W/S) agents were permitted to waive our basic group life product, because W/S has a Group Life product that was very similar to ours. Therefore, since the product was specific to W/S agents and it was a W/S group life product, we agreed if the group took W/S life coverage they would have the option to waive the JALIC Life product because the two were very similar in nature and W/S agents in many cases were selling their own company’s Life product.***”

The Company’s response indicated that it was mandatory for Western-Southern agents to require the purchase of life insurance with all group plans. Therefore, all the plans sold by those agents, and all other agents violated the guaranteed issue requirements of R.C. 3924.03(E)(1), 3901.21(V), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1). The Company practices and procedures for mandating life and AD&D insurance also resulted in the placing of adverse risks with other insurers in violation of R.C. 3901.21(V).

**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 indicated that 1409 small group plans terminated during the period under examination. A sample of fifty files was selected by use of the Excel Random Number Generator. Upon review, it was determined that only part of one group (one location) terminated. The group plan continued in force for the remainder of the employees. Therefore, the sample was reduced to 49 for purposes of testing of the validity of terminations. However, the file was tested for timeliness of issuing CCCs.

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

# of Files	Failed HIPAA	Failed Ohio	HIPAA % Failed	OHIO % Failed
50	46	46	92%	92%

**Issue No. 1 – Certificate of creditable coverage**

The Company *failed to issue* a certificate of creditable coverage (CCC) to any member of 41 of the 50 small groups tested, when their group plan terminated. Therefore, the 41 files were failed, because failure to automatic issue CCCs is a violation of R.C. 3924.03(A)(3), Public Law 104-191, Part A – Group Market Reforms, Sec. 2701(e) and 45 CFR § 146.115(a).

Automatic issue CCCs were not issued at the time a group terminated, for 21 of the 24 months under examination. Without knowing how many employees and dependents were insured when each group terminated, it is not possible to determine how many individuals were affected by the failure to provide CCCs.

**COMPANY RESPONSE:** The Company’s response stated in part, “. . . **programming changes needed to automate the generation of CCC when an entire group terminated** (as opposed to terminations of individual employees) **was not implemented until April 13, 2004.**”

**Issue No. 2 – Certificate of creditable coverage**

The Company failed to issue CCCs timely for members whose coverage terminated *while the group plan was in force*. The time period for issuance of CCCs is 14 days after the employer notifies the Company of the employee’s termination. Failure to timely issue CCCs is a violation of R.C. 3924.03(A)(3), Public Law 104-191, Part A — Group Market Reforms, Sec. 2701(e) and 45 CFR § 146.115(a)(2).

The Company had stated that “*CCCs were generated during the entire exam period at the time of terminations of individual employees or upon request.*” Therefore, three of the 41 files without CCCs at plan termination were selected for testing of issuance of CCCs upon termination of *individual employees’* coverage.

All three files were failed because the Company failed to issue the CCCs timely, as follows:

- (1) One file reflected issuance of a CCC for one member 25 days after the Company’s receipt of notice of termination for the member’s coverage. For six other members, CCCs were not issued until 30 days after receipt of notice of the termination of coverage.

**COMPANY RESPONSE:** The Company responded in part:

“(1) *File No. 3 . . . .*

*(a) See attached termination request for m#13 which we received on 1/30/03.*

*(b) At this time CCCs were not being printed on a daily basis. They were 2-3 weeks behind the process date. As of April 13, 2004, CCCs were printed on a daily basis.”*

The one member’s CCC was issued on 2/26/03, 25 days after termination. None of the other six employees were issued CCCs timely.

(2) One file reflected issuance of a CCC 25 days after notice was received by the Company of the termination of coverage.

**COMPANY RESPONSE:** The Company’s response stated in part, “*File No. 19 . . . .*

*(a) See attached termination request for member #15 which we received on 6/20/2003”*

The CCC was not issued until 7/16/03, which was not timely.

(3) One file reflected issuance of CCCs for two employees. Both employees had CCCs issued 34 days after the employees’ termination date.

**COMPANY RESPONSE:** The Company’s response, stated in part, “. . . .

*(a) See attached termination request for members #4 and 21. Both were based on a call to Customer Service. The request to terminate m#4 was received on 12/8/03. The request to terminate m#27 (sic) was received on 12/30/03.”*

The CCCs for the two members were issued on 2/4/04, and coverage terminated on 1/1/04. Therefore, the CCCs were not issued timely.

**EXAMINER RESPONSE:** As noted in a response above, the Company maintains that the industry standard is 45 days. However, that standard applies only for non-pay, which allows an insurer the 31 day grace period, and then 14 days to issue the CCC. Non-pay was not an issue with these terminations. Therefore, the CCCs issued for all three files were failed.

**Issue No. 3 – Guaranteed renewability**

The Company failed to guarantee the renewability of a legitimate small group plan in violation of R.C. 3924.03(B)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, 45 CFR § 146.152(b) and HCFA Bulletin, Transmittal No. 99-03, dated September 1999. The file evidenced the termination of a group of two employees for failure to (1) respond to requests for tax forms; (2) meet participation requirements.

(1) On November 6, 2002, the Company wrote to the employer requesting a business census and a wage & tax form. On November 22, the employer faxed the Company a business census, showing two full-time employees, but did not enclose the required tax forms.

On December 26, the Company wrote to the employer, terminating the group for non-response to the request for tax forms. Neither state nor federal law provide for an employer to submit tax forms to prove the legitimacy of a business. A census showing the number of employees and the hours worked by each should be sufficient. *On January 10, 2003, the Company received the Employer's 4<sup>th</sup> Qtr. tax forms.*

(2) On January 21, 2003, the Company sent a letter to the employer, terminating the group for failure to meet participation standards, despite the fact that the Business Census, which had been received on November 22, 2002, listed two full-time employees. The group had three employees, one of whom was covered as the dependent of another, leaving only two of the three employees classified as "employees." One of the two "employees" changed to part-time status and thus that employee became ineligible for coverage, leaving one "employee" and one "dependent employee" in the group.

A group of two eligible employees is a qualified small group under R.C. 3924.01(N)(1) and is guaranteed renewability. The employee covered as a dependent should have been reclassified as an employee (her true status) and the plan should have been renewed on that basis. Furthermore, if the Company believed that this group was a group of one, it should have delayed termination until the first renewal date following the new plan year as required by R.C. 3924.03(B)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, 45 CFR § 146.152(b), and as clarified in HCFA Bulletin, Transmittal No. 99-03, dated September 1999.

In an e-mail from the Company, dated October 27, 2005, JALIC stated that it was not its practice to terminate groups that fell from two to one eligible employee. The e-mail stated, "I have checked ALL of the JALIC eligibility reviews during this time period and none of the terminated cases were due to the groups falling below two participants. As stated before, this is not the JALIC practice."

The group continued to meet the Company's participation requirements (two eligible employees) and should not have been terminated.

**COMPANY RESPONSE:** The Company agrees. We will ensure that all legitimate groups with two or more employees are guaranteed renewable.

**Issue No. 4 – Waiting periods**

The Company failed to ensure that the waiting period did not exceed 90 days. To allow for a waiting period of greater than 90 days is a violation of R.C. 3924.03(E)(2).

In one file, it was found that an employee's employment began on August 22, 2003. Coverage started on December 1, 2003, 100 days later.

**COMPANY RESPONSE:** The Company agrees. As noted in our responses to JALIC Inquiry #5 and JALIC Inquiry #18, we have since amended administrative procedures to ensure that an employee's effective date of coverage falls not later than the 90<sup>th</sup> day following eligibility for enrollment. We further noted that we will amend certificate forms issued in Ohio accordingly.

Current underwriting guidelines with respect to the assignment of effective dates read as follows:

For NC and OH groups with a 90 day waiting period, if the application is received on or before the 90<sup>th</sup> day of employment, we must assign effective dates on the 90<sup>th</sup> day. Effective dates for these two states with the 90 day waiting period will be any date. Additions for these states will have effective dates other than the 1<sup>st</sup> and 15<sup>th</sup>. The insured would be considered Timely.

Count out the exact number of days to determine the correct effective date.

Example: The application is date stamped on 3/25/05, and the 90 day waiting period ends on 4/16/05. The insured is considered Timely and their effective date would be 4/16/05.

The application is date stamped on 4/14/05, and the 90 day waiting period ends on 4/21/05. The insured is considered Timely and their effective date would be 4/21/05.

#### Late Additions

If the enrollment form is received after the 90 day waiting period then their effective date would be the next 1<sup>st</sup> or 15<sup>th</sup> of the month and the insured would be considered Late. The 30 day grace period would not apply. The insured would be considered Late.

Example: The application is date stamped on 6/25/05 and the 90 day waiting period ends on 4/16/05. The insured is considered Late and their effective date would be 7/1/05.

The application is date stamped on 7/15/05 and the 90 day waiting periods on (sic) 6/25/05. The insured is considered Late and their effective date would be 7/15/05.

Later Effective Dates (The insured is Timely or Late and requests a later effective date than they are eligible for):

If the insured does have other medical coverage in effect they may have the later effective date to avoid duplicative coverage.

If the insured does not have other medical coverage in effect they can only have what they are eligible for as described above.

**EXAMINER RESPONSE:** The Company's amendments to its certificates and procedures for "Late Additions" (late enrollees), would result in some timely enrolled employees being considered late. This would violate R.C. 3924.03, Public Law 104-191, Part A — Group Market Reforms, Sec. 2701 and 45 CFR § 146.111. An employee must enroll timely with "the plan" (the employer). The date the Company receives the employee enrollment form is irrelevant to determining if the employee is a late addition. If the Company receives the enrollment form late, but the employer states it received the enrollment form timely, then the employee is *not* a late enrollee. However, for the protection of the insurer, it may bill for the premium it would have received if the enrollment form had been provided timely by the employer (the plan).

**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 stated there were no small groups declined that applied for coverage during the period under examination.

**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.*

JALIC stated that it had not issued a conversion certificate in the State of Ohio. FIC indicated that it had not either. Therefore, during the FIC examination a request was made for the Company to supply 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 rules. The FIC testing, as it applies to JALIC is indicated below.

**Issue No. 1 – Determination of FEI eligibility**

The Company indicated that conversion eligible individuals were not evaluated to determine if they were FEIs. 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 files to make that determination. HCFA Insurance Reform Bulletin - 98-02 and HCFA Bulletin, Transmittal No. 99-02, dated June 1999, both indicate that every applicant in the individual market must be determined by the issuer as meeting, or not meeting, the

definition of an eligible individual. 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.*” Therefore, the conversion plans were offered in violation of R.C. 3923.122(B), which indicates that a conversion policy will be issued upon receipt of a written application and upon payment of at least the first quarterly premium. Therefore, the Company must allow a minimum of a quarterly payment.

The certificate forms 390 and 397 and policy forms 208 and 209 were offered with monthly or quarterly modes for payment of premium.

In addition, the annual mode of payment also appears to be a violation of R.C. 3901.21(M), which provides in part, “Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in . . . practices or eligibility requirements, or in any of the terms or conditions of such contract, or in any other manner whatever.”

The Company has to accept all conversion eligible individuals. Therefore, the Company practice also appears to be a violation of R.C. 3901.21(V), because many conversion eligible individuals would not be able to afford a one time annual premium payment. Thus, the Company may be averting an adverse risk. The quotes for the J-1110 ranged from \$12,000 to \$25,000 annually.

Certificate forms 390 and 397 have optional maternity coverage. Policy form 209 (Ohio Standard Plan) has maternity coverage with no preexisting conditions limitation. Maternity coverage is not offered in policy form 208 (Ohio Basic Plan). The JALIC conversion form J-1110, did not allow maternity coverage if the group plan (insured’s prior group coverage) did not have maternity coverage. If the insured’s group plan had maternity coverage, JALIC Plan J-1110 only allowed maternity coverage for individuals who were already pregnant on the inception date of the conversion policy. R.C. 3923.122 (A) (1), requires an offer to individuals who are not FEIs, of “any of the individual policies . . . then being issued by the insurer with benefit limits not to exceed those in effect under the group policy,” which includes optional benefits (maternity coverage). R.C. 3923.122(A)(2), provides in part for FEIs, “a basic or standard plan . . . or plan substantially similar to the basic and standard plan in benefit design and scope of covered services.”

The Company is required to offer “any” (all) of its then issued individual plans, and offer each of the plans as offered in the open market (as marketed). Therefore, it should have offered certificate forms 390 and 397 to all non-federally eligible individuals with optional maternity coverage. In addition, the Company cannot restrict the maternity benefit to conversion eligible individuals who are currently pregnant. If the maternity

benefit is chosen by the conversion applicant, then the maternity coverage has to be the same coverage that is issued in the open market, and it must be an ongoing benefit. The Company practice to only offer maternity coverage if the applicant is pregnant is a violation of R.C. 3901.21(V), because it attempts to avoid future maternity claims.

**COMPANY RESPONSE:** The Company's response to the violations indicated above for its conversion plan and procedures stated in part, *"The Company believes that, except where noted, its practices and products meet the requirements of applicable statutes but is willing to make additional changes per the Department's recommendations as noted below. In addition, where deficiencies are identified, the Company is already undertaking corrective action. We welcome the opportunity to discuss this further with you and representatives of the Department of Insurance . . . The Company acknowledges the requirements of Section 3923.122(1) and agrees that all the conversion applicants were conversion eligible. The Company also believes its offering of the J-1110 meets the statute's requirements for the following reasons. As you noted, Section 3923.122(1) requires that a carrier offer its regular commercial plans to conversion eligible individuals. Section 3923.122(2) establishes a higher standard and requires a carrier to offer the Basic and Standard plans or their substantial equivalent, for federally eligible individuals. **The Company believes that the J-1110 qualifies as substantially equivalent to the Basic and Standard plans, and offers this higher standard 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. In addition to the above, several of the FIC forms identified, Forms 225, 227, . . . are not appropriate for conversion offerings as indicated below:*

*FIC form 225 is an association group product sold only to members of the association. It would be inappropriate to require conversion applicants to join an association and pay association dues to obtain conversion coverage. Form 227 is equivalent to FIC form 225 and was issued to a discretionary trust . . . . FIC forms 185 and 186 are the FIC Ohio Basic and Standard plans.*

***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). Therefore, determination of prior creditable coverage would be moot, as all received the same benefit as if creditable coverage were confirmed."*

The Company also stated in part, *"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 converttees.*

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

**EXAMINER RESPONSE:** The Company’s response and its procedures are not in compliance with the mandates of R.C. 3923.122. Conversion certificate J-1110, 1) did not allow maternity coverage if the group plan did not have maternity coverage, 2) only allowed maternity coverage for a current pregnancy if the group plan had maternity coverage, 3) restricted the providers of mental health, alcoholism, chemical dependency and drug addiction, to those providers licensed in the State of Ohio, 4) failed to provide coverage for all medical emergency services until stabilization, 5) defines dependent children in a manner that violates Ohio statutes, 6) does not provide the mandated benefits of Ohio Bulletin 2001-1 and WHCRA, 7) allows for termination for a misrepresentation (there must be an intentional misrepresentation of material fact), and 8) allowed for non-renewal if the insured was eligible for Medicare or other coverage, or failed to respond to a request for information. Therefore, certificate J-1110, was not substantially similar in benefits when compared to the Ohio Standard and Basic plans.

The Department has indicated that all insurers should offer the Ohio Standard and Basic plans to all conversion eligible individuals, or a substantially similar plan.

During the examination, the Company indicated that certificate forms 390 and 397 are offered with identical benefits, and Certificate 390 is offered through an association (joining the association and association dues are mandatory), while Certificate 397 is offered through a trust (no association dues). Therefore, if the Company agreed to offer certificate form 397 to all non-FEI conversion eligible individuals, with the Department’s approval the Company may be allowed to not have to offer certificate form 390 for conversion.

**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.*

The Company 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.” 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.*

The Company 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.” Therefore, there was no testing of declined conversion applications.

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

The Company indicated it would agree that all of the individual market operations for FIC were identical to the operations for JALIC, except JALIC did not offer the student select plan. Therefore, the testing of individual issued plans for FIC was duplicated into this Phase of the JALIC examination, except where the violation was in reference to the student select plan.

JALIC provided a listing of 8,677 individual policies/certificates issued during the period under examination. The listing did not include short-term certificates issued because the Department determined that the short-term certificates would not be tested with the issued files.

The Excel Random Number Generator was used to obtain a sample of 50 individual policies/certificates issued for testing. The results of testing are provided in the table below:

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

**Issue No. 1 – Determination of FEI eligibility**

The application, and the Company’s underwriting practices and procedures did not provide JALIC with the ability to determine which applicants were FEIs. In addition, even when the insured had provided adequate information at application (was an FEI), the Company did not offer the Ohio Standard and Basic plans. Therefore, all the files were failed because the Company did not determine the federal eligibility status of the applicants. The Company’s practices and procedures were a violation of R.C. 3923.581.

For 15 files tested, the applicants indicated their last coverage was under an individual policy/certificate, which would indicate the applicants were not FEIs. However, 35 files were also failed for failure to offer the Ohio Standard and Basic plans for those individuals who may have been FEIs.

Therefore, the Company was asked:

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

The Company's responses to the six questions stated:

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

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

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

The Company indicated it would agree that all of the individual market operations for FIC were identical to the operations for JALIC, except JALIC does not offer the student select plan. Therefore, the testing of individual terminated plans for FIC was duplicated into this Phase of the JALIC examination, except where the violation was in reference to the student select plan.

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

# of Files	Failed HIPAA	Failed Ohio	% Failed
50	4	4	8%

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

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

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

**EXAMINER RESPONSE:** Therefore, the Company was in violation of R.C. 3923.57(F), which indicates that certificates/policies are subject to section 2743 of the “Health Insurance Portability and Accountability Act of 1996,” Pub. L. No. 104-191, 110 Stat. 1955, 42 U.S.C.A. 300gg-21, as amended, and 45 CFR § 148.124.

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

The Company indicated it would agree that all of the individual market operations for FIC were identical to the operations for JALIC, except JALIC does not offer the student select plan. Therefore, the testing of individual declined plans for FIC was duplicated into this Phase of the JALIC examination, except where the violation was in reference to the student select plan.

JALIC provided a listing of 1,275 individual policies/certificates declined during the period under examination. The Excel Random Number Generator was used to obtain a sample of 50 individual policies/certificates declined for testing.

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

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

**Issue No. 1 – Determination of FEI eligibility**

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

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

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

**EXAMINER RESPONSE:** All the files failed because the underwriting method used by the Company for the period under examination, was not in compliance with R.C. 3923.581. None of the files contained a determination of federal eligibility until the applicant was declined coverage and requested a HIPAA plan. The only applicants that received an Ohio Standard or Basic plan were those that requested a HIPAA plan. The Company must determine who is eligible during the underwriting process, because if eligible for a Company plan and the Standard and Basic plans, they are to be offered both at the same time, so the applicant can best decide which plan meets his/her needs.

**Issue No. 2 – Declination letters**

Prior to the review of declinations, testing of complaints and grievances indicated the Company only provided medical information about adverse underwriting to the doctor if a declined applicant requested the reason for the declination. However, during testing of declinations, 12 of 50 files had letters indicating the applicant was provided with a declination letter that indicated the specific reason(s) for the declination. Testing indicated the other 38 files failed. Twenty of the failed files did not have a declination letter; two files had letters indicating the applicant would have to contact his doctor; and 16 files had letters indicating the applicant was declined because of Lab Results, “Confidential Medical Information,” “Confidential Information,” or “Medical Records.” Failure to provide a letter, or, to provide a letter without the specific adverse underwriting reason is a violation of R.C. 3904.10.

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

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

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

The Company provided a listing of 23 rescinded files for the period under examination. The entire population of 23 files was tested and the results of testing are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	Failed Notice	HIPAA % Failed	Ohio % Failed	Notice % Failed
23	0	4	0	0%	17%	0%

**Issue No. 1 – Rescission of coverage**

For four rescissions files, the Company failed to provide the medical records that were used for rescinding coverage.

**COMPANY RESPONSE:** The Company’s response stated, “Each of these files resulted from investigations commenced or concluded during the first half of 2003. As noted during the Fortis Insurance Company examination, we were transitioning from microfilm to electronic imaging for document storage during this period. The electronic imaging processes for underwriting records were completed in August, 2003 and all documentation is currently maintained in an accessible format. **We are unable to locate the medical records reviewed for these files, as reflected on the underwriting Referral forms included in the files.**”

**EXAMINER RESPONSE:** The files were failed because the Company could not produce documentation that served as the basis for the Company’s action. The Company is not in compliance with Ohio Adm.Code 3901-1-60(G).

**Issue No. 2 – Rescission of coverage**

For one of the files indicated above (medical records not available), the Company’s underwriting records indicated that the spouse had hyperlipidemia (not confirmed by medical records as indicated above). However, the letter to the insureds stated that the certificate was being amended for the hyperlipidemia (premium increase), and was also being amended by *adding tobacco user rates due to history of tobacco use*.

However, the Preferred Rating Questionnaire stated:

1. Has the applicant/enrollee(s) used tobacco products at any time in the past 3 years? . . . .  
“Yes”
2. Does the applicant/enrollee smoke 10 or more cigarettes a day? “Yes”

The Company is not allowed to re-underwrite a certificate and make a change effective back to the effective date of the certificate when the change is based on information provided at the time of application. The reduction of the preferred rating due to the hyperlipidemia was appropriate, because it was not disclosed on the application. However, for compliance with R.C. 3923.57(C), 45 CFR 148.122 and Public Law, 104-191, Part B – Individual Market Rules, Sec. 2742, the Company was not allowed to change the tobacco rating, because the applicant disclosed that information on the application. Therefore, the Company’s actions were a violation of the statutes and regulation noted above. For the same reason, reformation of the contract would have

been a violation of R.C. 3901.21(M), which provides in part, “Making or permitting any unfair discrimination between individual of the same class and of essentially the same hazard in the amount of premium . . . or in underwriting standards and practices or eligibility requirements . . . .”

**COMPANY RESPONSE:** The Company’s response stated, “Review of the medical records, as reflected on the Underwriting Referral form, resulted in reformation of the contract to reflect a 25% rating, which was applicable due to the non-disclosed history of hyperlipidemia, treated with Provochol. Because preferred rates are not available when coverage is issued with a substandard rating, the reformation included removal of the preferred rates. However, coverage was also issued with non-tobacco user rates. **Because the applicant disclosed tobacco use on the application, the reformation should not have included application of smoker rates.**”

**EXAMINER RESPONSE:** Therefore, the file was failed.

### CLAIMS PAID AND DENIED

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

**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 was requested to provide a listing of all claims paid and denied from selected Current Procedural Terminology (CPT) codes. The Company provided listings from two different claims systems. One system listed 224 paid and denied claims, and the other provided a listing of 56 paid and denied claims.

After a thorough review of the claims on the listing, a sample of 31 paid mastectomy claims was selected to determine if the breast reconstruction claim denial was in compliance with WHCRA and Ohio Bulletin 2001-1.

The results of the testing indicated that 2 files passed and 29 did not have a claim associated with the benefits of WHCRA. Therefore, none were failed as shown in the table below:

# of Files	Failed	Failed	WHCRA	Ohio
	WHCRA	Ohio	% Failed	% Failed
31	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 listings from two different claims systems. One system listed 224 paid and denied claims, and the other provided a listing of 56 paid and denied claims. There were 29 denied breast reconstruction claims from one system and none from the other.

A sample of 15 denied breast reconstruction files was selected for testing to determine if there was a breast reconstruction claim denied after a mastectomy in violation of WHCRA and Ohio Bulletin 2001-1. During testing it was determined that two of the 15 were duplicates. Therefore, a total of 13 files were tested.

Testing indicated the 13 files passed, and the results of testing are shown in the table below:

# of Files	Failed	Failed	WHCRA	Ohio
	WHCRA	Ohio	% Failed	% Failed
13	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 provided a listing of eight pre-certification breast reconstruction denials during the exam period. The eight denied pre-authorization files were sampled for testing to determine if the denials were in compliance with WHCRA and Ohio Bulletin 2001-1.

During testing it was determined that one of the files was for the same certificate holder with duplicate procedures. Therefore, that file was excluded as a duplicate.

The results of testing indicated none of the seven files were for an insured with a history of a mastectomy. Therefore, none of the insureds requested a benefit related to WHCRA (N/A). The results of testing are indicated in the table below.

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

## SUMMARY OF RECOMMENDATIONS

1. The Company should avoid contradictions between its individual guide (marketing materials) and underwriting guidelines for cesarean section deliveries. The contradiction made the marketing materials misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company stated, “In an effort to amicably resolve this matter, **we will be taking the necessary corrective action to address this issue.**” *See Marketing and Sales Standard #1.*
2. The individual guide is misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2), in that it instructs an insured to request adverse underwriting information, and if the information is confidential, the adverse underwriting decision will only be sent to a medical practitioner of the insured’s choosing. **The Company agreed to change its procedures and provide adverse underwriting notices in compliance with R.C. 3904.10(A).** *See Marketing and Sales Standard #1.*
3. The individual guide lists 19 occupations that are ineligible for coverage without indicating that there must be an exception for a federally eligible individual (FEI). Therefore, the marketing material was misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should not provide misleading information in its marketing materials. *See Marketing and Sales Standard #1.*
4. The Company’s commission schedules for its Ohio Basic or Standard plans provided a first year commission of 2 percent for agents, and renewal commissions of 2 percent for every year thereafter. R.C. 3923.58 indicates that commissions are mandated for five percent at initial placement, and four percent at renewal. Therefore, the schedules were misleading in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should discontinue the practice, and should reimburse the agents that were not paid the proper amounts during the period under examination. The Company responded twice, it first stated in part, “**Agree. We will be taking the necessary corrective action to address this issue . . .**”, and later, “Disagree . . . . Section 3923.58 requires commission rates of 5% for initial placement and 4% for renewal of Basic and Standard Plans. Therefore, **we believe that the Commission schedule set forth in Section 3923.58(K) is reasonable and have taken the necessary corrective action to address this issue . . .**” *See Marketing and Sales Standard #1.*
5. Two small group brochures discriminate among small groups in violation of R.C. 3901.21(M). The brochures indicated: (1) that for some small groups maternity is optional and mandatory for others, (2) that mental health benefits are automatic for some groups, (3) and that prescription drug options are not available for all groups. All three would be a violation of federal and state guaranteed availability requirements. Therefore, the brochures were misleading and untrue in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company stated in part, “. . . **the Company respects Ohio’s position on this matter, and we have changed practice regarding maternity benefits to offer optional maternity benefits to all small groups regardless of the**

**number of employees in the group. Moreover, we have changed our mental health/substance abuse and prescription drug options to be available to all small groups regardless of size.” See Marketing & Sales Standard #1.**

6. The Agent’s Guide (Guide) and a Brochure discriminated among small groups when offering its maternity benefits, which would be a violation of guaranteed availability requirements. Therefore, the Guide was provided in violation of R.C. 3901.21(B), and the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). **The Company agreed to change its practices and allow an optional maternity benefit for all small groups.** See Marketing & Sales Standard #1.

7. The Guide and a Brochure discriminated among small groups when offering its dental benefits, which would be a violation of federal and state guaranteed availability requirements. Therefore, the Guide was provided in violation of R.C. 3901.21(B), and the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). **The Company agreed to change how it offers dental benefits to small groups.** See Marketing & Sales Standard #1.

8. The Guide and a Brochure mandated group life and AD&D coverage for all small groups, which would be a violation of federal and state guaranteed availability requirements. Therefore, the Guide was provided in violation of R.C. 3901.21(B), and the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). **The Company has agreed to discontinue the required life and AD&D coverage.** See Marketing & Sales Standard #1.

9. The Brochure stated a small group could select a 30, 60 or 90 days waiting period. R.C. 3924.03 indicates that waiting periods are at the discretion of the employer, and the employer can select from a zero through a 90 days waiting period. Therefore, the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). The Company should allow an employer to choose a zero through 90 days waiting period in compliance with R.C. 3924.03. See Marketing & Sales Standard #1.

10. The Brochure stated “future employees” must furnish satisfactory evidence of insurability. Employees cannot be excluded from coverage based on health status. Therefore, the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). **The Company agreed to amend the materials to eliminate “evidence of insurability.”** See Marketing & Sales Standard #1.

11. The Brochure stated that employees must be actively at work to be eligible employees. Employees cannot be excluded from coverage based on health status. Therefore, the Brochure was provided in violation of R.C. 3923.16 and Ohio Adm.Code 3901-1-16(E)(2). **The Company agreed to amend the language, but did not indicate it would amend the Brochure.** See Marketing & Sales Standard #1.

12. The Brochure stated the Company could terminate coverage for a misrepresentation. The guaranteed renewability requirements of federal and state statutes indicates there

must have been an intentional misrepresentation of 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 stated in part, “It is not our practice to terminate all businesses which temporarily suspend business activity; 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.**” Whether the business is viable or not also is not a valid reason for the Company to terminate employer group coverage. *See Marketing and Sales Standard #1.*

13. The Guide stated that an employer “must” provide a quarterly state wage and tax statement with its application, which would be a violation of guaranteed availability requirements. Such a document cannot be mandated. Therefore, the Guide provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B). **The Company agreed to the violation and indicated it was correcting its procedures and forms to “request” a quarterly wage and tax statement, instead of requiring the statement.** *See Marketing & Sales Standard #1.*

14. The Guide stated that an employer “must” be in business for a minimum of six months to be eligible for small employer coverage, which would be a violation of federal and state guaranteed availability requirements. Therefore, the Guide provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B). **The Company agreed with the violation and indicated that it no longer requires a business to be in existence for a period of six months.** *See Marketing & Sales Standard #1.*

15. The Guide stated that an employee, to be eligible for coverage, “must” work at least 48 weeks per year, and that an employee cannot reside outside the U.S., which would be a violation of federal and state guaranteed availability requirements for the coverage of employees. Therefore, the Guide provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B). **The Company agreed to eliminate this eligibility requirement.** *See Marketing & Sales Standard #1.*

16. The Guide stated that an employee had to wait until the next available 1<sup>st</sup> or 15<sup>th</sup> day of a month for their effective date of coverage, after any applicable waiting period. To extend the waiting period past the days elected by the employer is a violation of R.C. 3924.03(E)(2). Therefore, the Guide provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B). **The Company agreed to amend its procedures to ensure that new enrollees and dependents effective dates do not exceed the employer’s waiting period.** *See Marketing & Sales Standard #1.*

17. The Guide stated that an employer could not have union employees to be an eligible group. This would be a violation of federal and state guaranteed availability requirements. Therefore, the Guide provided misleading, untrue and deceptive information in violation of R.C. 3901.21(B). The Company’s response stated, **“Agree: We will amend procedures and marketing materials to remove eligibility restrictions with respect to union membership.”** *See Marketing & Sales Standard #1.*

18. The JALIC State Provisions Supplement for Ohio (State Supplement) stated that mental illnesses and chemical dependency services must be provided by a State of Ohio licensed provider. This would not be in compliance with R.C. 3923.28. Therefore, the State Supplement provided untrue, misleading and deceptive language in violation of R.C. 3901.21(B). The Company stated in part, **“We will, however, amend language in both forms to delete references to licensure in a particular state.”** *See Marketing & Sales Standard #1.*

19. The JALIC State Supplement provided a definition of pre-existing conditions, which would be a violation of R.C. 3924.01(L) and federal statutes. Therefore, the State Supplement provided untrue, misleading and deceptive information in violation of R.C. 3901.21(B). **The Company agreed to amend the pre-existing conditions definition.** *See Marketing & Sales Standard #1.*

20. The Company failed to provide small employers with the four mandated disclosures of information at the time of solicitation as required of R.C. 3924.033 and federal law. **The Company agreed it had not provided all the materials necessary for compliance with R.C. 3924.033, and agreed to provide the required marketing materials going forward.** *See Marketing & Sales Standard #1.*

21. The Company provided one Department complaint file incomplete. Therefore, the Company was in violation of Ohio Adm.Code 3901-1-60(H(3)). **The Company orally agreed that it should maintain complete complaint files.** *See Complaints and Grievances Standard #1.*

22. The Company’s certificate and its procedures provide for permanent pre-existing condition(s) exclusions in violation of R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701 and 45 CFR § 146.111. An employee was denied coverage because of the illegal provision. **The Company agreed it was a violation, and agreed to amend the limitation on reconstructive surgery for those conditions resulting solely from injuries which occurred while covered under the insured’s current certificate.** The Company should be required to allow coverage for such injuries, and pay the claims for this insured. *See Complaints and Grievances Standard #1.*

23. The Company indicated to an insured that an eligible employee must receive minimum wage, and insisted that the employer provide information to determine if the business was viable. The Company defined an eligible employee in violation of R.C. 3924.01. An eligible employee must work 25 or more hours per week, whether paid or not, is not applicable to determining the eligibility status of an employee. In addition, whether the group is viable has nothing to do with the guaranteed availability requirements at R.C. 3924.03, P.L. 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. Therefore, the Company’s practices for determining viability of a small employer group business should be discontinued. *See Complaints and Grievances Standard #1.*

24. The Company's method of applying an employer's waiting period was a violation of R.C. 3924.01(M) and R.C. 3924.03(E)(2). An employee insured by JALIC could only receive an effective date of the 1<sup>st</sup> or 15<sup>th</sup> day of the month after the waiting period. This employee received an effective date greater than 90 days because of the only allowable effective dates. In addition, most of the employees added to group coverage by JALIC would have received an effective date of coverage greater than the waiting period chosen by the employer in violation of R.C. 3924.03(E)(2). **The Company agreed, and stated it will amend its procedures to ensure than an employee's effective date of coverage is not greater than 90 days.** The Company's response did not address the employer's that chose a 30 or 60 days waiting period. The Company should ensure that all employees not have coverage extended past the waiting period chosen by the employer. *See Complaints and Grievances Standard #1.*

25. The Company only allows an employer's effective date to begin on the 1<sup>st</sup> or 15<sup>th</sup> of a month after the employer requests coverage. To limit coverage to the 1<sup>st</sup> and 15<sup>th</sup> is a violation of guaranteed availability requirements found at R.C. 3924.03(E), P.L. 104-191, Part A – Group Market Reforms, Sec. 2711 and 45 CFR § 146.150. The Company should allow an employer to elect the effective date of its choice. *See Complaints and Grievances Standard #1.*

26. The Company failed to assist the insured in retrieving information concerning creditable coverage in violation of 45 CFR § 146.115(c). **The Company agreed that it failed to assist the insured.** The Company pended claims for the same insured in violation of 45 CFR § 146.115, P.L. 104-191, Part A – Group Market Reforms, Sec. 2701(e) and R.C. 3924.03. If the insured is cooperating with the Company during a pre-existing conditions applicability period then an insurer is not to pend or deny claims as pre-existing. Therefore, for this insured, the Company failed to pay the insured's claims timely in violation of R.C. 3901.381 and R.C. 3901.385, and failed to pay interest for the untimely paid claims in violation of R.C. 3901.389, and initially denied the claims in violation of Ohio Adm.Code 3901-1-07(C). The Company should pay claims timely and not "pend" potential pre-existing conditions claims during a lengthy investigation, when the insured is cooperating. *See Complaints and Grievances Standard #1.*

27. The employee was provided with a waiting period of greater than 90 days in violation of R.C. 3924.03(E)(2). The Company failed to assist the insured in retrieving information concerning creditable coverage in violation of 45 CFR § 146.115(c). The employee was determined to be a "late enrollee" in violation of 45 CFR § 146.111, P.L. 104-191, Part A – Group Market Reforms, Sec. 2701(e) and R.C. 3924.03. The insured's claims were denied as pre-existing as determined by the Company in violation of the above stated laws. Therefore, the Company failed to pay the insured's claims timely in violation of R.C. 3901.381 and R.C. 3901.385, and failed to pay interest for the untimely paid claims in violation of R.C. 3901.389, and initially denied the claims in violation of Ohio Adm.Code 3901-1-07(C). **The Company has agreed to no longer allow waiting periods of greater than 90 days.** However, the Company did not indicate it would not extend the waiting period past the period selected for all small employers. **The**

**Company should define a late enrollee in compliance with the statutes and regulation noted above, and should pay all claims for insureds that have been incorrectly defined as late enrollees.** *See Complaints and Grievances Standard #1.*

28. The Company failed to provide one of the grievance files in violation of Ohio Adm.Code 3901-1-60(H)(3). **The Company agreed that it should maintain all grievance files in their entirety.** *See Complaints and Grievances Standard #3.*

29. The Company failed to file its certificates and riders with the Department in violation of R.C. 3923.02. The Company response about the failure to file certificates stated, **“We regret the oversight.”** The response about the failure to file the riders for the certificates stated in part, **“. . . the riders . . . were not filed with the Ohio Department of Insurance.”** The Company should file all certificates and riders prior to use. *See Contract/Policy Language Standard #1.*

30. The Company’s current marketed certificates and the Ohio Basic and Standard plans allow for carve out of Medicare benefits in violation of HIPAA. The Company first disagreed, and later stated in part, **“. . . we will only coordinate benefits with Medicare to the extent that Medicare pays.”** *See Contract/Policy Language Standard #1.*

31. The Company’s maternity rider does not allow for postpartum care in compliance with R.C. 3923.63. Therefore, the rider language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to modify the rider language.** *See Contract/Policy Language Standard #1.*

32. The Company’s maternity rider allows for a 270 days look forward provision and a 270 days waiting period. For compliance with R.C. 3901.21(O), the Company is only allowed to assess a 270 days delivery waiting period. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company should discontinue this practice and pay for all the maternity claims denied due to this provision, for the period under examination and to-date after that period. *See Contract/Policy Language Standard #1.*

33. Certificates 390 and 397 do not provide the mandated benefits of WHCRA, which would be a violation of WHCRA and Ohio Bulletin 2001-1. The certificates have language which restricts prostheses after a mastectomy, and restricts breast reconstruction to the initial reconstructive surgery. Neither provision is allowed. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). A certificate should provide the actual benefits of the certificate. Administrative compliance may still harm certificate holders that read the certificate. In addition, the Company continues to refuse to add the mandated language, “coverage provided in consultation with the attending physician and the patient.” The Company should provide contract language indicating it provides the mandated benefits of WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

34. The Company's individual market certificates and policies limit coverage for breast prostheses in a manner less favorable than required by WHCRA and Ohio Bulletin 2001-1. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company should provide contract language in compliance with WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

35. Certificates 390 and 397 do not allow the mandated 31 days for adding newborns in compliance with R.C. 3923.26. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company's certificates should provide benefits in compliance with R.C. 3923.26. *See Contract/Policy Language Standard #1.*

36. The Company's procedures did not allow it to determine who is a federally eligible individual (FEI) at the time of application, which was a violation of R.C. 3923.581. **The Company agreed to change its underwriting practices by determining an applicant's federal eligibility.** However, the suggested new underwriting method would still not be in compliance with R.C. 3923.581, because the Company did not indicate it would determine eligibility at the time of application. *See Contract/Policy Language Standard #1.*

37. The conversion J-1110 certificate failed to provide the mandated benefits for child health services in compliance with R.C. 3923.55. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company stated, **"Agree: The Company will take the appropriate steps to ensure compliance with R.C. 3923.55."** *See Contract/Policy Language Standard #1.*

38. The J-1110 certificate failed to provide maternity coverage in compliance with R.C. 3923.122 (because it did not offer its other plans 390 and 397). In addition, the Company failed to offer the Ohio Basic and Standard plans to conversion eligible individuals, which is also a violation of R.C. 3923.122. The Company should offer its Ohio Basic and Standard plans to all conversion eligible individuals, or provide a substantially similar plan. *See Contract/Policy Language Standard #1.*

39. The Company failed to determine federally eligible for conversion eligible individuals at the time of application, in violation of R.C. 3923.581. However, **the Company has agreed to offer the Ohio Basic and Standard plans to eligible individuals in the future.** *See Contract/Policy Language Standard #1.*

40. A J-1110 rider only allowed services for mental health and alcoholism/drug addiction if the provider was licensed in Ohio. This provision would not be in compliance with R.C. 3923.28 and R.C. 3923.38. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company stated in part, **"We will take the necessary steps to ensure that conversion coverage offered and issued in Ohio provides the coverage required . . ."** *See Contract/Policy Language Standard #1.*

41. The J-1110 certificate failed to provide for renewal if the insured was 1) eligible for Medicare, 2) covered under a similar plan, and 3) failure to respond to a request. To

terminate coverage for these reasons would be a violation of R.C. 3923.57, Public Law 104-191, Part B-Individual Market Rules, Sec. 2742(b) and 45 CFR § 148.122. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend (eliminate) the three provisions.** *See Contract/Policy Language Standard #1.*

42. The J-1110 certificate failed to provide coverage for injuries that were not repaired within 12 months. This provision is unfairly discriminatory in violation of R.C. 3901.21(M). Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate exclusions that limit coverage to treatment of injuries sustained while covered under the plan, or within 12 months following the injury.** *See Contract/Policy Language Standard #1.*

43. The J-1110 certificate failed to provide the mandated benefits of WHCRA and Ohio Bulletin 2001-1. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to provide coverage for reconstructive surgery following a mastectomy.** *See Contract/Policy Language Standard #1.*

44. The J-1110 certificate provided for nonrenewal if the insured made a misrepresentation when applying for renewal. An insured never applies for renewal in the individual market. In addition, to nonrenew for a misrepresentation without proof it was material and intentional would be a violation of R.C. 3923.57, Public Law 104-191, Part B-Individual Market Rules, Sec. 2742(b) and 45 CFR § 148.122. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to include the phrase “of a material fact.”** However, this amendment did not include the mandatory “intentional” misrepresentation provision. *See Contract/Policy Language Standard #1.*

45. Rider R(OH) 12/97, for certificate J-1080, failed to provide coverage for compliance with R.C. 3923.55 for hearing screening associated with child health supervision services. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company’s contract language should accurately define all mandated benefits. *See Contract/Policy Language Standard #1.*

46. The J-1080 certificate failed to provide the mandated benefits of WHCRA and Ohio Bulletin 2001-1. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company’s certificate should provide all the mandated benefits of WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1.*

47. Certificates J-1080 and J-1110 failed to provide WHCRA enrollment and annual notices in compliance with language mandated at the CMS website. Therefore, the notices are provided in violation of WHCRA and Ohio Bulletin 2001-1. The language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company’s

WHCRA notices should comply with the CMS mandated language on the CMS website. *See Contract/Policy Language Standard #1.*

48. Certificates J-1080 and J-1110 failed to provide the Company's complaint procedures in violation of Ohio Adm.Code 3901-1-60(H)(1). Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed that the certificates did not contain the required complaint procedures.** *See Contract/Policy Language Standard #1.*

49. The Company failed to file its employer applications and employee enrollment forms in violation of R.C. 3923.02. **The Company agreed that it had not filed the applications or enrollment forms.** *See Contract/Policy Language Standard #1.*

50. The employer applications and group certificate J-4000 allowed for unfair discrimination on the basis of travel in violation of R.C. 3901.21(M). In addition, a question about travel in the application was misleading and deceptive in violation of R.C. 3901.21(B). The Company should not discriminate among employees of small groups. *See Contract/Policy Language Standard #1.*

51. The Company's employer applications and enrollment forms indicated that an agent represents the insured's interest and not the Company's. The statement was not in compliance with R.C. 3923.141. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed, but stated that it will amend the forms to clarify that the agent may represent the interests of both the insured and the insurer.** The Company's suggested amendment would not comply with R.C. 3923.141. An agent represents an insurer. *See Contract/Policy Language Standard #1.*

52. The employer applications allowed for rescission of coverage, which would not be in compliance with R.C. 3923.14. Therefore, the applications were misleading and deceptive in violation of R.C. 3901.21(B). The Company should not provide provisions for rescinding coverage, which are not in compliance with R.C. 3923.14. *See Contract/Policy Language Standard #1.*

53. The employee enrollment form allowed for rescission of coverage, which would not be in compliance with R.C. 3923.14. Therefore, the enrollment form was misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed that it could not rescind or void coverage based solely on incorrect or incomplete information.** *See Contract/Policy Language Standard #1.*

54. The employer applications indicated an employer *must* provide certain forms to gain coverage. Such a provision would violate the guaranteed small group provisions of R.C. 3924.03(E)(1), Public Law 104-191, Part A-Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1). Therefore, the applications were untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed not to require tax forms as part of the application process.** *See Contract/Policy Language Standard #1.*

55. The employer applications mandated an employer business check must be provided to gain coverage. Such a provision would violate the guaranteed small group provisions of R.C. 3924.03(E)(1), Public Law 104-191, Part A-Group Market Reforms, Sec. 2711(a)(1)(A) and 45 CFR § 146.150(a)(1). Therefore, the applications were untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company should not indicate that only a business check will be accepted for payment of the initial premium. A cashier's check, bank draft and other forms of payment must be accepted by an insurer. *See Contract/Policy Language Standard #1.*

56. The employer applications and employee enrollment forms condition eligibility based on health status, which would not be in compliance with R.C. 3901.21(T)(1), R.C. 3924.03(C), Public Law 104-191, Part A-Group Market Reforms, Sec. 2702 and 45 CFR § 146.121. Therefore, the forms were untrue, misleading and deceptive in violation of R.C. 3901.21(B), and unfairly discriminatory in violation of R.C. 39021.21(M). **The Company agreed to revise any forms in use by removing any references to “evidence of insurability.”** *See Contract/Policy Language Standard #1.*

57. Group certificate J-3000 and J-4000 allowed for a requirement of proof of insurability for group coverage in violation of R.C. 3901.21(T), R.C. 3924.03(C), Public Law 104-191, Part A-Group Market Reforms, Sections. 2702(a)(1) and 2711(a)(1)(B), and 45 CFR § 146.121(a). Therefore, the language was a violation of R.C. 3901.21(B). **The Company agreed to revise any forms requiring “proof of good health” or “proof of insurability.”** *See Contract/Policy Language Standard #1.*

58. A rider for the J-3000 certificate indicated employees or dependents may be required to provide proof of good health in violation of R.C. 3901.21(T)(1)(b), Public Law 104-191, Part A-Group Market Reforms, Sections. 2702(a) and 45 CFR § 146.121(a). Therefore, the language was a violation of R.C. 3901.21(B). **The Company agreed to revise any forms requiring “proof of good health” or “proof of insurability.”** *See Contract/Policy Language Standard #1.*

59. An employer application and certificate J-4000 indicated that employee eligibility is based on a 30 hour work week. R.C. 3924.01(G) indicates that eligibility must be based on a 25 hour work week. Therefore, the provision was not true, making it misleading and deceptive in violation of R.C. 3901.21(B). The Company's response stated, **“Agree: the Company will correct the certificate issue system so that certificates issued reflect that 25 hours per week is the full-time standard in Ohio.”** *See Contract/Policy Language Standard #1.*

60. The Company practices and procedures during the period under examination made Life and AD&D coverage mandatory to be sold with all small group health plans. This practice is a violation of the guaranteed issue requirements of R.C. 3924.03(E)(1), R.C. 3901.21(V), Public Law 104-191, Part A-Group Market Reforms, Sections. 2711(a) and Part C, 2791(e), and 45 CFR § 146.150(a). **The Company stated it would change its**

**practices by discontinuing mandatory Life and AD&D coverage with health coverage sold to small employers. See Contract/Policy Language Standard #1.**

61. For group certificates J-3000 and J-4000, the Company provided a deferred effective date based on the employee's health status for the employee and his/her dependents. The provisions would violate R.C. 3924.03(C), R.C. 3901.21(M), R.C. 3901.21(T)(1)(b)(3), Public Law 104-191, Part A-Group Market Reforms, Sections. 2702(a)(1)(A) and Part C, 2711(a)(1)(B), and 45 CFR § 146.121(a)(1), and HCFA Bulletins, Transmittal Nos. 00-01 and 00-04. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the contract language for deferral of the employee's effective date. See Contract/Policy Language Standard #1.**

62. Certificate J-4000 required employees to work a minimum of 48 weeks per year in order to be an eligible employee for health coverage. Neither R.C. 3924.01(G), nor 45 CFR § 146.143 contain such a requirement for determining whether an employee is eligible for coverage. Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B), and the Company procedures were a violation of the statute and regulation noted above. **The Company agreed to remove and amend the language for employee eligibility based on working 48 weeks per year. See Contract/Policy Language Standard #1.**

63. The employer group applications provided for a 100% participation requirement for employees in non-contributory groups. However, the Company practices and procedures did not follow this provision for all groups that applied for coverage. Therefore, the language in the applications was untrue, misleading and deceptive in violation of R.C. 3901.21(B), and the Company procedures were unfairly discriminatory in violation of R.C. 3901.21(M). The Company's response stated, **"We have reminded staff of the requirement and the importance of adhering to established guidelines."** See *Contract/Policy Language Standard #1.*

64. Certificates J-3000 and J-4000 had six (6) provisions, which contained requirements for dependent eligibility that would not be in compliance with R.C. 3924.46(B)(3), R.C. 3924.47(B), R.C. 3924.51(A)(3), or 45 CFR § 146.143(a) and 45 CFR § 146.150(B)(3). Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed that all six provisions were violations and that the certificates would be amended. See Contract/Policy Language Standard #1.**

65. Certificate J-4000 allowed for a waiting period greater than employer elected, and also allowed for a waiting period greater than allowed by R.C. 3924.03(E)(2). Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed and indicated it would amend the certificate.** However, the amendment suggested by the Company defined a late enrollee in a manner not in compliance with R.C. 3924.03, Public Law 104-191, Part A-Group Market

Reforms, Sec. 2701 and 45 CFR § 146.111. The Company has indicated that an employee enrolls with an insurer. However, employees enroll with the employer plan, not the insurer. *See Contract/Policy Language Standard #1.*

66. Certificate J-4000 placed a \$2,000 cap on dental congenital defects in violation of R.C. 3923.26(B)(3). Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to remove benefit caps on congenital defects.** *See Contract/Policy Language Standard #1.*

67. Certificates J-3000 and J-4000, failed to provide continuation of coverage provisions in compliance with R.C. 3923.38. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company stated it would take the necessary steps to ensure in force certificates meet the requirements of R.C. 3923.38.** *See Contract/Policy Language Standard #1.*

68. Certificate J-4000 denied COBRA continuation rights to employees who were entitled to Medicare, which would be a violation of COBRA eligibility rights. Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to comply with COBRA.** *See Contract/Policy Language Standard #1.*

69. Certificates J-3000 and J-4000, failed to comply with R.C. 3923.381, concerning the rights of reservists called or ordered to active duty. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). The Company response stated, **“We will take the necessary steps to ensure that in force certificates in Ohio provide notice of the continuation rights as required by R.C. 3923.381.”** *See Contract/Policy Language Standard #1.*

70. Certificate J-3000 offered a financial incentive to forgo inpatient care required to be provided by R.C. 3923.63. Financial incentives are prohibited by the statute, and the provision would be an unfair practice in violation of R.C. 3901.19 through R.C. 3901.26. Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company indicated it would amend the certificate to comply with the requirements of R.C. 3923.63.** *See Contract/Policy Language Standard #1.*

71. Certificates J-3000 and J-4000, failed to provide coverage for providers that were not licensed in Ohio for mental health, alcoholism and drug abuse. This provision would be a violation of R.C. 3923.28 and R.C. 3923.29. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to include all qualified providers.** *See Contract/Policy Language Standard #1.*

72. Certificates J-3000 and J-4000, failed to comply with the limitations applicable to pre-existing conditions in compliance with R.C. 3924.01, R.C. 3924.03, R.C. 3923.571,

R.C. 3923.40, R.C. 3924.51 and Public Law 104-191, Part A-Group Market Reforms, Sec. 2701 or 45 CFR 146.111. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificates, by changing language for pre-existing conditions.** See *Contract/Policy Language Standard #1*.

73. Certificates J-3000 and J-4000, provided permanent pre-existing condition(s) limitations in violation of R.C. 3901.21(M), R.C. 3924.03(A)(1), Public Law 104-191, Part A-Group Market Reforms, Sec. 2701(a)(2), 45 CFR § 146.150(a)(2) and 45 CFR § 146.111(a). Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificates to comply with permissible pre-existing condition limitations.** See *Contract/Policy Language Standard #1*.

74. Certificates J-3000 and J-4000, imposed coverage for some accidental injuries in violation of R.C. 3901.21(M), R.C. 3924.03(C), R.C. 3901.21(T)(1)(b), Public Law 104-191, Part A-Group Market Reforms, Sec. 2702(a)(1)(D) and (2)(B), and 45 CFR § 146.121(a) and (a)(iv). Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificates to comply with permissible pre-existing condition limitations.** See *Contract/Policy Language Standard #1*.

75. Certificate J-4000 failed to provide credit for previous coverage to reduce a pre-existing conditions limitation period for some services in violation of R.C. 3901.21(M), R.C. 3924.03(A), Public Law 104-191, Part A-Group Market Reforms, Sec. 2701(a) and 45 CFR § 146.111(a). Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificates to comply with permissible pre-existing condition limitations.** See *Contract/Policy Language Standard #1*.

76. Certificate J-3000 failed to provide language to issue certificates of creditable coverage in compliance with R.C. 3924.03(A), Public Law 104-191, Part A-Group Market Reforms, Sec. 2701 and 45 CFR § 146.115. Therefore, the language in the certificate was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend procedures for issuing CCCs at termination of employer coverage and continuation coverage.** See *Contract/Policy Language Standard #1*.

77. Certificates J-3000 and J-4000, failed to provide language for the mandated benefits of WHCRA and Ohio Bulletin 2001-1. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the language in both certificates.** However, the Company's amendment failed to include the mandated language that "coverage will be determined in a manner determined in consultation with the attending physician and the patient." See *Contract/Policy Language Standard #1*.

78. Certificates J-3000 and J-4000, allowed for termination of a group if the employer suspended business operations or changed the nature of the business. In compliance with R.C. 3924.03, Public Law 104-191, Part A-Group Market Reforms, Sec. 2712 and 45 CFR § 146.152, termination can only be enacted if there was fraud or an intentional misrepresentation of a material fact made on an application. Therefore, the language in the certificates was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company indicated it was willing to modify the language in the certificates for suspension of business operations, but refused to modify the language due to the nature of the business.** The Company should also amend its provision for the “nature of the business,” because whatever the “nature of the business,” the Company cannot terminate coverage. *See Contract/Policy Language Standard #1.*

79. The Company failed to file with the Department any of the employer and employee enrollment forms in violation of R.C. 3923.02. The Company should file all applications and enrollment forms prior to putting into use. *See Underwriting Standard #1.*

80. Two of the Company’s employer applications and one employee enrollment form indicated that “evidence of insurability” may be required. This is not allowed for compliance with R.C. 3924.03(C), P.L. 104-191, Part A – Group Market Reforms, Sec. 2702(a) and 45 CFR § 146.121(a). **The Company agreed to remove references to “evidence of insurability.”** *See Underwriting Standard #1.*

81. The Company’s employer applications required the employer to provide a state quarterly wage and tax statement, or a current business federal tax form. These cannot be required, to do so was a violation of guaranteed availability of coverage for small employers, and therefore, was a violation of R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2711 and 45 CFR § 146.150. The Company’s response stated in part, “**Agree: . . . . Employers unable to provide a quarterly Wage & Tax statement will be afforded the opportunity to submit alternative means of establishing eligibility.**” *See Underwriting Standard #1.*

82. The Company’s procedures allowed it to terminate coverage if certain tax forms were not provided. This provision would violate guaranteed renewability of coverage provisions at R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2712 and 45 CFR § 146.152. **The Company agreed to allow employers to provide alternative means for supplying information other than mandating certain tax forms.** *See Underwriting Standard #1.*

83. The Company’s employer applications and enrollment forms indicated that an agent selling group coverage represents the employer’s interest. This provision was a violation of R.C. 3923.141. Therefore, the language was untrue, misleading and deceptive in violation of R.C. 3901.21(B). **The Company agreed to amend the certificate to clarify that the agent may represent the interests of both the insured and the insurer.** The Company’s suggested amendment would still be a violation of R.C. 3923.141. The agent represents the insurer. *See Underwriting Standard #1.*

84. The Company failed to consistently enforce its participation requirements in violation of 3901.21(M). The Company should apply its participation requirements equally among all small groups. *See Underwriting Standard #1.*

85. The Company required the sale of life insurance with its small employer group plans in violation of R.C. 3924.03(E)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2711, 45 CFR § 146.150. **The Company disagreed, but stated it had elected to change its business practice and permit employees to purchase Life and AD&D coverage as an option, rather than requiring it.** *See Underwriting Standard #1.*

86. The Company failed to issue certificates of creditable coverage (CCC) when group plans terminated for a period of time during the period under examination, in 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). This was true until April 13, 2004. **The Company agreed it had not provided CCCs to any of the employees when an entire group terminated. The Company indicated it amended its procedures April 13, 2004.** *See Underwriting Standard #2.*

87. The Company failed to issue CCCs timely for all three employers tested that had employees terminated while coverage remained in force. To not issue CCCs timely 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)(2). The Company should issue CCCs timely. CCCs are to be issued within 14 days after non-payment, or 14 days after the Company has been notified of termination. *See Underwriting Standard #2.*

88. The Company failed to guarantee the renewability of a legitimate small group plan in violation of R.C. 3924.03(B)(1), Public Law 104-191, Part A – Group Market Reforms, Sec. 2712, 45 CFR § 146.152(b) and HCFA Bulletin, Transmittal No. 99-03, dated September 1999. The group was terminated for participation even though it had two employees, and was told it would be terminated for failure to respond to requests for tax forms. The group had met the standards in the above statutes and regulation. Therefore, it should never have been terminated. The Company's response stated, **“Agree: We will ensure that all legitimate groups with two or more employees are guaranteed renewable.”** *See Underwriting Standard #2.*

89. The Company provided a waiting period of greater than 90 days for an employee in a group. The employer chose a waiting periods of 90 days, therefore, a period of greater than 90 days was a violation of R.C. 3924.03(E)(2). **The Company stated it had amended its administrative procedures to ensure that employees will not be assessed a waiting period of greater than 90 days.** However, the correction for its procedures also created a violation, because the Company failed to define a late enrollee in compliance with R.C. 3924.03, Public Law 104-191, Part A – Group Market Reforms, Sec. 2701 and 45 CFR § 146.111. *See Underwriting Standard #2.*

90. JALIC 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 . . . forms 185 and 186 to all conversion eligible individuals.”** JALIC forms 208 and 209 are the equivalent of the FIC forms 185 and 186, which are the FIC versions of the Ohio Standard and Basic plans. The Company is mandated to offer the Ohio Basic and Standard plans to all eligible individuals, including FEI’s. Therefore, the Company should determine who is federally eligible in order to offer the plans to those that are eligible, or offer the Basic and Standard plans to all conversion eligible individuals. During the period under examination it did neither. *See Underwriting Standard #4.*

91. JALIC 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 among 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 converttee.”** *See Underwriting Standard #4.*

92. The JALIC Conversion plan 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 390 and 397, or the Ohio Standard plan (form 209 with maternity included). Therefore, the JALIC plan was offered in violation of R.C. 3923.122. The Company’s procedures and practices for maternity coverage in a conversion plan, attempts to avoid adverse risks in violation of R.C. 3901.21(V), because it avoids coverage for future maternity claims. The Company’s response stated in part, **“The Company acknowledges and agrees to offer maternity coverage to all individuals eligible for conversion and will immediately implement measures to ensure that all enrollees are provided with maternity services as an ongoing, covered benefit under JALIC form J-1110. The Company believed its practice of issuing the J-1110 form (a substantial equivalent to the Basic and Standard Plans) without requiring evidence of insurability and without preexisting condition limitations without requiring conversion applicants to produce evidence of prior coverage exceeds the requirements of Group Conversion Section 3923.122.”** *See Underwriting Standard #4.*

93. All of the individual market issued files were failed because the Company did not determine if the applicants were FEIs at the time of application. This Company practice

and procedure was a violation of R.C. 3923.581. The Company's response stated in part, "**Agree:** The Company acknowledges that we did not consistently determine the HIPAA eligibility status of all applicants during the examination period . . . . The Company will implement procedures to ensure that HIPAA Eligibility Form 25238, or an updated version of the form, will be required as part of each application for individual market product . . . or will develop processes that will otherwise provide for the offer of Basic and Standard plans to HIPAA eligible individuals . . . . The Company will either file HIPAA Eligibility Form 25238, or an updated version of the form, with the Ohio Department of Insurance as part of the applications for the forms or will develop processes that will otherwise provide for the offer of the Basic and Standard plans to HIPAA eligibles . . . the Company will ensure that an offer of the Basic and Standard plan is made to each HIPAA eligible applicant, regardless of whether or not an offer of fully-underwritten coverage may be made. **A corrective action plan is not available at this time as the Company needs to ensure all areas impacted by these workflows are involved in the corrective action process. We will update the Department of Insurance when a corrective action plan is implemented.**" The plan was not revealed to the examiners. *See Underwriting Standard #7.*

94. The Company failed to provide four individuals with an automatic issue CCC at the time their coverage was terminated. Therefore, the Company was in violation of R.C. 3923.57(F), Public Law 104-191, Part A - Group Market Reforms, Sec. 2743, and 45 CFR § 148.124. **The Company agreed it had not provided the CCCs.** *See Underwriting Standard #8.*

95. All 50 individual market declined applicants were failed, because the Company did not determine the FEI status of the applicants at the time of application in violation of R.C. 3923.581. The Company has acknowledged it did not determine eligibility at the time of application. The Company should determine eligibility at the time of application, because it cannot offer the Ohio Standard and Basic plans and the Company plans to federally eligible individuals without such a determination. *See Underwriting Standard #9.*

96. Thirty-eight of the 50 declined applicants were failed because the Company did not provide an adequate adverse underwriting notice in violation of R.C. 3904.10. **The Company agreed**, and stated, "We respectfully note that **the Company had modified its administrative practices** such that both confidential and non-confidential information that is related to the specific reason for an adverse underwriting action is disclosed directly to the insured. **We are in the process of performing an audit to identify any and all gaps in this process, as well as related documentation, to ensure consistency and compliance with this practice. . . .**" *See Underwriting Standard #9.*

97. The Company failed to retain records for four rescinded files. Therefore, it was not possible for the examiners to make a determination on whether the rescissions were made in compliance with R.C. 3923.14, or whether claims were denied because of the rescission in violation of Ohio Adm.Code 3901-1-60(G). **The Company indicated it**

**could not produce the records.** The Company should maintain all files in their entirety for examination purposes. *See Underwriting Standard #10.*

98. For one file, the Company allowed the policy/certificate to be re-underwritten with information that was disclosed on the application. However, an insurer is not allowed to re-underwrite for information that was provided at the time of application. Therefore, the Company's actions were a violation of R.C. 3923.57(C), 45 CFR 148.122, Public Law, 104-191, Part B – Individual Market Rules, Sec. 2742 and R.C. 3901.21(M). The Company agreed to the violation when it stated, **“Because the applicant disclosed tobacco use on the application, the reformation should not have included application of smoker rates.”** *See Underwriting Standard #10.*

## **ACKNOWLEDGEMENT**

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

Respectfully submitted,

---

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



**APPENDIX A – MANAGEMENT LETTER OF REPRESENTATION**



**ASSURANT**  
Health

501 West Michigan  
P.O. Box 3050  
Milwaukee, WI 53201-3050  
T 800.800.1212

May 16, 2006

Thomas McIntyre, CIE, CPCU, FLMI, AIRC, APA  
For: Ohio Department of Insurance  
Huff Thomas & Company  
4700 Belleview Suite 208  
Kansas City, MO 64112

Re: Representation Letter

Dear Mr. McIntyre:

In connection with the target market conduct examinations of Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company (collectively, "the Company") in the time period of July 1, 2002 through June 30, 2004, for the purpose of determining the Company's compliance with policy provisions and the Ohio Insurance Code and Rules and Regulations in regard to all phases of health insurance lines, I hereby represent, to the best of my knowledge and belief, that the following:

1. The Company uses its best efforts to conduct its transactions and business in compliance with the statutes, rules and regulations and procedures of the State of Ohio which pertain to health insurance companies.
2. All corporate powers are exercised by or under the authority of the duly qualified and constituted Board of Directors of the Company. The business affairs and transactions of the Company are managed under the direction of the Board of Directors, in accordance with the duties and responsibilities conferred upon the Board by its Articles of Incorporation, By-laws and applicable state law.
3. Pursuant to Ohio Rev. Code 3916.11, we have made available to you all books, records, accounts, papers, documents, computer records and recordings in the Company's possession which you have requested to review in connection with the examination.
4. To the best of my knowledge and belief,
  - a. The Company has not taken disciplinary action or terminated any company employee for irregularities which relate to the record keeping system or the internal controls of the Company as it relates to compliance with Ohio health insurance laws or regulations for the examination period.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

- b. Reports from any other state insurance agencies regarding alleged noncompliance with applicable state regulatory requirements and our response to those reports are collected and review by our domiciliary state Department of Insurance.
5. The examiner has been provided access to information concerning any lawsuits brought in the State of Ohio for the examination period.
  6. The Company has provided any requested information regarding events occurring subsequent to June 30, 2004 to the examiner.
  7. You have represented to us that your market conduct examination was conducted in accordance with the examination standards established by the Ohio Department of Insurance, and procedures established by the National Association of Insurance Commissioners.

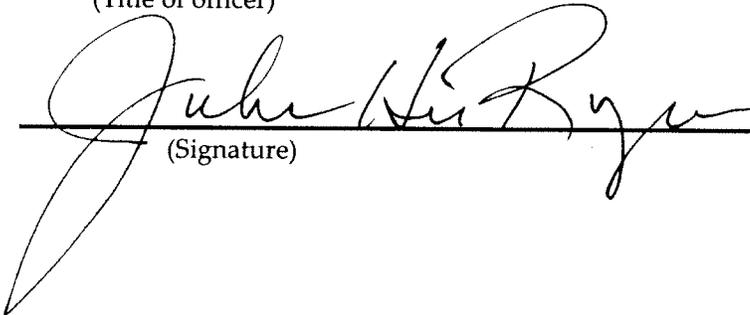
Time Insurance Company  
Union Security Insurance Company  
John Alden Life Insurance Company

Julia Hix-Royer, Vice President Compliance

(Title of officer)

5/14/06

(Date)



(Signature)

STATE OF OHIO

DEPARTMENT OF INSURANCE

IN THE MATTER OF:	)	
	)	
JOHN ALDEN LIFE INSURANCE COMPANY	)	CONSENT ORDER
TARGETED MARKET CONDUCT EXAMINATION	)	

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. John Alden Life Insurance Company (“the Company”), a Wisconsin-domiciled life and health insurer, is authorized to engage in the business of insurance in the State of Ohio pursuant to R.C. section 3911.01 and, as such, is under the jurisdiction of the Superintendent. The Superintendent conducted a targeted market conduct examination of the Company covering the period July 1, 2002, through June 30, 2004 (“Examination”).

The focus of the Examination was to determine the Company’s compliance with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”); the Women’s Health and Cancer Rights Act (“WHCRA”); the Newborns’ and Mothers’ Health Protection Act of 1996 (“NMHPA”); as well as the Ohio Revised Code and Ohio Administrative Code.

The details of the Examination are contained in *The Ohio Department of Insurance, A Targeted Market Conduct Examination of John Alden Life Insurance Company, NAIC #65080 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 28, 2008, will become a public record.

SECTION I

**BASED UPON THE EXAMINATION, THE SUPERINTENDENT DETERMINED:**

The Company’s sales and marketing, policy drafting, underwriting, and information technology processes failed to comply with federal and Ohio laws during the examination period. The examination report includes numerous findings in these general areas, including, but not limited to, the following findings:

1. Company individual and short term medical policy forms (including riders) were marketed without being filed with the Department.
2. Company individual and short term medical policy forms failed to comply with state and federal laws in that they contained restrictive benefits language and lacked mandatory benefits language.

3. Company group policy forms failed to comply with state and federal laws in that they contained restrictive benefit language, lacked mandatory benefit language, and improperly defined pre-existing conditions.
4. The Company restricted the eligibility of potential enrollees for health insurance in a manner that violated state and federal laws, including but not limited to, restricting eligibility based on the fact of union membership.
5. The Company failed to determine whether its customers were Federally Eligible Individuals (“FEIs”) during the application process.
6. The Company required groups interested in purchasing health insurance to purchase group life insurance for all of the group’s enrollees.
7. The Company failed to provide mandated disclosures to small employer groups at the time of solicitation.

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.

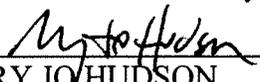
- D) The Company hereby waives all rights to challenge or to contest this Consent Order, in any forum now available to it or in the future, including the right to any administrative appeal, or an action or appeal filed in state or federal court.
- E) The Company has reviewed this Consent Order with counsel 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 targeted 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 John Alden Life 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 7<sup>th</sup> day of July 2008.

  
\_\_\_\_\_  
MARY JO HUDSON  
Superintendent of Insurance

**ACKNOWLEDGEMENT AND ACCEPTANCE**

By execution hereof, John Alden Life 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 John Alden Life Insurance Company to the terms and conditions of this Consent Order.

**JOHN ALDEN LIFE INSURANCE COMPANY**

By: Julia Hix-Royer

Print or type name: Julia Hix-Royer

Title: Vice President Regulatory Compliance

Date: June 27, 2008