STATE OF ARIZONA
FILED
APR 27 2012
DEPT OF INSURANCE
BY

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 12A-151-INS
GOLDEN RULE INSURANCE COMPANY, NAIC # 62286, Respondent	**CONSENT ORDER**

Examiners for the Department of Insurance ("the Department") conducted a targeted market conduct examination of Golden Rule Insurance Company ("GRIC" or "the Company"). The Report of Targeted Examination of Golden Rule Insurance Company, dated as of December 31, 2009, ("the Report") alleges that the Company has violated Arizona Revised Statutes ("A.R.S.") §§ 20-444(A), 20-448(B), 20-461(A)(3) and (4), 20-1379(L), 20-2110(A), 20-2533(C) and (D), 20-2537(A), and 20-3102, and Arizona Administrative Code ("A.A.C.") R20-6-201(C)(1), (2), (3), (7), (8), and (9), (F) and (P), and R20-6-801(F).

The Company 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. GRIC, an Indiana-domiciled company, is authorized to transact life and disability insurance in Arizona pursuant to a Certificate of Authority issued by the Director.

2. The Director authorized the Examiners to conduct a targeted market conduct examination of the Company. The examination covered the time period from

January 1, 2009, through December 31, 2009, and was concluded on May 24, 2011. Based on the examination findings, the Examiners prepared the Report, dated December 31, 2009.

3. With regard to advertising used during the examination period, the Company:

a. Failed to identify the source of statistics cited, or the time period from which the statistics were derived, in 25 individual medical advertising forms reviewed;

b. Used 36 individual medical advertising forms containing untruthful or misleading statements that did not accurately describe policy benefits or advantages and/or exaggerated policy benefits or advantages;

c. Used one short term medical advertising form that made incomplete and misleading comparisons with COBRA coverage;

d. Used one individual medical advertising form that listed specific policy benefits but failed to disclose a waiting period, related exclusions, reductions and limitations, and/or exclusions, reductions or limitations applicable to preexisting conditions;

4. The Company declined to offer association group individual medical insurance to one applicant on the basis of applicant's age of 64 years and 6 months.

5. With regard to new business issued during the examination period, the Company:

a. Issued 10 certificates out of the sample of 110 Association Group New Business files to HIPAA-eligible individuals subject to a 14-day waiting period while waiving the waiting period for other HIPAA-eligible insureds;

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b. Issued certificates in Arizona that limit benefits for AIDS and AIDS-related claims if AIDS or AIDS-related claims are incurred during the first year of coverage.

6. The Company failed to provide a Summary of Rights in the case of two Association Group applications declined by the Company.

7. The Company may have failed to perform a reasonable investigation before denying seven claims of 55 claims reviewed.

8. The Company used an Explanation of Benefits ("EOB") form that did not include a notice of the right to appeal the denied claim.

9. The Company issued certificates of creditable coverage that failed to provide consumer contact information on the certificate of credible coverage.

10. The Company used an outdated contact phone number for the Department's Consumer Affairs Division on its correspondence and notices related to appeals.

11. The Company failed to provide notice of the right to proceed to an external independent review following two second-level appeals.

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CONCLUSIONS OF LAW

1. The Company violated A.R.S. § 20-444(A) and R20-6-201(F) and (P) by failing to identify the source(s) of statistics or the time period from which the statistics were derived.

2. The Company violated A.R.S. § 20-444(A) and R20-6-201(C)(1), (C)(2) and (C)(3) by using individual medical advertising forms containing untruthful or misleading statements that did not accurately describe policy benefits or advantages and/or exaggerated policy benefits or advantages.

3. The Company violated A.R.S. § 20-444(A) and R20-6-201(C)(1) and (C)(2) by making incomplete and misleading comparisons between Short Term Medical and COBRA coverage.

4. The Company violated A.R.S. § 20-444(A) and R20-6-201(C)(1), (2), (7), (8), and/or (9) by using an advertising form that listed specific policy benefits but failed to disclose a waiting period and other related exclusions, reductions and limitations.

5. The Company violated A.R.S. § 20-448(B) by unfairly discriminating among insureds of the same class and essentially the same hazard by:

a. Declining coverage to an otherwise eligible individual solely on the basis that she was 64.5 years of age;

b. Issuing policies to some HIPAA-eligible insureds subject to a 14-day waiting period while issuing the same coverage to other HIPAA-eligible insureds without the waiting period.

6. The Company violated A.R.S. § 20-2110(A) by failing to provide the required Summary of Rights when declining an application for insurance.

7. The Company violated A.R.S. § 20-461(A)(3) and (4) and A.A.C. R20-6-801(F) by failing to perform a thorough investigation before denying claims.

8. The Company violated A.R.S. § 20-2533(D) by using an Explanation of Benefits ("EOB") form that did not include a notice of the right to appeal the denied claim.

9. The Company violated A.R.S. § 20-1379(L) by using certificates of creditable coverage forms that failed to meet the specifications for consumer inquiry information.

10. The Company violated A.R.S. § 20-2533(C) by failing to provide an updated phone number for the Department's Consumer Affairs Division in an appeals correspondence and notices.

11. The Company violated A.R.S. § 20-2537(A) by failing to provide notice of the right to an external independent review at the conclusion of two second-level appeals.

12. Grounds exist for the entry of the following Order in accordance with A.R.S. §§ 20-220, 20-456, and 20-2117 and 20-2508.

ORDER

IT IS ORDERED THAT:

1. Golden Rule Insurance Company shall:

a. Use marketing materials, advertising, and sales scripts that:

i. Identify the sources of all statistical data used, along with the pertinent time period from which the statistics were derived;

ii. Avoid using words, phrases, and statements that tend to mislead or deceive prospective insureds, including but not limited to the use of incomplete, deceptive, and misleading comparisons between Short Term Medical insurance and COBRA coverage;

iii. Provide the pertinent policy exclusions, reduction or limitations whenever specific benefits are listed;

b. Offer Association Group individual coverage to all individuals under age of 65 years who otherwise meet the underwriting guidelines for the coverage.

c. Waive the 14-day waiting period for all HIPAA-eligible certificates of insurance.

d. Issue new coverage that does not limit benefits for AIDS and AIDS-related claims.

e. Provide the required Summary of Rights to all applicants whose coverage is declined.

f. Perform a reasonable investigation before denying claims.

g. Pay adequate interest on late claims submitted by insureds or providers in accordance with relevant statutory requirements.

h. Use EOB forms that prominently display the notice of the next level of appeal.

i. Issue certificates of creditable coverage that comply with all statutory notice requirements.

j. Provide correct contact information for the Department's Consumer Affairs Division on all correspondences and notices related to appeals of denied claims.

k. Provide accurate information concerning the next level of appeal with every notice of the Company's decision to uphold the denial of a claim.

2. Within 120 days of filed date of this Order, the Company shall:

a. Perform a self-audit for the period of January 1, 2009 to present, of all claims denied because of a diagnosis of "overweight," "obesity," or "morbid obesity," using a reason code indicating that the coverage does not include benefits for weight

modification to determine whether these claims were for procedures, treatment, or services unrelated to weight loss or weight modification.

b. Reprocess all claims identified by the self-audit(s) as having been denied incorrectly.

c. For all reprocessed claims, pay restitution to the insured with interest at the legal rate of 10% in accordance with A.R.S. §§ 20-462(A) or 20-3102.

d. With each such payment, provide a Department-approved letter to the insured stating that an audit of claims following an examination by the Arizona Department of Insurance had resulted in the identification and correction of the previous denial.

3. Within 90 days of the filed date of this Order, the Company shall submit to the Arizona Department of Insurance, for approval, evidence that corrections have been implemented and communicated to the appropriate personnel, regarding all of the items listed above in Paragraph 1 of the Order section of this Consent Order. Evidence of corrective action includes but is not limited to memos, bulletins, emails, correspondence, procedures manuals, print screens and training materials.

4. The Department shall be permitted, through authorized representatives, to verify that The Company has complied with all provisions of this Order.

5. The Company shall pay a civil penalty of $49,000.00 to the Director for deposit in the State General Fund in accordance with A.R.S. § 20-220(B). This civil penalty shall be provided to the Market Conduct Examinations Section of the Department prior to the filing of this Order.

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6. The Report of Examination of the Market Conduct Affairs of Golden Rule Insurance Company dated December 31, 2009 including the letter submitted in response to the Report of Examination, shall be filed with the Department after the Director has filed this Order.

DATED in Arizona this 13th day of April, 2012.

Christina Urias,
Director of Insurance

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CONSENT TO ORDER

1. Golden Rule Insurance Company has reviewed the foregoing Order.

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

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

5. Golden Rule Insurance Company acknowledges that the acceptance of this Order by the Director of Insurance, State of Arizona, is solely to settle this matter against it and does not preclude any other agency or officer of this state or its subdivisions or any other person from any other civil or criminal proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future.

6. Michael Corne, who holds the office of VP of Golden Rule Insurance Company, is authorized to enter into this Order for it and on its behalf.

GOLDEN RULE INSURANCE COMPANY

4/9/2012
Date

By: _____

COPY of the foregoing mailed/delivered
this 27th day of April , 2012, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Helene I. Tomme
Market Examinations Supervisor
Market Oversight Division
Dean Ehler
Assistant Director
Property and Casualty Division
Kurt Regner
Assistant Director
Financial Affairs Division
David Lee
Chief Financial Examiner
Alexandra Shafer
Assistant Director
Life and Health Division
Chuck Gregory
Special Agent Supervisor
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