STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 04A-024-INS
FORTIS BENEFITS INSURANCE COMPANY, NAIC # 70408, Respondent.	**CONSENT ORDER**

Examiners for the Department of Insurance (the "Department") conducted a market conduct examination of Fortis Benefits Insurance Company ("FBIC"). In the Report of Examination of the Market Conduct Affairs of FBIC, the Examiners allege that FBIC violated A.R.S. §§20-461, 20-466.03, 20-448.01, 20-2106, 20-2110, 20-2304,20-2307, 20-2309, 20-2310, 20-2323, 20-2533, 20-2535, 20-2536, 20-3102, and A.A.C. R20-6-210, R20-6-801, and R20-6-1203.

FBIC wishes to resolve this matter without formal proceedings, admits that the following Findings of Fact are true, and consents to the entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. FBIC is authorized to transact life and disability insurance pursuant to a Certificate of Authority issued by the Director.

2. The Examiners were authorized by the Director to conduct a market conduct examination of FBIC. The on-site examination covered the time period from October 1, 2001 to September 30, 2002 and was concluded on May 8, 2003. Based on their findings, the Examiners prepared the "Report of Examination of the Market Conduct Affairs of Fortis Benefits Insurance Company" dated May 8, 2003.

3. The Examiners reviewed all of the forms used by the Company during the

time frame of the examination and found as follows:

a. FBIC used one HIV-related test consent form [95603 Fortis 11/98] that was neither filed nor approved by the Director.

b. FBIC used a non-compliant Summary of Rights letter that was sent in the event of an adverse underwriting decision.

c. FBIC used three claim forms [F32 R301 AZ, F32 R0600 AR, 088 52(R496) AZ] and 29 form letters [ME0041, ME0046, ME0049, ME0081, ME0082, ME0083, ME0095, ME0111, ME0114, ME0116, ME0120, ME0407, DE0603, DE0604, DE0605, DE0606, ME0804, ME0888, ME0889, ME0891, CB0892, CB0895, CB0909, ME0939, ME0940, ME0951, ME0952, ME0986, ME0987] that failed to contain a compliant fraud warning notice.

d. FBIC used one advertising form that failed to disclose:

i. The exceptions, reductions and limitations that affect the basic provisions of the policy.

ii. The extent to which any loss, that is traceable to a preexisting condition, is not covered.

e. FBIC used three advertising forms [Key 516, Key 293, Key 913] that failed to disclose the exceptions, reductions and limitations that affect the basic provisions of the policy.

f. FBIC used one group health certificate [C61.100.SID.AZ] that allowed cancellation of individual coverage for reasons not allowed by statute.

g. FBIC used two group health insurance renewal letters that failed to contain a notice regarding the extent to which the actual or expected claims experience of the group covered under the health benefits plan affected any change in premium.

h. FBIC used one preexisting condition notification letter that failed to

contain all of the required provisions of such notice.

i. FBIC used one employee enrollment form [27085 (Rev. 2/2001)] that failed to include notice that the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

j. FBIC used two claim authorization forms [ME0128, TE-0000099050-001-1-01-00-000] that failed to include notice:

i. That the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

ii. That the authorization remains valid for the duration of the claim.

4. The Examiners reviewed the appeal procedures used by the Company during the time frame of the examination and found that FBIC did not include in its renewal notices, instructions regarding how its members could obtain a replacement packet that explains the appeals process.

5. The Examiners reviewed 11 of 11 group health insurance appeals and 41 of 41 dental care appeals processed by the Company during the time frame of the examination and found as follows:

a. FBIC failed to mail to the member and the member's treating provider within 30 days of receipt of the request for reconsideration a notice of the utilization review agent's decision and the criteria used and the clinical reasons for that decision in three group health insurance appeals.

b. FBIC failed to provide the member and the member's treating provider with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation, and a notice of the option to proceed after the formal appeal process to

an external independent review in three group health insurance appeals.

c. FBIC failed to mail a written acknowledgement, including the information packet described in section 20-2533, to the member and the member's treating provider within five business days after the agent received the formal appeal in three group health insurance and 40 dental care appeals.

d. FBIC failed to notify the member, whose denial relating to a claim that has already been provided, within 60 days of receipt of the written appeal, of the utilization review agent's decision and the criteria used and the clinical reasons for that decision in eight dental care appeals.

e. FBIC, upon denial of a formal appeal and in the event that the agent did not initiate the external review process, failed to provide the member with the notice of the option to proceed to an external independent review in one group health insurance and 22 dental care appeals.

6. The Examiners reviewed the underwriting procedures used by the Company during the time frame of the examination and found as follows:

a. FBIC established eligibility requirements for employees who would be covered under the health benefits plan.

b. FBIC denied or failed to offer coverage to small groups whose employees did not meet the eligibility requirements established by FBIC.

c. FBIC failed to provide applicants and insureds with a compliant disclosure form.

d. FBIC failed to reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage for 13 applicants.

e. FBIC failed to provide a certificate of creditable coverage to 15

terminated group health members within 30 days of the event that triggered the issuance of the certification.

7. The Examiners reviewed 250 of 30,777 small and large group provider claims and 200 of 17,731 group dental provider claims processed by the Company during the time frame of the examination and found that FBIC failed to approve or deny 30 clean provider claims within 30 days of receipt or within the time frame specified in the contract.

8. The Examiners reviewed 129 of 584 short and long term disability claims and 100 of 539 group dental individual claims processed by the Company during the time frame of the examination and found that FBIC failed to:

a. Acknowledge the receipt of 32 claims within ten working days of receipt.

b. Accept or deny 23 claims within 15 working days of receipt of an acceptable proof of loss.

c. Reimburse eight insured's claims at a rate that was consistent with the full amount billed by in-network providers.

CONCLUSIONS OF LAW.

1. FBIC violated A.R.S §20-448.01(B) and A.A.C. R20-6-1203(C) by obtaining written consent for an HIV-related test on a form that was not filed nor approved by the Director.

2. FBIC violated A.R.S §20-2110(A) by using a non-compliant Summary of Rights letter that was used in the event of an adverse underwriting decision.

3. FBIC violated A.R.S §20-466.03 by using claim forms and claim letters that failed to contain a compliant fraud warning notice.

4. FBIC violated A.A.C. R20-6-201(C)(2) by circulating group health

insurance and group dental advertising forms that failed to disclose the exceptions, reductions, and limitations which affect the basic provisions of the policy.

5. FBIC violated A.A.C. R20-6-201(C)(3)(a) by circulating group health insurance advertising forms that failed to disclose the extent to which any loss is not covered if such loss is traceable to a preexisting condition.

6. FBIC violated A.R.S §20-2309(B) by issuing a group health certificate that permits cancellation of individual coverage for reasons other than those permitted by statute.

7. FBIC violated A.R.S §20-2309(A) by failing to include a notice in its group health insurance renewal letters regarding the extent to which the actual or expected claims experience of the group covered by the plan affects any increase in premium.

8. FBIC violated A.R.S §20-2310(K) by failing to include all of the required provisions for a preexisting condition notification letter.

9. FBIC violated A.R.S §20-2106(9) by failing to include in its authorization notice that the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

10. FBIC violated A.R.S §20-2106(8)(a) by failing to include in its authorization notice the correct amount of time that the authorization remains valid.

11. FBIC violated A.R.S §20-2533(C) by failing to include notice in its group health renewal letters that explains how a member could receive a replacement packet that explains the appeals process.

12. FBIC violated A.R.S §20-2535(D) by failing to mail to the member and the member's treating provider within 30 days of receipt of the request for reconsideration a notice of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

13. FBIC violated A.R.S. §20-2535(F) by failing to provide the member and the member's treating provider with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation, and a notice of the option to proceed after the formal appeal process to an external independent review.

14. FBIC violated A.R.S. §20-2536(B) by failing to mail a written acknowledgement, including the information packet described in section 20-2533, to the member and the member's treating provider within five business days after the agent received the formal appeal.

d. FBIC violated A.R.S. §20-2536(E)(2) by failing to notify the member, whose denial relating to a claim that has already been provided, within 60 days of receipt of the written appeal, of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

15. FBIC violated A.R.S. §20-2536(G) by failing to provide the member with the notice of the option to proceed to an external independent review upon denial of a formal appeal and in the event that the agent did not initiate the external review process.

16. FBIC violated A.R.S. § 20-2307(A) by establishing eligibility requirements for employees who would be covered under the health benefits plan.

17. FBIC violated A.R.S. § 20-2304(A) by declining or failing to offer coverage to small employer groups in the event that the group failed to met the eligibility requirements for employees established by FBIC.

18. FBIC violated A.R.S. § 20-2323(A) and (B) by failing to provide applicants and insureds with a compliant disclosure form.

19. FBIC violated A.R.S. § 20-2310(B)(2) by failing to reduce the period of

any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage.

20. FBIC violated A.R.S. § 20-2310(F)(1) by failing to provide a certificate of creditable coverage to terminated members within 30 days of the event that triggered the issuance of the certification.

21. FBIC violated A.R.S. § 20-3102(A) by failing to approve or deny clean provider claims within 30 days of receipt of within the time frame specified in the contract.

22. FBIC violated A.R.S §20-461(A)(5) and A.A.C. R20-6-801(G)(1)(a) by failing to accept or deny a claim within 15 working days of receipt of an acceptable proof of loss.

23. FBIC violated A.R.S §20-461(A)(2) and A.A.C. R20-6-801(E)(1) by failing to acknowledge the receipt of a claim within ten working days of receipt.

24. FBIC violated A.R.S §20-461(A)(6) by failing to reimburse insured's claims at a rate that was consistent with the full amount billed by in-network providers.

25. Grounds exist for the entry of the following Order in accordance with A.R.S. §§ 20-220, 20-456 and 20-2117.

ORDER

IT IS HEREBY ORDERED THAT:

1. FBIC shall cease and desist from:

a. Using an HIV-related test consent form that has not been filed nor approved by the Director.

b. Using claim forms and claim letters that fail to contain a compliant fraud warning notice.

c. Using advertising forms that fail to disclose:

i. The exceptions, reductions, and limitations that affect the basic provisions of the policy.

ii. The extent to which any loss that is traceable to a preexisting condition is not covered.

d. Issuing group health certificates that allow for cancellation of individual coverage for reasons that are not allowed by statute.

e. Failing to include a notice in its group renewal notice regarding the extent to which the actual or expected claims experience of the group covered under the plan, affects any change in premium.

f. Using a non-compliant preexisting condition notification letter.

g. Using enrollment and authorization forms that fail to include notice:

i. That the individual or the individual's authorized representative is entitled to receive a copy of the authorization.

ii. That the authorization remains valid for the duration of the claim.

h. Sending a renewal notice that fails to inform the member how they can obtain a replacement packet regarding the appeals process.

i. Failing to mail a notice of the utilization review agent's decision and the criteria used and the clinical reasons for that decision, to the member and the member's treating provider within 30 days of receipt of the request for reconsideration.

j. Failing to provide the member and the member's treating provider with a written statement of the agent's decision and the criteria used and the clinical reasons for that decision, including any references to any supporting documentation, and a notice of the option to proceed after the formal appeal process to an external independent review.

k. Failing to mail a written acknowledgement, including the information packet described in section 20-2533, to the member and the member's treating provider within five business days after the agent received the formal appeal.

l. Failing to notify the member, whose denial relating to a claim that has already been provided, within 60 days of receipt of the written appeal, of the utilization review agent's decision and the criteria used and the clinical reasons for that decision.

m. Failing to provide the member with the notice of the option to proceed to an external independent review upon denial of a formal appeal and in the event that the agent did not initiate the external review process.

n. Establishing eligibility requirements for employees.

o. Denying or failing to offer coverage to employer groups who fail to meet FBIC's eligibility requirements.

p. Failing to provide applicants and insureds with a compliant disclosure form.

q. Failing to reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage.

r. Failing to provide a certificate of creditable coverage to terminated members within 30 days of the event that triggered the issuance of the certification.

s. Failing to approve or deny provider clean claims within 30 days or within the time frame specified in the contract.

t. Failing to acknowledge the receipt of a claim within ten working days of receipt.

u. Failing to accept or deny a claim with 15 working days of receipt of an acceptable proof of loss.

v. Failing to reimburse insured's claims at a rate that is consistent with the full amount billed by in-network providers.

2. Within 90 days of the filed date of this Order, FBIC shall submit to the Arizona Department of Insurance, for approval, evidence that corrections have been implemented and communicated to the appropriate personnel, regarding the issues outlined in Paragraph 1 of the Order section of this Consent Order. Evidence of corrective action and communication thereof includes, but is not limited to, memos, bulletins, E-mails, correspondence, procedures manuals, print screens, and training materials.

3. FBIC shall re-open and pay all claims listed in Exhibit A of this Order. These insureds were reimbursed at a rate that was inconsistent with the rates that were being charged by in-network providers. FBIC shall also pay interest, at the legal rate of ten percent per annum, calculated from the date that the Company originally received the claim, to the date of payment.

4. Each payment made in accordance with Item 3 above shall be accompanied by a letter to the insured in a form previously approved by the Director. A list of payments, giving the name and address of each party paid, the amount of the payment, the amount of interest paid, and the date of payment, shall be provided to the Department within 90 days of the filed date of this Order.

5. FBIC shall pay a civil penalty of $53,000.00 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §§ 20-220(B) and 20-456. The civil penalty shall be provided to the Market Oversight Division of the Department prior to the filing of this Order.

6. The Report of Examination of the Market Conduct Affairs of Fortis Benefits Insurance Company as of May 8, 2003, including the letter of objection to the Report of Examination, shall be filed with the Department upon the filing of this Order.

DATED at Phoenix, AZ this 6th day of February, 2004.

Christina Urias
Director of Insurance

EXHIBIT A

Violations of A.R.S. § 20-461(A)(6)

Examination ID Number

GDIN 1

GDIN 4

GDIN 5

GDIN 6

GDIN 14

GDIN 15

GDIN 16

GDIN 17

8 Files

CONSENT TO ORDER

1. Fortis Benefits Insurance Company has reviewed the foregoing Order.

2. Fortis Benefits Insurance Company admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Findings of Fact, and consents to the entry of the Conclusions of Law and Order.

3. Fortis Benefits Insurance Company is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. Fortis Benefits Insurance Company irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

4. Fortis Benefits Insurance Company states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. Fortis Benefits Insurance Company acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter and does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Dorothy H. Jensen, who holds the office of Second Vice President and Compliance Officer of Fortis Benefits Insurance Company, is authorized to enter into this Order for them and on their behalf.

FORTIS BENEFITS INSURANCE COMPANY

01/29/2004 By Dorothy H. Jensen
Date

COPY of the foregoing mailed/delivered
this 6th day of February, 2004, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Paul J. Hogan
Market Oversight Administrator
Market Oversight Division
Deloris E. Williamson
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
Alan Griffieth
Chief Financial Examiner
Alexandra Schafer
Assistant Director
Life and Health Division
Terry L. Cooper
Fraud Unit Chief

DEPARTMENT OF INSURANCE
2910 North 44th Street, Suite 210
Phoenix, AZ 85018

Rhonda L. Pierson, Compliance Specialist
Fortis Benefits Insurance Company
P.O. Box 419052
Kansas City, MO 64141-6052