REPORT OF TARGETED MARKET CONDUCT EXAMINATION

OF

UNION SECURITY INSURANCE COMPANY

NAIC# 70408

AS OF

JUNE 30, 2008

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CHRISTINA URIAS
Director of Insurance

Honorable Christina Urias
Director of Insurance
State of Arizona
2910 North 44th Street, Suite 210
Phoenix, Arizona 85108-7269

Dear Director Urias:

Pursuant to your instructions and in conformity with the provisions of the Insurance Laws and Rules of the State of Arizona, a targeted examination has been made of the market affairs of:

UNION SECURITY INSURANCE COMPANY

NAIC # 70408

The above examination was conducted by Sandra Lewis, CIE, MCM, Examiner-in-Charge; James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist; Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner; and Sondra Faye Davis, Market Conduct Examiner.

The examination covered the period of July 1, 2005, through June 30, 2008.

As a result of that examination, the following Report of Examination is respectfully submitted.

Sincerely yours,

Helene I. Tomme

Helene I. Tomme, CPCU, CIE
Market Examinations Supervisor
Market Oversight Division

AFFIDAVIT

STATE OF ARIZONA)
) ss.
County of Maricopa)

I, Sandra Lewis, CIE, MCM, being first duly sworn state that I am a duly appointed Market Conduct Examiner-in-Charge for the Arizona Department of Insurance, and that under my direction and with my participation and the participation of James R. Dargavel, CIE, MCM, Senior Market Conduct Examiner and Data Specialist, Jerry D. Paugh, AIE, MCM, Senior Market Conduct Examiner, and Sondra Faye Davis, Market Conduct Examiner, the examination of Union Security Insurance Company, hereinafter referred to as the "Company" was performed at the offices of the Arizona Department of Insurance. A teleconference meeting with appropriate Company officials was held to discuss the findings set forth in this Report. The information contained in this Report, consisting of the following pages, is true and correct to the best of my knowledge and belief and any conclusions and recommendations contained in and made a part of this Report are such as may be reasonably warranted from the facts disclosed in the Examination Report.

Sandra Lewis

Sandra Lewis, CIE, MCM
Market Conduct Examiner-in-Charge

Subscribed and sworn to before me this 16th day of June, 2010.

Notary Public

My Commission Expires June 1, 2011

OFFICIAL SEAL
AMANDA A. NEFF
NOTARY PUBLIC - State of Arizona
PINAL COUNTY
My Comm. Expires June 1, 2011

FOREWORD

This targeted market examination of Union Security Insurance Company ("Company"), was prepared by employees of the Arizona Department of Insurance ("Department") as well as independent examiners contracting with the Department. A targeted market examination is conducted for the purpose of auditing certain business practices of insurers licensed to conduct the business of insurance in the State of Arizona. The Examiners conducted the examination of the Company in accordance with Arizona Revised Statutes (A.R.S.) §§ 20-142, 20-156, 20-157, 20-158, and 20-159. The findings in this report, including all work products developed in the production of this report, are the sole property of the Department.

During Part 1, the examination consisted of a review of the following components of the Company's major medical health insurance business:

1. The Company conducts a reasonable and timely investigation before denial of claims, and
2. The Company has appropriate procedures in place to identify and correct errors in its claim processing system.

At the conclusion of Part 1, this market conduct examination was expanded (Part 2) to include all aspects of the Company's operations in Arizona, including but not limited to: Advertising, Sales and Marketing, Underwriting, Forms, Claims, Appeals and Grievances, Policyholder Services, and Terminations.

This Report of Examination ("Report") includes the findings from both Part 1 and Part 2, along with the standards of review for each.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Director.

Failure to identify or criticize specific Company practices does not constitute acceptance of those practices by the Department.

SCOPE AND METHODOLOGY

The examination of the Company was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners ("NAIC") and the Department. Part 1 of the targeted market conduct examination of the Company covered the period from July 1, 2005 through June 30, 2006 for the lines of business reviewed. Part 2 of the targeted market conduct examination of the Company covered the period from July 1, 2005 through June 30, 2008. The purpose of the examination was to determine the Company's compliance with Arizona's insurance laws and to determine whether the Company's operations and practices are consistent with the public interest. This examination was completed by applying tests to each examination standard to determine compliance with the standard. The standards applied during Part 1 of the examination are stated in this Report at page 15. The standards applied during Part 2 of the examination are stated in this Report at page 33.

In accordance with Department procedures, the Examiners completed a Preliminary Finding ("PF") on those policies, claims, complaints, and/or procedures not in apparent compliance with Arizona law. The PF forms were submitted for review and comment to the Company representative designated by Company management as being knowledgeable about the files. For each PF, the Company was requested to agree, disagree, or otherwise justify the Company's noted action.

The Examiners utilized both examination-by-test and examination-by-sample. Examination by test involves review of all records within the population, while examination by sample involves the review of a selected number of records from within the population. Due to the small size of some populations examined, examinations by test and by sample were completed as to those populations without the need to utilize computer software.

File sampling was based in part on statistical analysis of raw systems data provided by the Company. Samples were randomly or systematically selected by using ACL (formerly "Audit Command Language") software and computer data files provided by the Company's Representative, Amy Jo Jones, Director, Market Conduct. Samples were tested for compliance with standards established by the NAIC and the Department. The tests applied to sample data resulted in an exception ratio, which determined whether or not a standard was met. If the exception ratio found in the sample was, generally, less than 5%, the standard was considered as

"met." A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

On February 6, 2004, the Company (formerly called Fortis Benefits Insurance Company) entered into a Consent Order, Docket No. 04A-024-INS ("the Consent Order'), wherein the Company agreed to cease and desist certain business practices found to have violated Arizona insurance laws.

PART 1: HEALTHCARE DENIED CLAIMS MARKET CONDUCT EXAMINATION

Examination Period July 1, 2005, through June 30, 2006

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 15, and the examination findings are reported beginning on page 7.

1. The Company failed Standard No. 1 in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to conduct a timely and reasonable investigation of claims before denying claims. Two (13%) of 16 files reviewed for claims denied using Reason codes 0106, 0109 and 0516 failed Standard No. 1.
2. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a) by failing to provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal an adverse decision with regard to four (6%) of 69 files reviewed for claims denied using Reason codes 0005, 0113, and 0384.
3. The Company failed Standard No. 2, in apparent violation of A.R.S. § 20-461(A)(1) and A(15) by failing with regard to two Explanation of Benefits (EOB) forms reviewed, to:
   a. Prominently display appeal information; and
   b. Provide proper time frames for appeal.
4. The Company failed Standard No. 3 in apparent violation of A.R.S. § 20-461(A)(1) by failing, on first party claims not paid within 30 days after the receipt of an acceptable proof of loss by the insurer which contained all information necessary for claim adjudication, to pay interest at the legal rate from the date that the claim was received by the insurer.

PROCEDURES PERFORMED

The Examiners reviewed the Company's appeal policies and procedures, claims manuals, training manuals, and responses to interrogatories in preparation for the file reviews to be conducted.

The Company provided appeal logs indicating it had processed eight appeals from denied claims during the examination period. None of the appeals appeared relative to the scope of this examination and therefore none was selected for review.

The Company provided a population of 6,567 claims denied during the examination period. Using CPT codes and EOB codes identified during the review of denied claim populations, the Examination Data Specialist extracted a subpopulation of 537 denied claims in six categories based on the reasons given for the denial. During the Phase I review, the Examiners selected six random samples totaling 157 files based on the categories of denial codes reasons identified during the claims analysis. Based on the results from the Phase I examination, the Department initiated a Phase II examination of two of the categories of denial reason codes and selected two additional samples totaling 108 denied claims for review. One sample of 53 files was selected from the subpopulation of claims denied as "excluded," and this sample was reviewed under Standard 2 only. A second Phase II sample of 55 files was selected from the subpopulation of claims denied as "not covered," and this sample was reviewed under Standards 1 and 2. Of the 265 denied claims selected for review during Phase I and Phase II, 13 files did not fit the sample criteria. Therefore, a total of 252 files were reviewed during the Phase I and Phase II examinations.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's denied health care claims, the Company failed with regard to claims denied using Reason codes 0106, 0109 and 0516 to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation.	A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F)

Of the six categories of denied claims, the Examiners selected a sample of 16 (100%) from a subpopulation of 16 files denied using reason codes indicating the claim was denied for one of the following reasons: Not related to an illness or injury (code 0106); covered under workers compensation (code 0109); and/or not medically necessary (code 0516). The Company failed to meet the standard for this sample of claims denied using Reason codes 0106, 0109 and 0516 as follows:

The Company failed Standard 1 with regard to two claims (MC-003 and MC-008) claims denied using Reason codes 0106, 0109 and 0516. The Company failed to conduct a reasonable investigation prior to the denial of two (13%) of 16 claims in apparent violation of A.R.S. § 20-461(A)(3) and (4) and A.A.C R20-6-801(F). Reference PF # 004.

The Company coded the services presented on these five claims as "routine" or "not covered" despite diagnosis codes indicating that the services were provided due to injury, illness or to a possible medical condition. In each of these files the ICD-9 code was V82.81 osteoporosis) and the CPT-4 code was 76075 (bone density study). Despite information on the original claim, which indicated that the services were provided for a covered medical condition, the Company denied these claims without investigation to determine if the denied services were covered under the policy.

Summary of Standard 1 Findings

Denied Reason or CPT-4 Code	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0106, 0109, 0516	16	16	2	13%	004

Recommendations

Within 90 days of the filed Report, as prescribed by A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F), the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company conducts timely investigation of claims and does not deny claims without conducting a reasonable investigation;
2. Reprocess the two claim files identified in Preliminary Finding 004 where services were denied for Bone Density Scans (CPT-4 codes 76075) on the basis that the services were routine and preventive to determine whether these claims were denied inappropriately;
3. Perform a self-audit of all denied claims for Bone Density Scans (CPT-4 code 76075) denied during the three years prior to the date of the Report to determine whether other claims have been denied inappropriately and without adequate investigation;
4. Pay restitution including interest for any claim identified from the self-audit as having been denied inappropriately; and
5. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial.

EXAMINATION FINDINGS – FAILED STANDARD 2

Based on the Examiners' review of the Company's denied health care claims and EOB forms, the Company failed to meet the following standard for review with regard to:

1. Claims denied using Reason code 0106;
2. Claims denied using Reason codes 0005, 0113, and 0384: and
3. Two EOB forms.

#	STANDARD	Regulatory Authority
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision.	A.R.S. § 20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a)

Claims Denied Using Reason Codes 0005, 0105, 0107, 0113, 0120, 0384, 0428, 0432, 0514 and 0529

Of the six categories of denied claims, the Examiners selected samples during Phase I and Phase II totaling 82 (32%) files from a subpopulation of 258 files denied using one or more of the following 10 reason codes indicating the claim was denied as "not covered" using the policy. The Examiners determined that 13 of the 82 files selected did not meet the sample criteria, and these files were eliminated from the samples. The Examiners therefore reviewed a total of 69 files denied by the Company as "not covered." The Company failed to meet the standard for claims denied using Reason codes 0005, 0105, 0107, 0113, 0120, 0384, 0428, 0432, 0514 and 0529 as follows:

Four (6%) of 69 claims denied using Reason codes 0005, 0105, 0107, 0113, 0120, 0384, 0428, 0432, 0514 and 0529 were denied by the Company but the denials misrepresented or concealed pertinent facts or policy provisions pertinent to a claim and failed to provide a reasonable explanation along with the specific policy provision relied upon for the denial of the claim in sufficient detail to allow the member and or provider to appeal the adverse decision, all in apparent violation of A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(G)(1)(a). Reference PF # 007 and PF # 010.

- One of the Claims was denied using Reason code 0005, which states: "Benefits are not available for the expense submitted".

- One of the claims was denied using Reason Code 0113, which states: "This type of medical supply/equipment is not covered".
- Two of the claims were denied using Reason code 0384, which states: "This code represents charges for the professional interpretation of test results. You are being billed separately for the technical component, which represents the hospital's staff, equipment and administrative costs. Without further documentation supporting the profession interpretation of this procedure, reimbursement is allowable only for the technical component". The Company admitted that these two claims were denied in error as the denied services were covered under the policy. Since the denial of the claims was improper and since the denied services were covered under the policy, Reason code 0384 misrepresents or conceals pertinent or policy provisions pertinent to a claim.

Subsequent Events

Subsequent to the issuance of Preliminary Findings 007 and 010, the Company provided documentation to show that they had reprocessed the two claims denied using Reason Code 0384. This information was provided to the Department by the Examiners.

EOB Forms

As a result of the review of the EOB forms issued by the Company during the examination period the Examiners identified apparent violations of Standard 2. The Company failed to meet the standard for appeal messages on two EOB forms issued on denied Arizona claims because the forms:

- Failed to prominently display the appeal information in apparent violation of A.R.S. § 20-2533(D); and
- Provided erroneous information about the time allowed for filing a claim in apparent violation of A.R.S. § 20-2535(A). Reference PF # 008.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified, and therefore recommendations are warranted.

Summary of Standard 2 Findings

Denied Reason or CPT-4 Codes	Population	Sample	# of Exceptions	Error Ratio	PF Reference
0005, 0113, 0384	258	69	4	6%	007, 010
EOB Forms	NA	NA	2	NA	008

Recommendations

Within 90 days of the filed Report, as prescribed by A.R.S. § 20-461(A)(1) and (15) and A.A.C. R20-6-801(D)(1) and (G)(1)(a), the Company should:

1. Provide documentation that procedures and controls are in place to ensure that the Company does not misrepresent or conceal pertinent facts or policy provisions pertinent to a claim and provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision;
2. Provide documentation that EOB messages have been modified to prominently display appeal information to comply with A.R.S. § 20-2533(D); and
3. Provide documentation that EOB messages have been modified to correctly state information about the time allowed for filing a claim to comply with A.R.S. § 20-2535(A).

EXAMINATION FINDINGS – FAILED STANDARD 3

Based on the Examiners' review of the information provided by the Company in response to Attachment B-Interrogatories, the Company failed, with regard to claims paid to insured's, to meet the following standard for review:

#	STANDARD	Regulatory Authority
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims.	A.R.S. § 20-462(A)

The Company failed to meet the standard for claims paid to insured's as follows:

The Company's response to request B.13. stated as follows:

> We currently follow the guidelines below for Arizona.
> Interest and Penalty Requirements
> - 10% per year (This is based on the legal rate, unless a different rate is contracted in writing). The 2004 rate currently is being applied and will be updated as necessary.
> - Interest accrues from the date that payment is due to the date that payment is ultimately made.
> - We are only required to pay interest to the provider in AZ. Therefore, interest will not be paid to the insured if they reside in AZ.

Based on information provided by the Company, the Company failed Standard 3 by failing, on first party claims not paid within 30 days after the receipt of an acceptable proof of loss by the insurer which contained all information necessary for claim adjudication, to have procedures in place to pay interest at the legal rate form the date the claim was received by the insurer. Reference PF # 001

Recommendations

The Examiners recommend that, to comply with A.R.S. § 20-462(A), the Company, within 90 days of the filed Report, should:

1. Provide documentation that the Company has appropriate policies and procedures in place for the payment of interest at the legal rate of 10% per annum on all claims submitted by an insured whenever such claims are paid more than 30 days after receipt of adequate proofs of loss, as prescribed by A.R.S. § 20-462(A);
2. Perform a self-audit of all denied claims submitted by insured's, which were paid during the three years prior to the date of the Report, to determine if interest was paid on claims not paid within 30 days after receipt of adequate proofs of loss;

3. Pay interest at the legal rate of 10% per annum from the date that the claim was received until the date that the claim was paid for any claim identified from the self-audit as not having been paid within 30 days of receipt of an acceptable proof of loss; and

4. With each payment of interest, provide a letter indicating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification of claims were interest was owed.

SUMMARY OF PART 1 STANDARDS

#	STANDARD FOR REVIEW	PASS	FAIL
1	The Company conducts timely investigations of claims and does not deny claims without conducting a reasonable investigation, per A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F).		X
2	The Company provides a prompt and reasonable explanation for the denial of a claim in sufficient detail to allow members and providers to appeal an adverse decision, per A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801.		X
3	Where appropriate under the circumstances, the Company pays interest on overturned denied claims, per A.R.S. § 20-462(A).		X

PART 2: EXPANDED MARKET CONDUCT EXAMINATION

Examination Period July 1, 2005, through June 30 2008

EXECUTIVE SUMMARY

This examination was completed by applying tests to each examination standard to determine compliance with the standard. Each standard applied during the examination is stated in this report beginning at page 33, and the examination findings are reported beginning on page 19.

1. The Company failed Standard 1 in apparent violation of A.R.S. § 20-444 and R20-6-201 with regard to seven of 11 group advertising print ads reviewed.
2. The Company failed Standard 4 by using a policy form that failed to provide the required newborn coverage on one group policy certificate of coverage in apparent violation of A.R.S. § 20-1402(A)(2).
3. The Company failed Standard 7 in apparent violation of A.R.S. § 20-2323(A) by failing to provide the required disclosure forms to employers and certificate holders.
4. The Company failed Standard 8 in apparent violation of A.R.S. § 20-2310(E)(1) and the Consent Order by failing to give accurate credit for preexisting conditions to three individuals with proof of creditable coverage.
5. The Company failed Standard 9 in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1204 by using disclosure authorization forms that purport to authorize the release of HIV diagnosis and treatment information, but which fail to provide all of the information required for such a release.
6. The Company failed Standard 10 in apparent violation of A.R.S. §§ 20-2101, et seq., by
    a. Failing to provide a document that satisfies the requirement for a full Notice of Insurance Information Practices document, in apparent violation of A.R.S. § 20-2104(C);
    b. Using disclosure authorization provisions on its applications that failed to comply with the "no more than" 30-month limit prescribed by law, in apparent violation of A.R.S. § 20-2106(7)(a).
7. The Company failed Standard 14 in apparent violation of A.R.S. § 20-461(A)(1) by using letterheads, Explanation of Benefits ("EOB") forms and other claims-related correspondence documents which displayed the brand name "Assurant

Health" and which failed to identify the issuing carrier as Union Security Insurance Company.

8. The Company failed Standard 17 in apparent violation of A.R.S. § 20-191(A) and (B) because the Company failed to give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail.

9. The Company failed Standard 18 in apparent violation of A.R.S. § 20-2309(A) and the Consent Order by failing to provide, at least sixty days before the date of expiration of a health benefits plan, a written notice to the employer of the terms for renewal of the plan that includes an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the employer's health benefits plan contract.

10. The Company passed Standard 11 "With Comment" because it failed to pay interest on one claim not paid for 283 days after receipt of a clean claim, in apparent violation of A.R.S. § 20-3102(A). The Company subsequently paid the interest due, and no other restitution is due.

11. The Company passed Standards 2, 3, 5, 6, 12, 13, 15, and 16.

EXAMINATION FINDINGS – FAILED STANDARD 1

Based on the Examiners' review of the Company's group coverage print advertising, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
1	All advertising and sales materials are in compliance with applicable statutes and rules.	A.R.S. §§ 20-442, 20-443, 20-444, and A.A.C. R20-6-201 and R20-6-201.01

Group Advertising

The Examiners selected a sample of 11 (100%) of 11 group print advertisements used by the Company during the examination period. The Examiners found that seven of the ads failed Standard 1, as follows (see PF # 017-US):

1. The ads contained statements that "Assurant Health provides health insurance coverage for more than one million people nationwide" which does not accurately reflect relevant facts specific to the advertised insurer as Assurant Health is not an insurance company in apparent violation of A.R.S. § 20-444(A) and R20-6-201(P);
2. The ads contained the statement: "In business for more than 110 years, the company is a strong and stable industry leader that provides health insurance coverage to more than one million people nationwide," which misstates pertinent facts about the Company and its standing in the industry, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(P);
3. The source of the statistics relied upon in the ads is not identified in the advertisement, in apparent violation of A.R.S. § 20-444(A) and A.A.C. R20-6-201(F);
4. The ads referenced specific policy benefits such as Preventive Dental Services, Basic Dental Services and Major Dental Services but failed to disclose any related exclusion, reductions or limitations, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(7); and

5. The ads referenced specific policy benefits as indicated above but failed to disclose any exclusion, reduction or limitation applicable to pre-existing conditions, in apparent violation of A.R.S. § 20-444(A) and R20-6-201(C)(9).

Summary of Findings – Standard 1 Advertising Review

Type of Advertising	Population	Sample	Exceptions	Error Ratio	PF #
Group – Print ads	11	11	7	NA	017-US
Totals =	**11**	**11**	**7**	**NA**	

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified; therefore recommendations are warranted.

EXAMINATION FINDINGS – FAILED STANDARD 4

Based on the Examiners' review of the Company's procedure manuals, policy forms, including pertinent applications, policies, rider, endorsements, and other notices in use during the examination period, as well as the examiners' review of samples of New Business, Cancellation, and other underwriting files, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
4	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued.	A.R.S. §§ 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01

Certificates for Policies Issued Outside Arizona

The Examiners reviewed one group certificate form (Form Number C61.100.SIG.AZ) provided by the Company, in response to the Coordinator's Handbook, Attachment A, question II.B, which form was issued in a state other than Arizona. This form stated that the premium for the newly born child's coverage must be paid within 31 days of birth or coverage is not effective from the date of birth.

The Company has failed Standard 4, in apparent violation of A.R.S. § 20-1402(A)(2). See PF # 057-US.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 7

Based on the Examiners' review of the information provided by the Company in response to Attachment A, Section II(K) of the Coordinator's Handbook and a supplemental request for additional information, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
7	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan.	A.R.S. § 20-2323

In response to a request for copies of disclosure forms provided to employers and certificate holders in compliance with A.R.S. § 20-2323, and a description of how and when this disclosure form is provided, the Company did not provide any information concerning outline of coverage and disclosure forms provided to employers and certificate holders when responding to the Coordinator's Handbook.

The Examiners issued a supplemental request for additional information, and the Company advised that it does not have a record of disclosure forms provided to employers and certificate holders.

The Company has failed Standard No. 7 in apparent violation of A.R.S. § 20-2323(A) because the Company does not have a record of disclosure forms provided to employers and certificate holders. See PF # 112-US.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 8

Based on the Examiners' review of the sample of Small Group New Business Issued files provided by the Company in response to Request # 063-US, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
8	The Company does not impose exclusions or limitations for preexisting conditions except as permitted by law.	A.R.S. §§ 20-1379, 20-2308, 20-2310, 20-2321

The Examiners reviewed nine (100%) of nine Small Group New Business Issued files identified by the Company in its responses to the Coordinator's Handbook, Attachment C. In one file, the Examiners identified two individual enrollment certificates of coverage, covering a total of three individuals for group medical insurance, where the Company failed to give the individuals credit for each day that the individuals were covered by creditable coverage. See PF # 154-US. The Company failed Standard 8, apparent violation of A.R.S. § 20-2301(E)(1) and the Consent Order, as follows:

1. The Company failed on one certificate of coverage, covering the insured and a dependent, to reduce the preexisting condition limitation by giving credit for two months of documented coverage under AHCCCS.
2. The Company failed on a second certificate of coverage, covering the insured, to eliminate the preexisting condition limitation based on 12 months of prior coverage documented by the insured.

All three violations were identified in one group file reviewed. On the table below, the term "Exceptions" refers to the number of files found to be out of compliance, not to the number of violations.

Summary of Findings – Standard 10 Underwriting File Review

Sample Description	Population	Sample	Exceptions	Error Ratio	PF #
Small Group NB Issued	9	9	1	11%	154-US
Totals =	**9**	**9**	**1**	**11%**	

An 11% error ratio does not meet the standard; therefore recommendations are warranted.

Subsequent Events

The Examiners issued Request 144-US requesting claim information on the three insureds whose preexisting condition limitations were not reduced based on prior creditable coverage. The purpose of this Request was to determine whether the insureds had been harmed because claims had been denied due to preexisting condition exclusions, but which should have been covered. Based upon the Company's response to the Request no claims were improperly denied due to the Company's failure to reduce the insured's preexisting condition limitation by the amount of prior creditable coverage. Therefore, no restitution appears to be due to any of the three insureds.

EXAMINATION FINDINGS – FAILED STANDARD 9

Based on the Examiners' review of the Company's policy forms provided in response to Attachment A of the Coordinator's Handbook, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
9	The Company obtains prior written consent, using approved consent forms, before conducting tests for HIV or genetic disorders.	A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C)

The Examiners reviewed 54 Small Group New Business Canceled files provided by the Company in response to Request 064-US. Three of the files included medical disclosure authorization forms that purported to authorize the release of information regarding the diagnosis and/or treatment for HIV. See PF # 130-US. The following form numbers were cited:

- Form U4969 (New 2/2005)
- Form U4969 (Rev. 8/2005)
- Form U4918 (Rev. 8/2005)

The forms do not comply with the notice and disclosure requirements of A.A.C. R20-6-1204 in that they do not:

1. Contain the name and address of the person to whom the information is to be disclosed;
2. State the specific purpose for which disclosure is to be made; and/or
3. Limit the time period for the disclosure to no more than 180 days.

The Company has therefore failed Standard 9 in apparent violation of A.R.S. § 20-448.01 and A.A.C. R20-6-1204, by using HIV disclosure authorization forms that do not meet the prescribed format for the release of HIV-related information.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

EXAMINATION FINDINGS – FAILED STANDARD 10

Based on the Examiners' review of the forms, documents, and information provided by the Company in response to the Coordinator's Handbook and supplemental requests for information, as well as New Business and Cancellation/Termination files, the Company failed the following standard for review:

#	STANDARD	Regulatory Authority
10	The Company complies with all notice of insurance information and privacy requirements.	A.R.S. §§ 20-2101, *et seq.*

Notice of Insurance Information Practices

The Company was unable to provide the Examiners with a copy of the full Notice of Insurance Information Practices as prescribed by A.R.S. § 20-2104(C). The Company provided only a "Time Insurance Company" abbreviated Notice allowed by A.R.S. § 20-2104(D). The Company did not produce either a full Notice or an abbreviated Notice for use by "Union Security Insurance Company." Therefore the Company failed Standard 10, in apparent violation of A.R.S. § 20-2104(C), by failing to provide a Notice of Insurance Information Practices that complies with the statutory requirements. See PF # 106-US.

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified.

Disclosure Authorizations

The Company failed Standard 10, in apparent violation of A.R.S. § 20-2106(7)(a) by using disclosure authorization provisions on its applications that failed to comply with the "no more than" 30-month limit prescribed by law in two of two Underwriting Authorization forms provided for review in response to the Coordinator's Handbook and Request # 077-US. The following form numbers were cited:

- 28291 (Rev. 8/2004)
- GD-2872

A standard in the areas of procedures, forms and policy forms use was not met if any exception was identified. See PF #109-US.

EXAMINATION FINDINGS – PASSED STANDARD 11 WITH COMMENT

Based on the Examiners' review of paid and denied claim samples provided by the Company, as well as a review of the Company's claim handling procedures and forms, the Company failed the following standard for review:

#	STANDARD	Regulatory Authority
11	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules.	A.R.S. § 20-3102

Payment of Interest

The Examiners reviewed 110 paid claims from the ACES system and found one file (1%) where the Company failed to pay interest on a claim not paid for 283 days after receipt of a clean claim. A violation rate of 1% passes the Standard, but due to the fact that restitution was owed, the Examiners have included this finding as "passed with comment." See PF # 127-US.

ADOI Claim File Number	Days to Pay Clean Claim	Payment Amount	Interest Due
US-ACESPD-035	283	$ 53.06	$ 3.69

Subsequent Events

The Company provided documentation, including EOB forms and proof of payment, showing that on January 20, 2010, it paid interest in the amount due of $3.69 to the provider that submitted this claim. No further restitution is due.

EXAMINATION FINDINGS – FAILED STANDARD 14

Based on the Examiners' review of the information provided by the Company in response to Attachment A materials of the Coordinator's Handbook, as well as claim sample file reviews, the Company failed to meet the following standard for review:

#	STANDARD	Regulatory Authority
14	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law.	A.R.S. § 20-461, A.A.C. R20-6-801

Failure to Identify Correct Name of Insurer

The Company failed Standard 14, in apparent violation of A.R.S. § 20-461(A)(1) by failing to identify the correct name of the insurer with regard to 52 (47%) of 110 Individual Medical Paid Claims files reviewed. The Company used "Assurant Health" letterheads and/or EOB forms that failed to otherwise identify the issuing carrier as "Union Security Insurance Company." See PF # 126-US.

Summary of Findings – Standard 14 Claim File Review

Description	Population	Sample	Exceptions	Error Ratio	PF #
IM Paid	39,008	110	52	47%	126-US
Totals =	**39,008**	**110**	**52**	**47%**	

A 47% error ratio does not meet the standard; therefore recommendations are warranted.

RECOMMENDATIONS

Within 120 days of the filed date of this Report, the Company should:

1. Perform a self-audit of all policies lapsed during the previous three years to determine whether any claims were denied inappropriately because the Company failed to credit premium payments based on the date premiums were mailed.
2. Pay restitution including interest at the legal rate for any claim identified from the self-audit as having paid without more than 30 days after receipt of a clean claim for which interest was not paid or was not paid in the correct amount; and
3. With each payment of restitution, provide a letter indicating that an audit of claims resulting from an examination by the Arizona Department of Insurance had resulted in the correction of the previous denial. This letter should be approved by the Department prior to its use.

Within 90 days of the filed date of this Report, the Company should provide documentation that procedures and controls are in place to ensure that:

4. All print advertisements, direct sales scripts, television advertisements, and other forms of advertising and/or marketing materials intended for use and/or distribution in Arizona comply with A.R.S. § 20-444 and A.A.C. R20-201, to ensure that these items:
    a. Disclose any related exclusions, reductions, or limitations, including but not limited to those applicable to preexisting conditions for any advertisements and/or marketing materials that describe policy benefits, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(C)(7) and (9);
    b. Do not use the aggregate number of years in business or number of insureds covered for the Company and its sister carriers to indicate the time the Company has been in business or its relative position in the insurance industry, to comply with A.R.S. § 20-444(A) and A.A.C. R20-201(P).
    c. Do not use statistical information in advertising without identifying the source of the information, to comply with A.R.S. § 20-444(A) and A.A.C. R20-6-201(F).

5. All policy forms comply with pertinent Arizona laws, and specifically provides evidence that certificates of coverage issued in Arizona include the correct policy benefits for newborns or newly adopted children to ensure coverage from the date of birth or adoption for 31 days, to comply with A.R.S. § 20-1402(A)(2).
6. The Company issues disclosure forms to employers and certificate holders, to comply with A.R.S. § 20-2323(A).
7. The Company applies accurate credit for documented prior coverage when applying a preexisting condition limitation, to comply with A.R.S. § 20-2310(E)(1) and the Consent Order.
8. The Company ensures that all of the information required for the release of HIV-related information is contained on the release form, to comply with A.R.S. § 20-448.01 and A.A.C. R20-6-1204.
9. The Company has a full Notice of Insurance Information Practices to be provided upon request by an insured, to comply with A.R.S. § 20-2104(C).
10. The Company uses disclosure authorization provisions on its applications that comply with the "no more than" 30-month limit prescribed by law, to comply with A.R.S. § 20-2106(7)(a).
11. The Company properly identifies the correct name of the issuing carrier on all claims-related correspondence with insureds, including but not limited to letters, memoranda, payment instruments, and EOBs, to comply with A.R.S. § 20-461(A).
12. The Company has procedures in place to give credit for premium payments as of the date that they were deposited in the United States mail or as of the date of registration or certification as established by the United States mail, to comply with A.R.S. § 20-191(A) and (B).
13. At least sixty days before the date of expiration of a health benefits plan, the Company provides a written notice to the employer of the terms for renewal of the plan, including an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individuals covered under the employer's health benefits plan contract, to comply with A.R.S. § 20-2309(A) and the Consent Order.

SUMMARY OF PART 2 STANDARDS

A. Advertising, Marketing and Sales

#	STANDARD	PASS	FAIL
1	All advertising and sales materials are in compliance with applicable statutes and rules. (A.R.S. §§ 20-442, 20-443, 20-444, and A.A.C. R20-6-201 and R20-6-201.01)		X
2	The Company markets its products in a fair and nondiscriminatory manner to all eligible individuals and/or groups. (A.R.S. §§ 20-448, 20-2313)	X	
3	The Company discloses information concerning the provisions of coverage, the benefits and the premiums available to small group employers as part of sales materials for its small group employers. (A.R.S. § 20-2304)	X	

B. Underwriting/Portability/Guaranteed Issue

#	STANDARD	PASS	FAIL
4	Policy forms, including but not limited to contracts, certificates, applications, riders, and endorsements, comply with pertinent Arizona laws and/or the laws of the state where the policy was issued. (A.R.S. §§ 20-1342, *et al.*, including but not limited to A.R.S. § 20-1401.01)		X
5	Individual insurance policy forms, except those for which no renewal is provided, contain a 10-day free look provision, which is prominently displayed on the first page of the policy. (A.A.C. R20-6-501)	X	
6	The Company issues coverage to all eligible groups and individuals. (A.R.S. §§ 20-1378, 20-1379, 20-2304, 20-2307, 20-2313, 20-2324)	X	
7	The Company provides approved disclosure of information forms to all group employers prior to executing a contract for coverage under a health care plan. (A.R.S. § 20-2323)		X
8	The Company does not impose exclusions or limitations for preexisting conditions except as permitted by law. (A.R.S. §§ 20-1379, 20-2308, 20-2310, 20-2321)		X
9	The Company obtains prior written consent, using approved consent forms, before conducting tests for HIV or genetic disorders. (A.R.S. §§ 20-448.01, 20-448.02, and A.A.C. R20-6-1203)		X
10	The Company complies with all notice of insurance information and privacy requirements. (A.R.S. §§ 20-2101, *et seq.*)		X

C. Claims Processing

#	STANDARD	PASS	FAIL
11	Claims are handled timely and appropriately in accordance with policy provisions and applicable statutes and rules. (A.R.S. §§ 20-461, 20-462, A.A.C. R20-6-801)	X (With comment)	
12	Claim files are adequately documented in order to be able to reconstruct the claim. (A.R.S. § 20-461 and A.A.C. R20-6-801)	X	
13	All claim forms contain an appropriate fraud warning. (A.R.S. § 20-466.03)	X	
14	The Company provides accurate benefits information to claimants and does not misstate pertinent provisions of the policy or Arizona law. (A.R.S. § 20-461, A.A.C. R20-6-801)		X

D. Policyholder Services

#	STANDARD	PASS	FAIL
15	The Company takes adequate steps to finalize and dispose of the complaints in accordance with policy provisions and applicable statutes and rules. (A.R.S. § 20-461, A.A.C. R20-6-801)	X	
16	The Company provides timely appeals from denied claims and/or denied services and provides appropriate and timely acknowledgments, responses, and notices throughout the appeal process. (A.R.S. §§ 20-2530, *et seq.*)	X	

E. Cancellation, Non-Renewals, and Rescissions

#	STANDARD	PASS	FAIL
17	The Company affords adequate grace periods without cancellation of coverage for the receipt of premiums as required by law. (A.R.S. §§ 20-191 and 20-1347)		X
18	The Company does not cancel, non-renew, or rescind coverage except as allowed by law (A.R.S. §§ 20-448, 20-1342, 20-1346, 20-1347, 20-1378, 20-1380, 20-1402, 20-1404, 20-1411, 20-2110, 20-2309, 20-2321)		X