THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

Division of Insurance

Report on the Limited Scope Market Conduct Examination of

The UICI Insurance Companies

North Richland Hills, Texas

For the Period January 1, 2002 through December 31, 2004

NAIC COMPANY CODES:
97055 MEGA Life and Health Insurance Company
66087 Mid-West National Life Insurance Company of Tennessee

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December 6, 2006

Honorable Julianne M. Bowler
Secretary, Northeastern Zone, NAIC
Commissioner of Insurance
Division of Insurance
Commonwealth of Massachusetts
One South Station
Boston, Massachusetts 02110-2208

Dear Commissioner Bowler:

Pursuant to your instructions and in accordance with Massachusetts General Law, Chapter 175, Section 4, a limited scope examination has been made of the market conduct affairs of

The UICI Insurance Companies
97055 MEGA LIFE AND HEALTH INSURANCE COMPANY
66087 MID-WEST NATIONAL LIFE INSURANCE COMPANY OF TENNESSEE

at its home office located at:

9151 Grapevine Highway
North Richland Hills, TX 76180

The following report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Massachusetts Division of Insurance ("the Division") conducted a limited scope market conduct examination of The UICI Insurance Companies ("the Company" or "UICI") for the period January 1, 2002 to December 31, 2004. The examination was called pursuant to authority in Massachusetts General Law Chapter (M.G.L. c.) 175, Section 4. The market conduct examination was conducted at the direction of, and under the overall management and control of, the market conduct examination staff of the Division. Representatives from the firm of INS Regulatory Insurance Services, Inc. were engaged to complete certain agreed upon procedures.

The claims business area has standards that the examination measured. Some standards have specific statutory guidance, others have specific Company guidelines, and yet others have contractual guidelines. Please note that some business areas in the NAIC Market Conduct Examiners Handbook do not have a Massachusetts statutory basis and have not been included in this examination. The product lines reviewed in this examination were health insurance products.

This examination was limited in scope. Review was confined to Standards in the following business area:

L. Claims

The examination did focus on the methods used by the Company to manage its operations for each of the business areas subject to this examination. This includes an analysis of how the Company communicates its instructions and intentions to its lower echelons, how it measures and monitors the results of those communications, and how it reacts to and modifies its communications based on the resulting findings of the measurement and monitoring activities. The examiners also determine whether this process is dynamic and results in enhanced compliance activities. Because of the predictive value of this form of analysis, focus is then made on those areas in which the process used by management does not appear to be achieving appropriate levels of statutory and regulatory compliance.

This examination report is a report by test rather than a report by exception. This means that all standards tested are described and results indicated.

EXECUTIVE SUMMARY

Mega Life and Health Insurance Company ("MEGA") is an insurer writing health insurance in all states except New York. MEGA is domiciled in the State of Oklahoma. Mid-West National Life Insurance Company of Tennessee ("Mid-West") is an insurer writing health insurance in all states except Maine, New Hampshire, New York and Vermont. Mid-West is domiciled in the State of Tennessee. The UICI Group consisting of the MEGA, the Mid-West and the Chesapeake Life Insurance Company ("Chesapeake") wrote coverage for Massachusetts business covering the period January 1, 2002 to December 31, 2004. Due to the limited writings in Massachusetts for Chesapeake, this Company's business was excluded from the examination.

The Commonwealth has recently conducted a limited scope market conduct examination of the MEGA and Mid-West in which issues found indicated the need for further specific review of MEGA and UICI.

This examination was a limited scope market conduct examination of the Claims business area. All Massachusetts paid and denied/closed without payment claims from MEGA and Mid-West were considered in this review of UICI claims payment practices.[1] During the examination, 5 Standards were tested with 20 testing criteria. Four of the 5 Standards tested, failed.

During the examination a number of critical failures were noted that are in violation of Massachusetts Law and require correction. The principal failures in this examination are listed here but are discussed in detail in the report with required actions noted. The Company:

- Failed to resolve claims submitted to UICI by policyholders and providers in a timely manner in compliance with M.G.L. c. 176D, § 3(9)(c) and M.G.L. c. 176D, § 3(9)(f).
- Failed to respond to claim related correspondence including claim related complaints/grievances in compliance with M.G.L. c. 176D, § 3(9)(b).
- Failed to provide adequate explanations relating to claim denials and partial payments in compliance with M.G.L. c. 176D, § 3(9)(n).
- Failed to provide adequate information regarding covered expenses applied to deductibles, and to properly and accurately apply covered benefits to certificate deductibles in compliance with M.G.L. c. 176D, § 3(9)(a); M.G.L. c. 176D, § 3(9)(e) and M.G.L. c. 176D, § 3(9)(n).

[1] A gross review of all claims revealed that 33% of submitted claims (from a population of 518,243) were listed as denied claims. Additionally, 14% of the total population of denied/closed without payment claims required more than 45 days to process. Finally, 84% of denied claims were found to be benefit related denials. Examiners performed analyses of the denied/closed without payment claims as requested by the Division. Codes and explanations were obtained from the "Reason Denied Crosswalk" listing. This information was used to sort the gross claim data into categories of denials relating to contract benefits. It should be noted that the Company's practice of assigning multiple claim numbers to a single claim event may have tended to skew the accuracy of the percentages derived from the entire population. Examiners had difficulty obtaining complete information from some files provided for a single claim number from the selected sample. It was determined that many of the claim "events" that examiners were attempting to review could only be completely understood when information was included from files relating to other claim numbers. Although not selected in the sample, these claim numbers were part of the single claim event. The Company provided a listing of some 56,000 claim events that contained multiple claim numbers.

- Failed to provide adequate explanations for non-covered portions of claims in compliance with M.G.L. c. 176D, § 3(9)(n).
- Failed to pay benefits under certificates and riders fairly and equitably without discrimination in compliance with M.G.L. c. 176D, § 3(7) and M.G.L. c. 176D, § 3(9)(f).

Required actions have been noted in the report to address these failures and appear in the "Required Actions" listed in the next section.

REQUIRED ACTIONS

It is the opinion of the examiners that the Company be required to take the following actions in order to meet the minimum standards of a company licensed in the Commonwealth:

Required Action L-Intro-1. The Company must implement comprehensive written claim adjudication procedures applicable to Company personnel as well as participating vendors that handle claims and correspondence with customers.

Required Action L-Intro-2. The Company must develop a means to provide a common claim number for a single claim that exceeds the file contents capacity currently resulting in multiple claim numbers for the same file.

Required Action L-03-1. The Company must assure that claim timeliness is compliant with Massachusetts law.

Required Action L-04-1. The Company must assure that communications with claimants is compliant with Massachusetts law.

Required Action L-04-2. The Company must identify and record all instances of customers' communications expressing a complaint/grievance relative to a claim.

Required Action L-05-1. The Company must revise its Explanation of Benefits statements ("EOB") to disclose complete and accurate information to insureds relative to the type and amount of all applicable deductibles as well as the current status of the deductible following claim settlement.

Required Action L-06-1. The Company must prohibit the acceptance and subsequent issuance of certificates where un-authorized alterations are found.

OTHER SIGNIFICANT ISSUES

In addition to the failures noted in the Executive Summary, other significant issues arose during the course of the examination. We found that the Company:

- Failed to maintain adequate documentation to support decisions made. (L-05-1)
- Failed to provide adequate information on EOBs used to deny coverage. (L-06-1)

Recommendations have been made to address the other significant issues identified during the examination. These are noted in the examination report.

HISTORY AND PROFILE

UICI's domestic insurance companies include MEGA, Mid-West and Chesapeake. MEGA is domiciled in Oklahoma and is licensed to issue health, life and annuity insurance policies in all states except New York. Mid-West is domiciled in Tennessee and is licensed to issue similar policies in Puerto Rico and all states except Maine, New Hampshire, New York, and Vermont. Chesapeake, a subsidiary of MEGA, is domiciled in Oklahoma and is licensed to issue health and life insurance policies in all states except New Jersey, New York and Vermont.

UICI offers health and life insurance and selected financial services to niche consumer and institutional markets throughout the United States and Puerto Rico. Its insurance subsidiaries distribute the products primarily through UICI's two dedicated agency field forces: UGA-Association Field Services and Cornerstone America.

The MEGA is domiciled in the State of Oklahoma and was incorporated on November 5, 1981. It commenced doing business on June 15, 1982. Originally incorporated as Etats Corp. in 1981, during 1982 the name was changed to Orange State Life and Health Insurance Company. In 1989, the name was again changed to U.S. Guardian Health Insurance Company and in 1990 the present title was adopted along with the Company being re-domiciled from Florida to Oklahoma.

MEGA mergers include Mark Twain Life Insurance Corporation, Oklahoma, in 1990 and United Group Insurance Company, Texas, in 1994.

During 1990, MEGA assumed substantially all of the business of Mark Twain Life Insurance Corporation, an affiliate. During 1991, MEGA assumed blocks of individual ordinary life business from Underwriters National Assurance Company and Great Fidelity Life Insurance Company. During 1993, assumption of closed annuity block from Mutual Security Life Insurance Company. Effective December 31, 1995, MEGA assumed all of the life, accident and health business of its affiliates, First Life Assurance Company and Southern Educators Life Insurance Company.

Mid-West is domiciled in the State of Tennessee and was incorporated on March 1, 1965. It commenced doing business on May 21, 1965.

UICI recently announced its entrance into the senior market by offering long-term care and Medicare supplement insurance products. Going forward, UICI's mission will be to generate long-term shareholder wealth as a leading provider of health and life insurance and related products, and to serve the self-employed individual, senior citizen and student markets through dedicated distribution channels.

METHODOLOGY

This examination is based on the Standards and Tests for a Market Conduct Examination of a Health Insurer found in Chapter XVII of the NAIC Market Conduct Examiners Handbook. The utilization of this Chapter reflects Massachusetts Insurance Statutes, Rules, and Regulations.

Some standards were measured using a single type of review, while others used a combination or all of the types of review. The types of review used in this examination fall into three general categories. The types of review are: Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook. For statistical purposes, an error tolerance of 7% was used for reviewed samples. The sampling techniques used are based on a 95% confidence level. This means that there is a 95% confidence level that the error percentages shown in the various standards so tested are representative of the entire set of records from which it was drawn. Note that the statistical error tolerance is not indicative of the Division's actual tolerance for deliberate or systemic error.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

The sampling methodology described in the NAIC Market Conduct Examiners Handbook generally calls for a sample of 100 files when the file population being sampled exceeds 5000. This was the case in samples developed for this examination. The Examiners, in discussions with the Company agreed to reduce the sample sizes to 50 for each company in order to reduce the time necessary to complete the review. This was done while maintaining an overall sample size of 100 for paid and denied claims. That is to say, samples of 50 were obtained from both MEGA and Mid-West from the populations of paid and denied claims. This was offered, provided that the Company agreed that the percentage results arising from the reduced sample would be accepted as though the sample size had been the larger sample size. The Company agreed in writing, stating that claim handling procedures were essentially the same for both Companies tested.

Standards were measured using tests designed to adequately measure how the examinee met the standard. The various tests utilized are set forth in the NAIC Market Conduct Examiners Handbook for a Health Insurer. Each standard applied is described and the result of testing is provided under the appropriate standard. The standard, its statutory authority under Massachusetts law, and its source in the NAIC Market Conduct Examiners Handbook are stated and contained within a bold border.

Most Standards are accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and examiner "Observations" are noted.

In some cases a "Required Action" is noted as necessary to bring the Company into compliance with Massachusetts Law. Additionally, other issues have been identified and corrective "Recommendation" made. Comments, Results, Observations, Required Actions and Recommendations are reported with the appropriate Standard.

REVIEW OF PROCEDURES

This is a limited scope examination concentrating on the Company's claims payment practices. However, certain observed deficiencies in procedures were observed in the course of the claims review and have been subject to examiners comments. These areas include complaints/grievances and underwriting and rating.

L. CLAIMS PRACTICES

Introduction

Comments: Evaluation of the Standards in this business area is based on Company response to various information requests and claim files at the Company. In this business area, both paid and denied/closed without payment claims were selected at random from lists provided by UICI.

Observations: Paid Claims: The total population of paid claims from MEGA and Mid-West totaled about 347,000. Examiners reviewed a sample of 100 paid claims, 50 from each company, MEGA and MidWest with agreement from the Company that the results of the reduced sample would be reflective of the entire population. Four standards were tested for each paid claim file. These were Standards L-03, L-04, L-05 and L-06 described below. Note that Standard L-04 was used to catalog instances where there appeared to be an unrecorded complaint/grievance in evidence in a claim file.

Denied/closed without payment claims: Denied/closed without payment claims populations from both companies totaled 171,222. Examiners reviewed a sample of 100 of these claims, 50 from each company, MEGA and MidWest with agreement from the company that the results of the reduced sample would be reflective of the entire population. Four standards were tested for each denied/closed without payment claim file. These were Standards L-03, L-04, L-05 and L-09 described below.

A significant UICI claim handling practice was observed during the course of the examination. Examiners noted UICI's practice of assigning additional, different claim numbers to a single event whenever the claim history screen information filled more than five lines of text. The new claim number was assigned to accept the additional information. The practice distorts the Company's claim count and potentially the confidence level used in the examiner sampling methodology. The Company was apprised of the concerns in writing during the examination.

Examiners additional concerns involve the adequacy of claim documentation provided in a sample file that may, as in this case, involve documentation located under another claim number where examiners would be unaware of its existence.

Examiners also found a correlation between UICI's failure to consistently handle claims within statutory time frames and the percentage of duplicate claim filings. It was observed that one third of the denied/closed without payment claim files tested had been submitted by an insured or a provider on their behalf, more than once and as duplicates were received they were provided with different claim numbers.

Of the total of 200 reviewed files, examiners submitted criticisms on 183 of the paid and denied/closed without payment claim files. A criticism is submitted when, in the opinion of the examiner, the reviewed file contains evidence of a failure in one or more of the measured standards. Following the Company's response to examiner criticisms, it was determined that 114 of the 400 paid claim standards were scored as failed. Additionally, the denied/closed without payment claim file reviews resulted in 45 standards that were scored as failed.

Required Action(s):
1. The Company must implement comprehensive written claim adjudication procedures applicable to Company personnel as well as participating vendors that handle claims and correspondence with customers.

2. The Company must develop a means to provide a common claim number for a single claim that exceeds the file contents capacity currently resulting in multiple claim numbers for the same file.

Recommendation(s):
It is recommended that the Company develop a formal claim adjudication training program for Company personnel to assure compliance with provisions of Massachusetts law.

Standard L-03

NAIC Market Conduct Examiners Handbook - Chapter XVII, §L, Standard 3.
Claims are resolved in a timely manner.
M.G.L. c. 175,§ 108 4(c)

Comments: This standard has a direct insurance statutory requirement. Failure to resolve claims timely can invite "bad faith" actions. In a Company setting, failure to resolve claims timely can result in a migration of providers from the insurer with resultant disruption of service to insureds. M.G.L. c. 175, § 108 4(c) requires claim resolution or written explanation within 45 day of receipt of claim. Review methodology for this standard is by "generic", "sample" and "electronic" review.

Standard L-03 includes five test criteria that must be answered affirmatively in order to be scored an overall "Pass." Any one of the questions receiving a "Fail" score will result in the entire standard failure for that file.
The test criteria are:

A. Are claims resolved in a timely manner?
B. Are reasons for delay appropriate and in accord with MA statute and regulation?

C. Are clean portions of claim paid without delay?
D. Have required delay notices been sent when applicable?
E. Has appropriate interest been paid on claims not paid within applicable time requirements?

Results: **Fail.**

Observations: Random samples of closed paid claims and denied /closed without payment claims were selected and reviewed from the listings of those types of claims made during the examination period.

Table L3-1 **Claims Sample Results**

Type	Sampled	Pass	Fail	NA	% Pass	% Fail
Paid, MEGA,Mid-West	100	80	20	0	**80%**	**20%**
Denied/closed without payment, MEGA,Mid-West	100	80	20	0	**80%**	**20%**
Total	200	160	40	0	**80%**	**20%**

UICI, as a regular business practice, fails to resolve claims in a timely manner. Examiners observed that 20% of the claim files reviewed, required more than the time allowed by statute.[2]

There appear to be inordinate delays between the time a claim form is completed by the provider and its receipt in the Insurance Center. The Insurance Center is the location in North Richland Hills, Texas, where the Association Group business of UICI is processed and serviced. Examiners found direct evidence, in a recently completed examination of MEGA, that this had to do with the vendor re-pricing (discounting the charges). Despite the described process of initially accepting claims only in the Insurance Center, it appears that some claims are first received by the Preferred Provider Organization ("PPO") who is a UICI vendor. UICI appeared only to count the time the claim was in its possession at the Insurance Center (not in the vendor's possession).

UICI admitted that they did not record when the PPO received a claim from the insured. In the course of the file review, UICI conceded that timeliness requirements begin when the claim is received either by the vendor or directly in the Insurance Center.

In response to examiner questions relative to training provided to claim adjudicators, UICI responded that the Company hires only experienced claim examiners, but did not specify what standards were used to evaluate experience. In response to one request for information UICI described a 2-6 week training program where new claims adjusters receive an overview of the various health products including discussions of the certificates and sales brochures.

[2] It was the examiners' intention to review a sample of 100 paid and 100 denied/closed without payment claims from the population of claim numbers provided by the Company. In the course of examiners' review it was discovered that the selection of a claim number did not always result in a claim file that contained all of the documentation examiners would require to accurately determine the timeliness of claims processing. In some instances, the examiner sought more complete information on a claim event by requesting related claim files kept under different claim numbers. If the information contained under a different but related claim number resulted in a failure to pay a claim timely, the selected file was scored as failed even though the complete information was located under more than one claim number.

However, in response to another request, UICI provided conflicting information, indicating a 3-4 week training period.

UICI has stated that a UICI claim manual, associated written procedures and written claim audit procedures do not exist. Written procedures governing the claim adjudicators' prompt pay procedures do not exist. However, examiners were informed that the claims department's verbally communicated procedures require that payment of benefits due for clean claims are to be made no later than 45 calendar days after receipt, in accordance with State regulatory requirements.

UICI stated that they have initiated interest payments on a number of claims, reviewed by examiners, that were found not to have been paid timely and for which interest was due according to M.G.L. c. 175, § 108 4(c).

Required Action(s): The Company must assure that claim timeliness is compliant with Massachusetts law.

Standard L-04

NAIC Market Conduct Examiners Handbook - Chapter XVII, §L, Standard 4.

The Company responds to claim correspondence in a timely manner.

M.G.L. c. 175, § 108-4(c); M.G.L. c. 176D, § 3(10); M.G.L. c. 176O, § 13(a)(4) and (5)

Comments: This standard has direct insurance statutory requirements. See M.G.L. c. 175, § 108-4(c); M.G.L. c. 176D, § 3(10). Massachusetts requires response to claim communications within 45 calendar days of receipt of the communication.

Additionally, M.G.L. c 176O, § 13(a)(4) and(5) requires: " (4) a written acknowledgement of the receipt of a grievance within 15 days and a written resolution of each grievance within 30 days from receipt thereof; and (5) a procedure to accept grievances by telephone, in person, by mail, or by electronic means, provided that an oral grievance made by an insured shall be reduced to writing by the carrier and a copy thereof forwarded to the insured by the carrier within 48 hours of receipt." Review methodology for this standard is by "generic", "sample" and "electronic" review.

Standard L-04 includes one test criteria that must be answered affirmatively in order to be scored an overall "Pass." The test criterion is:

A. Does company respond to claims correspondence in a timely manner?

Results: **Fail.**
Observation: Random samples of closed paid claims were selected and reviewed from the listings of those types of claims made during the examination period. Concerns tested with this Standard include:

- That correspondence related to claims is responded to in accordance with Massachusetts laws including, M.G.L. c. 176D, § 3(10).

Table L4-1 **Claims Sample Results**

Type	Sampled	Pass	Fail	NA	% Pass	% Fail
Closed Paid, MEGA,Mid-West	100	93	7	0	**93%**	**7%**
Denied/closed without payment, MEGA,Mid-West	100	83	17		**83%**	**17%**
Total	200	176	24	0	**88%**	**12%**

UICI was requested to provide information to examiners regarding claims handling procedures and examiner training. Most replies consisted of short statements in memorandum format consisting of one or two paragraphs, unaccompanied by supporting documentation.

In response to examiner requests for procedures relating to examiner training the Company stated: "We do not have any written instructions. It is all verbal. Examiners have 3-4 weeks training and after training they are on 100% audit."

In response to requests for procedures relating to claimant notice of denial the Company stated: "The claims department communicates with a claimant when coverage (sic) for a loss [i. e. a claim for loss] is denied or closed without payment by way of the EOB, written letters, and/or telephone. All claims are handled according to the plan provisions. The claims department makes every effort to adhere to regulatory requirements in its standards for the denial of claims."

It should be noted that there were no specific references to time frame requirements relating to communications with Massachusetts customers nor was there any reference to claim examiner training for identification or documentation of customer complaints whether filed verbally or in writing.

In the course of the examiners' review of the paid and denied /closed without payment claim files, examiners noted evidence of eight verbal complaints among entries in the "Notepad" system. This system is a subset of the UICI image system. It is used to document and store partially transcribed records of telephone conversations. Much of the recorded transcript is in truncated script or coded symbols. This transcription practice made it difficult for examiners to understand the entire content of these entries. However, examiners were able to discern clear expressions of dissatisfaction and complaint among those Notepad entries reviewed.
It was the opinion of examiners that these complaints/grievances were either directly or indirectly related to claim issues.

Among the 100 Paid Claim files there were seven instances where examiners found evidence of customers expressing a complaint/grievance. One additional complaint was noted among the denied/closed without payment claim files. In every instance, the Company disagreed with the examiner assessment of the verbal complaint/grievance.

Taken together, paid and denied claim reviews evidenced unrecorded verbal complaints/grievance in 4% of the files. Considering the total population of paid and denied claims exceeds 518,000 during the exam period, there exists a statistically valid probability that UICI may have received more than 20,000 verbal complaints from claims handling alone.

It appears that the practice of not reporting complaints is extensive but it is equally difficult to fully quantify.

There was little evidence of written communications between the claimant and the Company beyond the EOB. Among the denied/closed without payment claims, it was noted that 12% of claimants were not contacted by the Company within the statutory time period of 45 calendar days.

Required Actions:
1. The Company must assure that communications with claimants is compliant with Massachusetts law.

2. The Company must identify and record all instances of customers' communications expressing a grievance relative to a claim.

Standard L-05

NAIC Market Conduct Examiners Handbook Chapter XVII, §L, Standard 5.

Claim files are adequately documented.

Comments: Without adequate documentation, the various time frames in statute and/or regulation cannot be demonstrated. Review methodology for this standard is by "generic" and "sample" review. Standard L-05 includes two test criteria that must be answered affirmatively in order to be scored an overall "Pass." Any one of the questions receiving a "Fail" score will result in the entire standard failure for that file. The test criteria are:

A. Does claim documentation meet state requirements?
B. Is documentation sufficient to support or justify determination made?

Results: **Fail.**

Observation: Random samples of closed paid claims and denied/closed without payment claims were selected and reviewed from the listings of those types of claims made during the examination period. Concerns tested with this Standard include:

- That the quality of the claim documentation meets Massachusetts requirements; and
- That claim files documentation is sufficient to support or justify the ultimate claim determination.

Table L5-1 **Claims Sample Results**

Type	Sampled	Pass	Fail	NA	% Pass	% Fail
Closed Paid, MEGA,Mid-West	100	42	58		**42%**	**58%**
Denied/closed without payment, MEGA,Mid-West	100	95	5		**95%**	**5%**
Total	200	137	63		**69%**	**31%**

Examiners noted in their review of denied/closed without payment claims, in five (5) of the files, the Company did not provide adequate support for their denied claim decisions. In these instances, UICI did not provide complete claim file documentation. Examiners noted in some, that EOBs were not found and, in others, EOBs did not relate to the claims submitted to the Company. Additionally, it was noted in some of these files that date stamps were missing preventing examiners from determining if responses were made timely.

The paid claim files reviewed by examiners contained only the EOB from which to determine the accuracy of the Company's assessment of the application of paid benefits to a certificate deductible. The EOB contained the assessment, by the Company, that all or a portion of a covered claim was being applied to the claimant's deductible. Nowhere in the sample files was there located a sufficient record of the status of the insureds' coverage in relation to deductibles, nor was there a method for the examiner to ensure that the determination was accurate. Examiners found that the Company failed, in 58 of the selected files, to conform with the adequate documentation standards in L-5. The Company failed to include sufficient information to substantiate accurate claim handling. It was also found that the three files listed as having documentation deficiencies were among the 58 listed with deductible issues.

UICI policies, sold in Massachusetts, contain multiple deductibles both in the certificate and the various riders. Some deductibles are satisfied annually while others are imposed per occurrence. Without ongoing information from the Company to assist a claimant in keeping track of his/her deductible status, it would appear to be extremely difficult for claimants to determine their deductible status with accuracy. Additionally, it was noted in the Mid-West (Practice not noted in MEGA files) file reviews that 7 files or 14% contained evidence of the improper application of benefits to certificate deductibles. This erroneous practice is covered in detail under Standard L-06. Noting this admitted inaccuracy inherent in their claims adjudication processes, it would appear that providing on-going information involving deductibles is of great importance to consumers. It is the examiners' opinion that more complete information relating to deductibles is required to be located in the claim files in order to determine accurately, that covered benefits have been properly applied. The Company's stated position is that Massachusetts statutes do not require that such information be provided to insureds on an EOB.

Required Actions:
1.The Company must revise its Explanation of Benefits statements to disclose complete and accurate information to insureds relative to the type and amount of all applicable deductibles as well as the current status of the deductible following claim settlement.

Recommendations:
1. It is recommended that, in its adoption and implementation of written claim adjudication procedures, the Company include comprehensive file documentation standards.
These should include the accuracy and completeness of information provided to claimants on EOBs as well as date stamp procedures.

Standard L-06

NAIC Market Conduct Examiners Handbook - Chapter XVII, §L, Standard 6.
Claims are properly handled in accordance with policy provisions HIPAA and state law.
M.G.L. c. 175, § 181; M.G.L. c. 176D, § 3(9)(i) M.G.L. c. 176D. § 3(9)(j); M.G.L. c. 176D, § 3(11);

Comments: This standard has direct insurance statutory requirements. M.G.L. c. 175, § 181; deals with misrepresentation of policy terms, M.G.L. c. 176D, § 3(9)(i) deals with the settlement of claims where there was an altered application M.G.L. c. 176D. § 3(9)(j) requires claim settlements be accompanied by a statement setting forth coverage. See also M.G.L. c. 176D, § 3(11) relating to misrepresentations in applications. Review methodology for this standard is by "generic" and "sample" review.

Standard L-06 includes five test criteria that must be answered affirmatively in order to be scored an overall "Pass." Any one of the questions receiving a "Fail" score will result in the entire standard failure for that file. The test criteria are:

A. Has claim been paid to correct payee?
B. Determine if any required explanation of benefit statements are provided to claimants?
C. Reserved for future use
D. Have relevant facts or policy provisions relating to coverages at issue been properly represented?
E. Has claim been handled according to policy provisions?
F. Has Company attempted to settle or settled a claim on the basis of an application that was materially altered without the consent of the insured or where coverage was materially misrepresented at point of sale?

Results: **Fail.**

Observation: Random samples of closed paid claims were selected and reviewed from the listings of those types of claims made during the examination period. Concerns tested with this Standard include:

- That claim handling meets Massachusetts statutes and regulations.
- That coverage was checked for proper application of deductible or appropriate exclusionary language.

Table L6-1 **Claims Sample Results**

Type	Sampled	Pass	Fail	NA	% Pass	% Fail
Closed Paid, MEGA,Mid-West	100	84	16	0	**84%**	**16%**
Total	100	84	16	0	**84%**	**16%**

Five files were noted where policy provisions were not properly represented. In these files, statements in the EOB simply stated "Exceeds Maximum Benefit" without providing information regarding the name of the benefit and the maximum referred to. Claim files in this category also included those containing the statement "This charge is specifically excluded by policy provisions".

This statement, where used, was not accompanied by the actual exclusion referred to in the EOB. This practice is misleading and is in conflict with M.G.L. c. 176D, § 3(9)(j).

Test criterion 6-E requires that claims be settled according to policy provisions. Examiners noted a claims settlement practice involving Mid-West claim files. Amounts applied to the policy deductible were first incorrectly subjected to 80% co-pay. There were seven files where this practice was noted. This represents a 14% failure rate among MidWest files and represents a regular business practice. This claim settlement practice was recognized by the Company as erroneous. This practice resulted in the Company understating the insured's payments to satisfy the certificate deductible. Using this practice, for every $1000 of deductible, it would require an insured to post $1250 of covered charges to satisfy the deductible. This is an unfair practice described in M.G.L. c. 176D, § 3(9)(A).

Test criterion 6-F involves the settlement of claims where the application for insurance coverage had been altered without knowledge or consent of the applicant.
In their review of Paid Claim files (this standard was not applied to denied claims) all original applications were reviewed (applications were not available in 4 of the 100 files). Un-initialed alterations and/or scratch-outs that related to policy benefits were noted in 11 of the files reviewed. This represents 11% of Paid claim files that contained applications that were processed and policies issued from applications altered without authorization of the applicant. These incidents are in conflict with the unfair claims practices statute M.G.L. c. 176D, § 3(9)(i). UICI disagreed with examiners in some cases on the existence of alterations and in others on the importance of the alterations found in the applications.

UICI maintains that altered applications are not problematic in Massachusetts since it is a guaranteed issue state and an alteration will not prevent issuance of the contract. UICI also stated that it is their practice to provide an opportunity for a customer to object to an alteration as they provide a copy of the application in the welcome package following submission of the application to the Company. This is a procedure noted by examiners in the previous MEGA examination that was not consistently applied in their review of the issued policy files.
The statute prohibits claim settlement based on a policy with an altered application. The alterations noted by examiners involved changes affecting coverages and/or deductibles selected on the application. These changes could adversely affect a policyholder's claim regardless of the fact that the policy was guaranteed issue. Supplying copies of the application to proposed insureds does not correct the issue of UICI's non-compliance with Massachusetts statute M.G.L. c. 176D, § 3(11).
In addition to the practice described above, examiners noted 5 instances where the covered benefits were both applied to the certificate's deductible and then paid by one or more of the policy riders. This practice had the effect of "paying" benefits on some claims in excess of the charges submitted. The Company stated, in these instances, that the payment was made by applying eligible charges to the deductible under the base plan.
They were then "rolled to the rider" and considered for benefits under the rider. The company disagreed with the examiners' criticism of this practice, stating that customers are entitled to receive any and all benefits available on the plan purchased.

One example of this was seen in a claim that involved the Doctor Office Visit Rider ("DOV"). The language of the DOV Rider states, "Benefits are not payable under this Rider for any charge to the extent payable under any other Certificate provision or any other Rider. In the event the benefit is duplicated, only one will be paid." Under this context, the Company does not consider a benefit to actually be *paid* when the charges are applied to a deductible. This statement is inconsistent with actual claim payment practices. It is clear that applying a benefit to reduce a scheduled deductible is considered payment of the claim as UICI consistently considers claims to have been "paid" where there was no actual cash payment to the insured.

Reduction of a scheduled deductible represents payment and it clearly precludes the Company from also making payment in the form of applying the same charges under a rider where policy language specifically prohibits such payment. In this case (as well as the other 4 instances) the benefits, including amounts paid in cash and applied to deductible(s) exceed the charges under consideration. This practice violates policy provisions.

Required Actions:
1. The Company must prohibit the acceptance and subsequent issuance of certificates where un-authorized alterations are found.

Recommendations:
1. It is recommended that in its adoption and implementation of written claim adjudication procedures the Company include methods for completely representing certificate coverages in all claims whether paid, denied in part or closed without payment. These written procedures should include standards for the accuracy and completeness of information provided to claimants on EOBs.

2. It is recommended that the Company review all policy forms including riders in order to provide clear, accurate and substantive descriptions of coverages provided under these forms.

Standard L-09

NAIC Market Conduct Examiners Handbook - Chapter XVII, §L, Standard 9.

Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPAA where applicable and Massachusetts law.

M.G.L. c. 176D, § 3(9)(j)

Comments: This standard has a direct insurance statutory requirement M.G.L. c. 176D, § 3(9)(j). The statute requires claim settlements be accompanied by a statement setting forth coverage. Review methodology for this standard is by "generic", "sample" and "electronic" review.

Standard L-09 includes seven test criteria that must be answered affirmatively in order to be scored an overall "Pass." Any one of the questions receiving a "Fail" score will result in the entire standard failure for that file. The test criteria are:

A. Are denied and closed-without-payment claims based on policy provisions and state law?
B. Do notices of claim denial reference specific policy provisions or exclusions?
C. Does company provide claimant with reasonable basis for denial?
D. Does company provide claimant with instructions for having rebuttals to denials reviewed?
E. Does claim handling include proper referral of suspicious claims?
F. Has claim been handled according to policy provisions and HIPAA?
G. Has Company attempted to settle or settled a claim on the basis of an application that was materially altered without the consent of the insured or where coverage was materially misrepresented at point of sale?

Results: **Pass.**

Observation: A random sample of denied/closed without payment claims was selected and reviewed from the listings of claims made during the examination period. Concerns tested with this Standard include:

- That denied and closed-without-payment claims are based on policy provisions and applicable Massachusetts statutes and regulations.
- That notices of claim denials reference specific policy provisions or exclusions.
- That claimants are provided with a reasonable basis for the denial when required by statute or regulation.

Table L9-1 **Claims Sample Results**

Type	Sampled	Pass	Fail	NA	% Pass	% Fail
Closed Denied, MEGA,MidWest	100	97	3		**97%**	**3%**
Total	100	97	3		**97%**	**3%**

Examiners noted three denied claim files contained inadequate information. In two instances there was no reference to the maximum benefit or the maximum deductible that was required to be satisfied. In one file there was no claim number listed. In one file there was an incorrect assessment of benefits that resulted in payment after 223 days. These instances are inconsistent with the provisions of M.G.L. c. 176D, § 3(9)(j).

Recommendations: See first recommendation for Standard L-06.