THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

MID-WEST NATIONAL LIFE AND HEALTH INSURANCE COMPANY OF TENNESSEE

AS OF

July 16, 2010

NAIC COMPANY CODE: 66087
NAIC GROUP CODE: 00264

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EXECUTIVE SUMMARY

A target market conduct examination of Mid-West National Life and Health Insurance Company of Tennessee 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 Rule 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
Rule 69O-154.112(6) and (7), F.A.C	Failure to perform reasonable diligence in determining an applicant's eligibility for guaranteed issue coverage.	226	18
627.6515(2)(c), F.S.	Failure to properly pay benefits for baseline mammograms, which are exempt from any deductible. (Paid claims)	209	1
627.6515(2)(c), F.S.	Failure to properly pay benefits for children from birth to age 16, which are exempt from any deductible. (Paid claims)	209	2
627.6515(2)(c), F.S.	Failure to provide policy benefits for children from birth to age 16, which are exempt from any deductible. (Denied claims)	209	1
627.9175, F.S.	Failure to provide supporting documentation for the 2009 GAP 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 Mid-West National Life and Health Insurance Company of Tennessee (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of the target 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 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

Mid-West National Life and Health Insurance Company of Tennessee, a foreign Life and Health insurer domiciled in Texas, was licensed to conduct business in the state of Florida on September 11, 1975. 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	35,334,475	2,164,163
2009	26,417,978	1,735,021

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 on both an individual or group basis. In 2009, a subsidiary of the Company's parent, 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.

Prior to HealthMarkets' exit from the Life Insurance Division business, the Company distributed its life insurance products to the middle-income individuals in the self-employed and senior markets through relationships with two independent marketing companies and independent agents contracted with its insurance subsidiaries. The Company ceded most of the insurance policies associated with the Company's Life Insurance Division effective July 1, 2008.

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 benefits are paid. Additional claims were 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 who 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 Rule 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 the 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 would be 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.

1b.) **CORRECTIVE ACTION:** Since the Company has not marketed new health benefit plans in Florida since August 2010, no corrective action relating 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 applied for, declined, terminated/cancelled, 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 113 denied applications, from a total population of 639, and 113 certificates issued "other than applied for," from a total population of 966, were reviewed.

1) **In 18 of 226 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) and (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 who had answered "yes" to "currently" having insurance. Of these 18 applicants, 15 were denied coverage and 3 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.

Withdrawals

A sample of 79 withdrawn applications, from a total population of 187, 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.

Terminations

A sample of 116 termination/cancellations, from a total population of 7,870, was reviewed to determine whether insureds were offered conversion policies. No exceptions were found.

Conversions

All 45 conversion issued certificates were reviewed to determine whether mandated benefit exclusions or pre-existing exclusions were imposed. No exceptions were found.

Rescissions

All 6 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 or denied based on Section 627.6515 and 627.6487(1) and (2), Florida Statutes.

A. Paid Claims

A sample of 184 paid claims, from a total population of 97,719, was reviewed to determine compliance. However, only 7% 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.

1.) **In 1 of 184 instances the Company failed to properly pay mandated benefits for a baseline mammogram by applying the charges to the insured's deductible, a violation of Section 627.6515(2)(c), Florida Statutes.** Charges for a routine mammogram screening were applied to the insured's deductible.

1a.) CORRECTIVE ACTION: The Company should ensure that all claims for baseline mammograms are properly paid. The claim should be paid with interest.

1b.) COMPANY RESPONSE: The Company agreed with this finding.

2.) In 1 of 184 instances and in 1 of 25 instances, the Company failed to properly pay mandated benefits for children from birth to age 16, which must be exempt from any deductible, a violation of Section 627.6515(2)(c), Florida Statutes. Charges for a routine child health care exam were applied to the insured's deductible.

2a.) CORRECTIVE ACTION: The Company should ensure that all claims for newborn care are properly paid. The claim should be paid with interest.

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

B. Denied Claims

A sample of 184 denied claims, from a total population of 51,433, was reviewed to determine compliance. However, only 2% 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.

1.) **In 1 of 184 instances the Company failed to pay mandated benefits for children from birth to age 16, which are exempt from any deductible, a violation Section 627.6515(2)(c), Florida Statutes.** The Company failed to provide a child well-care vaccination under the Child Health Supervision mandate. Although the diagnosis code was not specific to child vaccine, the CPT procedure codes were specific to chicken pox vaccine and immunization administration.

1b.) **CORRECTIVE ACTION:** The Company should ensure that all claims for newborn care are properly paid. The claim should be paid with interest.

1c.) **COMPANY RESPONSE:** The Company disagreed with this finding. It stated that the claim was filed using an incorrect diagnosis code of V05.8, which is classified as "Other specified disease." In order to consider this charge it would need a correct immunization code to determine eligibility under the mandated benefits.

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 Number of Days to Pay Claims
Major Medical and/or Hospital/Surgical/Medical Expenses								
Individually Underwritten	$ 38,144.00	$ 15,361.00	$ -	N/A	10	3	13	14
Conversions	$ -	$ -	$ -	N/A	0	0	0	0

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)	$ 54,932.00	$ (1,016.00)	$ 1,086.00	N/A	7	0	7	18
Individually Underwritten	$ 25,319,393.00	$ 12,803,256.00	$ 2,118,023.00	24	5,710	3,425	9,135	14
Other Accident and Health Coverages								
Accident Only	$ 56,213.00	$ 325.00	$ 12,675.00	0	73	7	80	0
Dental	$ 123,344.00	$ 26,038.00	$ 17,031.00	0	414	229	643	0
Disability Income	$ 2,662.00	$ 41.00	$ -	0	2	0	2	0
Hospital Indemnity	$ 130,741.00	$ 16,850.00	$ 31,671.00	0	708	359	1,067	0
Limited Benefit	$ 529,004.00	$ 115,508.00	$ 88.919.00	0	2,592	1,052	3,644	0
Prescription Drug	$ -	$ -	$ -	0	0	0	0	0
Student	$ -	$ -	$ -	0	0	0	0	0
Vision	$ 167,331.00	$ 75,734.00	$ 32,674.00	0	2,786	1,974	4,760	0
Reconciliation								
Accident and Health Insurance Premiums, Including policy, membership and other fees	**$ 26,421,764.00**							

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 $25,342 between the 2009 GAP Filing's Direct Premiums Earned of $26,421,764 and its supporting documentation provided to the Examiners of $26,447,106. 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 data 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.