THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

GOLDEN RULE INSURANCE COMPANY

AS OF

October 28, 2010

NAIC COMPANY CODE: 62286
NAIC GROUP CODE: 00707

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EXECUTIVE SUMMARY

A target market conduct examination of Golden Rule Insurance Company was performed to determine compliance with Florida Statutes and Florida Administrative Code.

The following represent general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
626.9541(1)(a)1, F.S. & 627.429, F.S.	Failure to provide coverage for HIV infection or acquired immune deficiency syndrome, except as provided in pre-existing condition exclusion through exclusionary riders. (Underwriting)	116	1
627.6515(2)(c), F.S. & 627.6613, F.S.	Failure to provide policy benefits for baseline mammograms through exclusionary riders. (Underwriting)	116	2
627.6515(2)(c), F.S. & 627.6579, F.S.	Failure to provide policy benefits for children from birth to age 16 which are exempt from any deductible. (Claims)	2785	597
627.6515(2)(c), F.S. & 627.6613, F.S.	Failure to provide policy benefits for baseline mammograms. (Claims)	209	8

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of Golden Rule Insurance Company (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of the examination for mandated benefits and guaranteed issue coverage compliance was January 1, 2008 through December 31, 2009. The scope period for the GAP Reporting Review was January 1, 2009 to December 31, 2009. The onsite examination began September 6, 2010 and ended October 28, 2010.

The purpose of the examination was to review the Company's business practices and compliance relating to mandated benefits, guaranteed issue coverage, and GAP reporting.

The examination included the following procedures:

- The Company's underwriting guidelines and procedures were reviewed to determine whether the Company performed its reasonable diligence in reviewing and underwriting all applications relative to eligibility for guarantee issue coverage pursuant to Section 627.6487, Florida Statutes, and Rule 69O-154.112, Florida Administrative Code.
- Master policies, policyholder certificates, and form filings were reviewed to determine if mandated benefits were inappropriately excluded or limited in violation of Section 627.6515, Florida Statutes.
- Applications denied, withdrawn, rescinded, terminated, issued with limitation or other than as applied for, and conversions were reviewed to determine the Company's

compliance with laws regulating Out-of-State Groups regarding rating practices and mandated benefits per Section 627.6515, Florida Statutes.

- Claims processing was reviewed to determine whether paid and denied claims were appropriately handled as regards mandated benefits pursuant to Sections 627.6515(2)(c), Florida Statutes.
- The Company's procedures and complaint registers were reviewed to determine compliance with Section 626.9541(1)(j), Florida Statutes.
- Documentation was reviewed to determine the accuracy of information reported to the Office in the Company's GAP Report, which is filed pursuant to Section 627.9175, Florida Statutes.

In reviewing materials for this report, the examiner relied on records 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 (NAIC) and/or consistent with the pre-determined market conduct program presented to and approved by the Office.

Sample sizes were determined using the Acceptance Samples Table of the NAIC Market Regulation Handbook or by the Audit Command Language (ACL) software. The handbook allows several methods for determining sample sizes. Two methods were used during the examination. For populations of less than 50,000 the Acceptance Samples Table was used and for populations of over 50,000 ACL was used. In utilizing ACL to determine the sample sizes, the parameters consisted of a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% in accordance with the handbook.

COMPANY OPERATIONS

Golden Rule Insurance Company, a foreign Life and Health insurer domiciled in Indiana, was licensed to conduct business in the state of Florida on November 8, 1976. The Company is a wholly owned subsidiary of Golden Rule Financial Corporation, which was acquired by United Health Group on November 13, 2003. It was re-domesticated to Indiana on October 2, 2006.

Effective October 1, 2005, the Company entered into an indemnity reinsurance agreement to reinsure all life and annuity business, except for group life and term life rider business.

Total Direct Premiums Written in Florida for accident and health insurance was as follows:

	Total Written Premium In Florida (Per Schedule T of the Annual Statement)
Year	Accident and Health
2008	290,579,212
2009	302,864,807

UNDERWRITING AND RATING - ACCIDENT & HEALTH

I. UNDERWRITING AND RATING PRACTICES:

The underwriting and rating practices review was performed to determine whether policies were issued other than applied for, declined, withdrawn, terminated/cancelled, converted, or rescinded in compliance with Florida Statutes relating to mandated benefits or guaranteed issue eligibility.

Issued Other Than Applied For

A sample of 116 certificates issued "other than applied for," from a total population of 28,975, was reviewed.

1.) **In 1 of 116 instances the Company failed to provide for HIV/AIDS coverage through an exclusionary rider in violation of Sections 626.9541(1)(a)1 and 627.429, Florida Statutes.** The Company attached an exclusionary rider, which specifically excluded sexually transmitted diseases.

1a.) **CORRECTIVE ACTION:** The Company should clarify that the sexually transmitted disease exclusionary rider does not exclude benefits required under Section 627.429. The Company should mail amended riders to all insureds who have a rider that excludes sexually transmitted diseases.

1b.) **COMPANY RESPONSE:** The Company disagreed with this finding, but agreed to revise the rider.

2.) **In 2 of 116 instances the Company failed to provide for additional mammograms for high risk women and prosthetic device coverage through an exclusionary rider in violation of Sections 627.6515(2)(c) and 627.6613, Florida Statutes.**

2a.) **CORRECTIVE ACTION:**

- The Company should amend the rider to state that mammograms are covered as mandated by Florida Statutes.
- The Company should discontinue offering riders excluding Florida mandated benefits in lieu of declining an applicant as uninsurable on policies that are individually underwritten.
- The Company should allow one or more mammograms a year per Section 627.6613(1), Florida Statutes.
- The Company should provide additional training to its claims staff regarding Florida mammography claims.

2b.) **COMPANY RESPONSE:** The Company disagreed with this finding responding that they are not aware of any Florida statute that would prevent them from underwriting coverage on an individual basis based on the applicant's medical history, and subsequently offering an exclusionary rider

rather than declining an applicant as uninsurable. The Company stated an exclusionary rider may exclude benefits that are included in mandates such as Section 627.6613, Florida Statutes. The Company stated they would allow one mammogram every 12 months regardless of the exclusionary rider.

Denied

A sample of 116 denied applications, from a total population of 14,657 was reviewed. No exceptions were found.

Withdrawals

A sample of 115 withdrawn applications, from a total population of 5,761, was reviewed to determine whether the reason for the withdrawal was based on the availability of guarantee issue coverage or mandated benefit exclusions. No exceptions were found.

Terminations/Cancellations

A sample of 116 terminations/cancellations, from a total population of 45,332, was reviewed to determine whether insureds were offered conversion policies. No exceptions were found.

Conversions

Only two conversion certificates were issued during the scope. Both were reviewed to determine whether mandated benefit exclusions or pre-existing exclusions were imposed. The Company stated those eligible for conversions were issued continuation policies, not conversions. No exceptions were found.

Rescissions

A sample of 79 rescinded certificates, from a total population of 343, was reviewed to determine whether the rescissions were appropriate and whether documentation supported the Company's decision to rescind. No exceptions were found.

II. FORM FILINGS:

The forms filing review included verification that all forms used were properly filed for informational purposes with the Office, and verification that the mandated benefits are included in the Schedule of Benefits and certificates. Policy forms filed during the scope were in compliance and included mandated benefits. Review of policy forms used prior to the scope of the examination, which were issued as conversions or continuation policies, determined the forms do not include the mandated benefits. However, it is the Company's contention that the benefits are paid. Additional claims were reviewed, and no violations were found for policies issued on prior forms. No exceptions were found.

I. CLAIMS HANDLING

The claims review was limited to identifying whether mandated benefits were appropriately paid based on Sections 627.6515(2)(c) and 626.9541(i)3.d., Florida Statutes.

A. Paid Claims:

A sample of 184 paid claims, from a total population of 812,576, was reviewed to determine compliance.

1.) **In 1 of 184 instances the Company applied charges to the insured's deductible from birth to age 16 which are exempt from any deductible in violation of Sections 627.6515(2)(c) and 627.6579, Florida Statutes.** Charges for an HPV vaccination were applied to the insured's deductible.

As a result of the above finding, the Company was asked to identify all claims for HPV vaccinations submitted between 12/1/07 and 12/1/08. The Company provided a spreadsheet of 2,601 applicable claims.

2.) **In 596 of 2,601 instances the Company applied charges to the insured's deductible from birth to age 16 which are exempt from any deductible in violation of Sections 627.6515(2)(c) and 627.6579, Florida Statutes.** The Company used a Table of Recommended Childhood Vaccinations by the American Academy of Pediatrics to determine payment of claims, that was 2 years out-of-date.

2a.) **CORRECTIVE ACTION:** The Company should review all denied claims and readjudicate as appropriate. The Company should ensure that all future claims for child vaccinations are properly paid.

2b.) **COMPANY RESPONSE:** The Company agreed with this finding.

B. Denied Claims:

A sample of 184 denied claims, from a total population of 166,224, was reviewed to determine compliance.

Based on the initial review, an additional sample of 25 denied mammogram claims was reviewed to determine whether there was a violation of Section 626.9541 (1)(i)3.d, Florida Statutes.

1.) **In 8 instances (5 - initial sample and 3 - additional sample) the Company failed to provide policy benefits for baseline mammograms in violation of Sections 627.6515(2)(c) and 627.6613, Florida Statutes.** The Company failed to provide baseline mammograms as required by mandate due to exclusionary riders.

1a.) CORRECTIVE ACTION:

- The Company should review all denied mammogram claims and re-adjudicate as appropriate. The Company should ensure that all future claims for baseline mammograms are properly paid.
- The Company should allow one or more mammograms a year per Section 627.6613(1)(d), Florida Statutes.
- The Company should provide additional training to its claims staff regarding Florida mammography claims.
- The Company should change all breast related exclusionary riders by adding language that clarifies mammograms are covered. The Company should mail modified riders to all affected policyholders.

1b.) COMPANY RESPONSE: The Company did not agree with this finding but did re-adjudicate the 8 claims. The Company has agreed to review all denied mammogram claims and re-adjudicate as appropriate. The Company proactively provided additional training to its Claims Department staff regarding this issue.

ACCIDENT AND HEALTH PREMIUM AND ENROLLMENT REPORTING

I. GROSS ANNUAL PREMIUM (GAP) FILING

The Company is required to annually file a Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans issued to Florida Residents (GAP Report) pursuant to Section 627.9175, Florida Statutes.

The Calendar Year 2009 GAP Report was reviewed. The Company timely submitted its filing on March 13, 2010, reporting the following figures:

Description	Direct Premiums Earned	Direct Losses Incurred	New Direct Premiums Earned	Group Coverage	Primary Insureds	Dependents	Covered Lives	Average Number of Days to Pay Claims
Major Medical and/or Hospital/Surgical/Medical Expenses								
Individually Underwritten	$ 1,755,719.00	$ 1,911,891.00	$ 17,907.00	N/A	213	89	302	7
Conversions	$ 17,385.00	$ 5,387.00	$ -	N/A	5	1	6	7
Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to Out-of-State Group as defined by §627.6515, F.S.								
Guarantee Issue (HIPAA)	$ 14,794,729.00	$ 18,592,295.00	$ 2,967,871.00	N/A	1,431	235	1,666	7
Individually Underwritten	$ 281,016,837.00	$ 170,271,599.00	$ 50,911,166.00	1	68,742	47,968	116,710	6
Short Term Major Medical	$ 1,391,354.00	$ 1,114,980.00	$ 1,211,787.00	1	1,022	423	1,445	18
Other Accident and Health Coverages								
Accident Only	$ -	$ -	$ -	0	0	0	0	0
Dental	$ 1,091,394.00	$ 590,532.00	$ 790,363.00	0	3,423	1,734	5,157	0

Disability Income	$ 1,352.00	$ -	$ -	0	2	0	2	0
Hospital Indemnity	$ 700.00	$ 1,273.00	$ -	0	5	0	5	0
Limited Benefit	$ -	$ -	$ -	0	0	0	0	0
Medicare Supplement	$ 3,353,217.00	$ 3,009,623.00	$ 834.00	0	1,287	0	1,287	0
Prescription Drug	$ -	$ -	$ -	0	0	0	0	0
Student	$ -	$ -	$ -	0	0	0	0	0
Vision	$ -	$ -	$ -	0	0	0	0	0
Reconciliation								
Accident and Health Insurance Premiums, Including policy, membership and other fees	**$ 303,422,687.00**							

The Examiner reviewed work papers and source documentation to verify the accuracy of the reporting areas required on the GAP submission. No errors were found.

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.