THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

MEGA LIFE AND HEALTH INSURANCE COMPANY

AS OF

July 15, 2010

NAIC COMPANY CODE: 97055
NAIC GROUP CODE: 00264

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EXECUTIVE SUMMARY

A target market conduct examination of Mega Life and Health 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)(k)2, F.S. and 69O-154.112(6)and (7), F.A.C.	"Statement of Eligibility Status" form is misleading and does not collect information necessary to perform reasonable diligence in determining an applicant's eligibility for guaranteed issue coverage.	NA	NA
69O-154.112(6) and (7), F.A.C.	Failure to perform reasonable diligence in determining an applicant's eligibility for guaranteed issue coverage.	229	40
627.6515(2)(c), F.S.	Failure to pay mandated benefits. (Denied Claims review)	209	2
627.6487(1)&(2), F.S.	Failure to pay mandated benefit claims, imposing pre-existing condition limitations on applicants eligible for guaranteed issue coverage. (Denied Claims review)	209	3
627.9175, F.S.	Failure to provide documentation supporting the 2009 GAP Report Filing's Direct Premiums Earned Account.	N/A	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of Mega Life and Health 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 through December 31, 2009. The onsite examination began May 17, 2010 and ended July 16, 2010.

The purpose of the examination was to review the Company's business practices and compliance relating to mandated benefits coverage, guaranteed issue coverage, anti-fraud plan and procedures 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 guaranteed 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 limitations 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 procedures were reviewed to determine whether paid and denied were appropriately handled as regards mandated benefits pursuant to Sections 627.6515(2)(c) and 626.9541, Florida Statutes.
- The Company's procedures and complaint registers were reviewed to determine compliance with Section 626.9541(1)(j), Florida Statutes.
- The Company's anti-fraud plan, employee training procedures, and reporting procedures were reviewed to determine compliance with Section 626.9891, Florida Statutes, and Rule 69D-2.001 thru 2.005, Florida Administrative Code.
- Procedures and documentation were 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

Mega Life and Health Insurance Company, a foreign Accident and Health insurer domiciled in Oklahoma, was licensed to conduct business in the state of Florida on June 15, 1982. The Company is a wholly owned subsidiary of HealthMarkets Inc., a holding company.

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

	Total Written Premium In Florida (Per Schedule T of the Annual Statement)	
Year	Accident and Health	Life
2008	55,766,433	867,186
2009	39,505,221	758,022

The Company is headquartered in North Richland Hills, Texas. During the scope of the examination, business was produced through a dedicated agency field force consisting of independent agents contracted with the Company's insurance subsidiaries. The Company offers a range of health insurance and supplemental products for individuals, families, the self-employed and small business markets on both an individual or group basis. In 2009, a subsidiary of HealthMarket, LLC formed Insphere Insurance Solutions, Inc. ("Insphere"), a Delaware corporation. Insphere is an authorized insurance agency in 50 states and the District of Columbia, specializing in small business and middle-income market life, health, long-term care, and retirement insurance. Insphere distributes products underwritten by the Company, as well as affiliated and non-affiliated insurance companies.

UNDERWRITING AND RATING - ACCIDENT & HEALTH

I. FORM FILINGS:

The forms filing review included verification that all forms used were 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 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 mandated benefits are paid. Additional claims were subsequently reviewed, and no mandated benefit exceptions were found for policies issued on prior forms.

1) **The Company uses a "Statement of Eligibility Status" form that is misleading to applicants that may be eligible for guaranteed issue coverage, in violation of Section 626.9541(1)(k)2, Florida Statutes, and does not collect information needed by the Company to perform the reasonable diligence required by 69O-154.112(6) and (7), Florida Administrative Code.** The initial question on the Company's eligibility form asks if the applicant "currently" has insurance. If the applicant answers "yes", the form states that, "you are not a HIPAA Eligible Individual" (i.e. eligible for guaranteed issue coverage under state statute or under the Health Insurance Portability and Accountability Act) and instructs the applicant to skip the remaining eligibility related questions. Because the form instructs applicants who "currently" have health insurance to not answer the questions that follow, the form is misleading to applicants who are informed they are not "currently" HIPAA eligible, even though they may be applying for

coverage that is to begin on a date when they are eligible for a guaranteed issue policy. By not collecting the additional information addressed in the subsequent questions, the Company is not performing reasonable diligence in determining if an applicant is eligible for guaranteed issue coverage.

1a.) CORRECTIVE ACTION: Since the Company has not marketed new health benefit plans in Florida since August 2010, no corrective action to the "Statement of Eligibility" form is relevant.

II. UNDERWRITING AND RATING PRACTICES:

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

Denied or Issued Other Than Applied For

A sample of 114 denied applications, from a total population of 1,182, and 115 certificates issued "other than applied for," from a total population of 3,727, were reviewed.

1) **In 40 of 229 instances, the Company did not collect the information necessary to exercise reasonable diligence in determining the availability of guaranteed issue coverage as required by Section 627.6487, Florida Statutes and Rule 69O-154.112 (6)&(7), Florida Administrative Code.** Due to the misleading nature of the "Statement of Eligibility Status" form, the availability of guaranteed issue coverage was not offered to applicants that had answered "yes" to "currently" having insurance. Of these 40 applicants, 28 were denied coverage and 12 were issued policies other than applied for.

1a.) CORRECTIVE ACTION: Since the Company has not marketed new health benefit plans in Florida since August 2010 it should review all policies issued other than applied for to determine whether applicants were eligible for guaranteed issue coverage. In the aforementioned instances where applicants were eligible for but not offered guaranteed issue coverage, the Company should remove any exclusionary waivers or pre-existing condition limitations and remediate any claims that have been denied due to an exclusionary waiver or pre-existing condition limitation.

1b.) **COMPANY RESPONSE:** The Company advised it discontinued offering new health benefit plans in Florida in August 2010 and, as a result, the use of the Statement of Eligibility Status form (the form) was discontinued. The Company has also advised that its use of the form was intended to obtain complete information in order to determine whether an applicant qualifies as a "HIPAA eligible individual" (HEI) who was eligible for guaranteed-issue coverage. The Company believes it made a concerted effort to design a form that would collect the information needed to determine if an applicant was a HEI and also understood by the consumer.

A. Withdrawals

A sample of 113 withdrawn applications, from a total population of 665, was reviewed to determine whether the reason for the withdrawal was based on the availability of guaranteed issue coverage or mandated benefit exclusions. No exceptions were found.

B. Terminations

A sample of 116 termination/cancelations, from a total population of 18,256, was reviewed to determine whether insureds were offered conversion policies. No exceptions were found.

C. Conversions

All 29 conversion issued certificates were reviewed to determine whether mandated benefit exclusions or pre-existing exclusions were imposed. No exceptions were found.

D. Rescissions

All 34 rescinded certificates were reviewed to determine whether the rescissions were appropriate and whether documentation supported the Company's decision to rescind. It was determined that all rescissions were appropriate. No exceptions were found.

CLAIM HANDLING

I. CLAIMS HANDLING

The claims review was limited to identifying whether mandated benefits were appropriately paid based on Sections 627.6515 & 627.6487(1) and (2), Florida Statutes.

A. Paid Claims

A sample of 184 paid claims, from a total population of 163,029, was reviewed to determine compliance. However, only 9% of the claims in the sample were related to

mandated benefits. It was determined that a more representative sample was required, and an additional sample of 25 paid claims was reviewed. The additional claims in the sample were selected from a population of mandated benefit claims. Review of the additional claims found that mandated benefits were properly paid. No exceptions were found.

B. Denied Claims

A sample of 184 denied claims, from a total population of 92,742, was reviewed to determine compliance. However, only 5% of the claims in the sample were related to mandated benefits. It was determined that a more representative sample was required, and an additional sample of 25 denied claims was reviewed. The additional claims in the sample were selected from a population of mandated benefit claims.

Review of denied claims identified the following two (2) exceptions:

1) **In 2 of 184 instances the Company failed to pay mandated benefits in violation of Section 627.6515(2)(c), Florida Statutes.** The Company failed to provide newborn services under the Child Health Supervision mandate and a baseline mammogram.

1a.) **CORRECTIVE ACTION:** The Company should ensure that all claims for mandated benefits are properly paid. The claims should be paid with interest.

1b.) **COMPANY RESPONSE:** The Company agreed with these findings.

2) **In 3 of 209 instances the Company failed to pay mandated benefit claims, imposing pre-existing condition limitations on applicants apparently eligible for guaranteed issue coverage, a violation of Section 627.6487(1)&(2), Florida Statutes.** The Company denied 3 mandated benefit claims due to pre-existing conditions where the claimants were eligible for guaranteed issue coverage according to their applications.

2a.) **CORRECTIVE ACTION:** The Company should re-adjudicate these 3 claims without a pre-existing condition limitation if they were HEI's.

2b.) **COMPANY RESPONSE:** The Company will clarify with these customers whether they qualified as HEI's at the time of application. If they were qualified at the time of application, the Company is agreeable to reprocessing the subject claims without a pre-existing condition limitation.

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 that was due on April 1, 2010 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 # of Days to Pay Claims
Major Medical and/or Hospital/Surgical/Medical Expenses								
Individually Underwritten	$ 20,169	$ 427,929	$ 0	N/A	42	31	73	14
Conversions	$ 98,076	$ 689,088	$ 0	N/A	53	11	64	12
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)	$ 37,539	$ (8,878.00)	$ 4,558	N/A	2	0	2	18
Individually Underwritten	$ 7,776,518	$ 21,770,047	$ 2,947,045	56	6,297	3,641	9,938	14
Other Accident and Health Coverages								
Accident Only	$ 113,135	$ 21,146	$ 8,440	0	96	24	120	
Dental	$ 395,501	$ 77,855	$ 21,744	0	955	531	1,486	
Disability Income	$ 274,780	$ 25,268	$ 24,123	0	709	0	709	
Hospital Indemnity	$ 206,868	$ (4,068)	$ 25,799	0	742	433	1,175	
Limited Benefit	$ 770,973	$ (10,660.00)	$ 76,034	0	2,172	1,060	3,232	
Prescription Drug	$ 34,629	$ 18,068	$ 0	0	56	30	86	
Student	$ (9.00)	$ 0	$ 0	0	0	0	0	
Vision	$ 199,885	$ 90,855	$ 17,405	0	2,830	1,889	4,719	
Reconciliation								
Accident and Health Insurance Premiums, Including policy, membership and other fees	**$40,628,068**							

The Examiner reviewed work papers and source documentation to verify the accuracy of the reporting areas required on the GAP submission. There was a variance of $79,901 between the 2009 GAP Filing's Direct Premiums Earned of $40,628,068 and its supporting documentation

provided to the Examiners of $40,707,969. The Company agreed there was a discrepancy between the detail sheet and the GAP Report due to the fact that the numbers come from two accounting systems, but stated that the variance was insignificant. The Company stated that the GAP Report matched the Annual Statement. Although the variance was less than 0.2%, the Company should maintain documentation supporting the numbers filed in the GAP Report and Annual Statement.

ANTI-FRAUD PLAN

The Company has filed its Anti-Fraud Plan with the Division of Insurance Fraud as required by Section 626.9891, Florida Statutes, and Rule 69D-2.001 through 2.005, Florida Administrative Code. All areas of the anti-fraud plan including the Company's employee training reporting procedures, and staffing of the Special Investigative Unit were reviewed. No exceptions 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.