STATE OF ARIZONA
FILED

JAN 10 2013

DEPT OF INSURANCE
BY

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 13A-012-INS
TIME INSURANCE COMPANY,	
NAIC # 69477,	**CONSENT ORDER**
Respondent	

Examiners for the Department of Insurance ("the Department") conducted a targeted market conduct examination of Time Insurance Company ("TIC" or "the Company"). The Report of Targeted Examination of Time Insurance Company, dated as of June 30, 2008, ("the Report") alleges that the Company has violated Arizona Revised Statutes ("A.R.S.") §§ 20-444, 20-461(A)(1), (3), (4), (15) and (17), 20-462(A), 20-1377(E), 20-1379(L), 20-1401.01, 20-2104(B)(1)(b), 20-2106(7)(a), 20-2110(A) and (D), 20-2323, 20-2533(D), 20-2535(B) and (D), 20-2536(B) and (E)(2), 20-3102, and Arizona Administrative Code ("A.A.C.") R20-6-201, R20-6-801(F), R20-6-1203, and one prior consent order: Consent Order, Docket No. 04A-026-INS dated February 11, 2004, ("Consent Order").

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.

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FINDINGS OF FACT

1. TIC, a Wisconsin-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 July 1, 2005, through June 30, 2008, and was concluded on September 2, 2010. Based on the examination findings, the Examiners prepared the Report, dated June 30, 2008.

3. With regard to the processing of health insurance claims, the Company:

a. Failed to conduct a timely and reasonable investigation before denying claims;

b. Failed to provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal the adverse decision;

c. Failed to adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim and to pay claims within 30 days of the adjudication date;

d. Used Explanation of Benefits ("EOB") forms that:

i. Failed to prominently display the notice of the right to appeal; and

ii. Incorrectly stated the time period for filing a first-level appeal.

e. Failed to pay adequate interest on late claims by adopting policies and procedures that precluded the payment of interest on claims paid directly to the insured.

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4. The Company used marketing materials, advertising and sales scripts that:

a. Made statements implying that Short Term Medical insurance is similar to COBRA without disclosing the differences and possible loss of rights by selecting Short Term Medical insurance instead of COBRA;

b. Referenced policy benefits without disclosing pertinent policy exclusions, reductions and limitations, including but not limited to those applicable to preexisting conditions;

c. Contained unsupported, unsubstantiated and incomplete comparisons with other policies or benefits;

d. Failed to state the name of the insurer or to clearly identify the insurer, and/or used a trade name or insurance group designation; and

e. Failed to identify the source of statistics and contained misleading statements about the time in which claims are processed.

5. The Company used policy forms that:

a. Contained exclusions of benefits for treatment provided by chiropractic physicians;

b. Incorrectly stated the appeal rights prescribed by Arizona law;

6. The Company failed to issue certificates of creditable coverage with respect to terminated policies.

7. The Company failed to give credit for preexisting conditions where the exclusionary period had been satisfied under prior coverage.

8. The Company failed with regard to four employer group certificate of coverage forms to include the notice that states "Notice: This certificate of insurance

may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully."

9. The Company used two group certificate forms that contain subrogation language without a clarification that this provision does not apply in Arizona.

10. The Company used forms entitled Notice and Consent Form for AIDS Virus (HIV) Antibody/Antigen Testing which were not approved by the Department.

11. The Company failed to provide required disclosure forms to employers and certificate holders.

12. With regard to adverse underwriting decisions, the Company:

a. Failed to provide applicants with a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party;

b. Failed to provide the reason(s) for an adverse underwriting decision along with a Summary of Rights to individuals who completed an application; and

c. Used disclosure authorization provisions on its applications that failed to limit disclosures to "no more than" the 30-month limit prescribed by law.

13. With regard to appeal procedures, the Company:

a. Failed to send acknowledgments to appeals within five business days;

b. Failed to resolve the first level appeal within 30 days of receipt; and

c. Failed to resolve second level appeals within 60 days.

14. The Company used health history information collected during the underwriting process and known to the Company prior to the issuance of the coverage, but not included in the application file, to later rescind coverage based on this same information.

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15. The Company failed to include in the renewal notice for group coverage an explanation of the extent to which the increase in premium was due to the actual or expected claims experience of the individuals covered under the plan.

CONCLUSIONS OF LAW

1. The Company violated 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 before denying claims as "not necessary."

2. The Company violated A.R.S. § 20-3102 by failing to adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim.

3. The Company violated A.R.S. §§ 20-461(A)(1) and (15) by failing to provide a reasonable explanation for the denial of claims.

4. The Company violated A.R.S. §§ 20-462(A) and 20-3102, as well as a previous Order of the Director, by failing to pay the correct interest on claims not timely paid.

5. The Company violated A.R.S. § 20-444 and A.A.C. R20-6-201 by using noncomplying marketing materials, advertising, and sales scripts that failed to provide required information, or in the alternative made unsubstantiated claims about the Company's products, operations, and/or relative strength and experience.

6. The Company violated A.R.S. § 20-461(A)(17) by issuing policy forms that exclude coverage for chiropractors.

7. The Company violated A.R.S. § 20-1379(L) and (M) by failing to issue certificates of creditable coverage within 30 days of the termination of policies.

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8. The Company violated A.R.S. § 20-1377(E) by failing to properly credit new insureds for preexisting conditions exclusionary period satisfied under prior coverage.

9. The Company violated A.R.S. § 20-2533(D) by failing to prominently display on its EOB forms the notice of the right to appeal a denied claim.

10. The Company violated A.R.S. § 20-2535(A) and/or 20-2536(A) by incorrectly stating appeal rights, procedures, and time periods within the policy form and on its EOB forms.

11. The Company violated A.R.S. § 20-1401.01 by failing to include the required notice on four employer group certificate forms issued in the State of Arizona for a policy with situs in other states.

12. The Company violated A.R.S. § 20-448.01 and A.A.C. R20-6-1203(C) by using HIV consent forms that had not been prior approved by the Director.

13. The Company violated A.R.S. § 20-2323 by failing to provide the required disclosure forms to employers and certificate holders.

14. The Company violated A.R.S. § 20-2104(B)(1)(b) by failing to provide the applicant with a Notice of Insurance Information at the time it requested personal information from a third party.

15. The Company violated A.R.S. § 20-2110(A) and (D), as well as a previous order of the Director, by failing to provide the reasons for a adverse underwriting decision along with the Summary of Rights prescribed by A.R.S. §§ 20-2108 and 20-2109 to individuals who have completed the application process.

16. The Company violated A.R.S. § 20-2106(7)(a) and Consent Order 2004 by failing to limit disclosure of information on applications to no more than 30 months.

17. The Company violated A.R.S. §§ 20-2535(B) or 20-2536(B) and Consent Order 2004 by failing to acknowledge appeals within five business days.

18. The Company violated A.R.S. § 20-2535(D) by failing to resolve first level appeals within 30 days of receipt.

19. The Company violated A.R.S. § 20-2536(E)(2) by failing to resolve second-level appeals within 60 days of receipt.

20. The Company violated A.R.S. § 20-2309(A) by failing to include in the renewal notice for group coverage an explanation of the extent to which the increase in premium was due to the actual or expected claims experience of the individuals covered under the plan.

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

ORDER

IT IS ORDERED THAT:

1. Time Insurance Company shall:

a. Perform timely and reasonable investigations prior to denying claims;

b. Provide a reasonable explanation for the denial of claims in sufficient detail to allow members and providers to appeal the adverse decision;

c. Adjudicate claims submitted by and paid to providers within 30 days of receipt of a clean claim;

d. Provide accurate information on all policy and EOB forms concerning the appeal process, including but not limited to the time limits for filing appeals;

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

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

i. Disclose pertinent policy exclusions, reductions and limitations; reference "practices" not to cancel small group coverage due to experience;

ii. Avoid using words, phrases, and statements that are not accurate and could mislead prospective insureds, including but not limited to comparisons implying that Short Term Medical insurance is a similar product to COBRA;

iii. Avoid making vague and ambiguous promises regarding the speed and accuracy with which it processes claims, which promises are not supported by verified statistical data; or

iv. Identify the name of the issuing carrier(s) on all advertising and marketing materials.

g. Use policy forms and EOB forms that provide the correct time period for filing a first-level appeal;

h. Use policy forms and EOB forms that prominently display the notice of the right to appeal;

i. Issue certificates of creditable coverage within 30 days of the termination of coverage;

j. Properly credit insureds for preexisting conditions exclusionary periods satisfied under prior coverage;

k. Use policy forms that provide benefits for treatment provided by chiropractic physicians if the services are within the lawful scope of practice of the physician and the insurance coverage includes diagnosis and treatment of the condition or complaint, regardless of the nomenclature used to describe the condition, complaint or service;

l. Provide the required notice on certificates delivered in Arizona for policies issued in other states;

m. Use policy certificate forms that omit subrogation language unless a clarification is included in the policy language that this provision does not apply in Arizona;

n. Provide required disclosure forms to employers and certificate holders;

o. Use HIV testing consent forms that have been approved by the Director;

p. Provide applicants with a copy of the Notice of Insurance Information Practices prior to obtaining personal information from a third party;

q. Provide the reason(s) for an adverse underwriting decision along with a Summary of Rights to individuals who have completed an application;

r. Use application disclosure authorization provisions that limit disclosures to "no more than" 30 months as prescribed by law;

s. Send acknowledgments to appeals within five business days;

t. Resolve the first level appeal within 30 days of receipt;

u. Resolve second level appeals within 60 days;

v. Adopt policies and procedures that 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;

w. Discontinue the practice of relying on health history information collected during the underwriting process but not made part of the application file to later rescind coverage based on that same information known to the Company at the time the policy was issued; and

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x. Fully disclose to applicants using electronic applications the significance of their electronic signature and offer them the opportunity to review and correct the application prior to its submission.

y. Include in the renewal notice for group coverage an explanation of the extent to which the increase in premium was due to the actual or expected claims experience of the individuals covered under the plan.

2. 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.

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

4. The Company shall pay a civil penalty of $60,000.00 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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5. The Report of Examination of the Market Conduct Affairs of Time Insurance Company dated June 30, 2008 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 8th day of January, 2013.

Germaine L. Marks
Director of Insurance
Arizona Department of Insurance

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CONSENT TO ORDER

1. Time Insurance Company has reviewed the foregoing Order.

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

4. Time 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. Time 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. Julia M. Hix, who holds the office of Vice President, Compliance of Time Insurance Company, is authorized to enter into this Order for it and on its behalf.

TIME INSURANCE COMPANY

December 31, 2012
Date

By: _____

COPY of the foregoing mailed/delivered
this 10th day of January, 2013, to:

Germaine L. Marks
Director of Insurance
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
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Julia M. Hix, Vice President, Compliance
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