



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

GOLDEN RULE INSURANCE COMPANY

AS OF

JANUARY 15, 2009

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EXECUTIVE SUMMARY

A target market conduct examination of the Golden Rule Insurance Company was performed on the Company's activities related to Out-of-State Group Short-term Major Medical Health Plans. A review of the Company's claim settlement practices was conducted to determine compliance with Section 626.9541, Florida Statutes. The Company's claim settlement procedures and policy forms were reviewed for compliance with Section 627.6515, Florida Statutes. The Company's rescission practices were examined to determine if contracts were rescinded according to policy provisions. A review of the Company's complaint handling procedures was conducted to determine compliance with Section 626.9541, Florida Statutes. The Company's fraud plan was reviewed to determine compliance with Sections 626.9891, Florida Statutes.

The following violations were found during this examination:

<u>TABLE OF VIOLATIONS</u>				
Statute or Rule Cite	Description	Total Universe of Files	Files Reviewed	Number of Violations
Section 624.318, Florida Statutes	Failure to provide requested documentation or Maintain Adequate Records	13,917	212	4
Section 626.9891(3)(b), Florida Statutes	Anti-Fraud Plan failed to contain a description of procedures for mandatory reporting of possible fraudulent acts	N/A	N/A	1
Section 626.9891(3)(d), Florida Statutes	Anti-Fraud Plan failed to contain a written description or chart outlining the organizational arrangement of anti-fraud personnel	N/A	N/A	1

This examination was conducted by INS Regulatory Insurance Services, Inc.

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market examination of Golden Rule Insurance Company (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by INS Regulatory Insurance Services, Inc. The scope period of this examination was January 1, 2005 through June 30, 2008. The onsite examination began October 10, 2008 and ended January 15, 2009.

The purpose of this examination was to review the Company's activities related to its Out-of-State Group Short-term Major Medical Health Plans. The examination included the following procedures:

- The Company's claim settlement procedures were reviewed to determine if all claims were acknowledged, investigated appropriately and then paid or denied in compliance with Section 626.9541, Florida Statutes.
- An examination of the Company's claim settlement procedures and policy forms was conducted to determine if mandated benefits were covered for Out-of-State Group Short-term Major Medical Healthcare policies in compliance with Section 627.6515(2)(c), Florida Statutes.
- The Company's rescission practices were examined to determine if contracts were rescinded according to policy provisions.
- A review of the Company's complaint handling procedures was conducted to determine compliance with Section 626.9541(1)(j), Florida Statutes.
- The Company's fraud plan was reviewed to determine compliance with Sections 626.9891(1) and (3), Florida Statutes.

The Company records were examined at its Indiana office located at 7440 Woodland Drive, Indianapolis, IN 46278. This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

Golden Rule Insurance Company is a foreign life and health insurer licensed to conduct business in the State of Florida on November 8, 1976. The Company provides life, accident and health and individual and group annuities in the State of Florida.

Total Direct Premiums Written in Florida for Out-of-State Group Short-term Major Medical Health Plans were as follows:

Year	Total Written Premium In Florida (Per information provided by Company)
2005	\$788,513
2006	\$1,211,746
2007	\$1,622,022
2008	\$1,588,507

EXAMINATION FINDINGS

I. INVESTIGATION AND CLAIMS SETTLEMENT

The Company identified 13,917 Out-of-State Group Short-term Major Medical health claims that were paid, denied, closed without payment (CLDWOP) or were compromised during the scope period. Samples from each category were reviewed to determine if all claims were investigated and either paid or denied in compliance with Florida Statutes.

Payment Status	Total Number Of Claims	Number Reviewed
Paid (Paid as Billed)	62	62
Denied or Closed w/o Payment	4301	50
Compromised (Paid other than as Billed)	9554	100

A. PAID CLAIMS

The examiners reviewed all 62 claims the Company paid as billed during the scope period with the following violations noted:

1. **During the review of 62 sample files, the examiners found 1 file that contained inaccurate data.** The Proof of Loss (POL) date did not match the date on the data listing in violation of Section 624.318, Florida Statutes.
 - 1a.) **Corrective Action:** The Company should review its procedures to ensure that accurate and adequate information is provided to examiners in accordance with Section 624.318, Florida Statutes.
 - 1b.) **Company Response:** The Company acknowledged the proof of loss date was inaccurate, however noted that it only differed by one day.

B. DENIED or CLOSED WITHOUT PAYMENT CLAIMS

A random sample of 50 of 4,301 claims the Company denied or closed without payment during the scope period was reviewed. During this review, the examiners found no instances where claims for mandated benefits were inappropriately denied.

C. COMPROMISED CLAIMS

A random sample of 100 of 9,554 claims the Company paid other than as billed during the scope period was reviewed with the following violations found:

1. **Three of the files reviewed had missing, incomplete or inaccurate data in violation of Section 624.318, Florida Statutes.** In one file the proof of loss date did not match the date on the data listing, a second file was missing the application, and the third file had an incomplete Explanation of Benefit form.
 - 1a.) **Corrective Action:** The Company should review its procedures to ensure that accurate and adequate information is provided to examiners in accordance with Section 624.318, Florida Statutes.
 - 1b.) **Company Response:** The Company agreed with the above findings.

Claim Repricing

There is a Cost Reimbursement Agreement between UnitedHealthCare Services, Inc. and Golden Rule Financial Corporation, Golden Rule's parent company. UnitedHealth Networks (UHN), a division of UnitedHealthcare, reprices most Golden Rule claims and has a team who assists when questions are received from providers relative to the repriced amount of a claim. The Company reported that UnitedHealthCare periodically audits the accuracy of their repricing process and the software tools used to determine the appropriate fee schedules for network providers. The Company also has a designated analyst who performs daily random audits of the repricing activities related to claims.

In reviewing the Company's repricing procedures, the examiners noted that adjusters are instructed to use the submitted charges on any claim that is repriced higher than the submitted charges. Although a claim may be repriced higher, the provider reimbursement would be limited to the actual charges submitted.

II. RESCISSIONS

The Company identified a total of 17 certificates rescinded during the scope period. These 17 certificates had a total of 303 associated claims. All 17 rescission files and a random sample of 50 claims associated with those contracts were reviewed with the following noted:

It was determined that 14 of 17 certificates rescinded during the scope period were rescinded due to pre-existing conditions not disclosed on the application and 3 certificates were rescinded for failing to disclose other coverage in effect at the time of application.

Of the 50 rescinded claims reviewed, 43 were categorized as having a disposition of Denied while the remaining 7 had a different disposition category. In 1 claim under a

certificate the disposition was listed as CLDWOP while 4 other claims under the same certificate had a final disposition of Denied. In 11 of the 12 claims under another certificate the final disposition was Denied while the remaining claim listed Credit as the final disposition status. Although the examiners found inconsistency in the Company's recording of disposition status of rescinded claims, no exceptions were noted.

III. COMPLAINTS

The Company provided a complaint register listing 25 complaints during the examination scope period. Of the 25 complaints reviewed, 4 certificates had more than 1 complaint filed during the scope period. All complaints associated with each of these certificates were given the same complaint number but each complaint was recorded separately on the complaint register. No exceptions were noted.

IV. ANTI-FRAUD PLAN and INVESTIGATIVE UNIT

The examiners reviewed a copy of the Company's anti-fraud investigative unit description and anti-fraud investigative unit procedure manual used during the scope period.

The Company did not report any suspected fraudulent actions nor conduct any fraud audits related to Florida Association Group Short Term policies during the scope period.

The Company was also asked to provide a listing of all training relative to the detection and investigation of fraudulent insurance acts for all personnel involved in anti-fraud related efforts during the scope period. The listing was to include the date and a brief summary of the training activity. Lists of training conducted in each year from 2005-2008 were provided. The information on each listing included the date of the training, department, instructor, the duration of training and a roster of attendees. The listings failed to include a summary of the training activity conducted, as requested.

After review of the above materials, the examiners subsequently requested a copy of the Company's anti-fraud plan that was filed with the Division of Insurance Fraud and in effect during the scope period. A copy of any updates filed during the scope period was also requested. The Company provided a 7 page document entitled, "Policy Statement on Fraud and Abuse." During the scope period the Company filed updates to the anti-fraud plan, however, the Division of Fraud deemed these updates to be insufficient.

The following violations were found during the review of the Company's anti-fraud plan:

1. **The Company's anti-fraud plan failed to include a description of the procedures for mandatory reporting of possible fraudulent acts to the Division of Insurance Fraud as required by Section**

626.9891(3)(b), Florida Statutes. The anti-fraud plan included a statement that when the Special Investigations Department has cause to believe that insurance fraud has been committed, a written report is submitted to the Department of Insurance. This statement does not meet the requirements of the specified statute.

1a.) **Corrective Action:** The Company should modify its anti-fraud plan to comply with all requirements.

2. **The Company's anti-fraud plan failed to include a written description or chart outlining the organizational arrangement of the Company's anti-fraud personnel as required by Section 626.9891(3)(d), Florida Statutes.** The anti-fraud plan included a list of the titles of the Special Investigative Unit staff with a description of their credentials and experience. The list did not include a description of the responsibilities or job functions of each position nor did it include a copy of the organizational arrangement of the personnel.

2a.) **Corrective Action:** The Company should modify its anti-fraud plan to comply with all requirements.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.