State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Jorge Gomez, *Commissioner*

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

Fortis Insurance Company
501 West Michigan
Milwaukee, WI 53201

dated March 15 - 29, 2004, and served upon the company on November 9, 2004, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 4th day of March, 2005.

Jorge Gomez
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

FORTIS INSURANCE COMPANY
MILWAUKEE, WISCONSIN

MARCH 15 - 29, 2004

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April 2, 2004

Honorable Jorge Gomez
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted March 15, to March 29, 2004, of:

FORTIS INSURANCE COMPANY

Milwaukee, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

The company is a stock life insurer that was organized and incorporated in Wisconsin on February 11, 1910, as Time Insurance Company, and commenced business on March 6, 1910. In April 1969, Time Holdings, Inc., was formed to become the parent company of Time Insurance Company and enable the marketing of a total package of financial services through various subsidiary organizations. During 1978, control of Time Holdings, Inc., was acquired by N.V. AMEV, a financial services concern located in The Netherlands. During 1992, N.V. AMEV became Fortis AMEV. FIC's direct parent was Interfinancial, Inc., which in turn, was controlled by Fortis, Inc. The ultimate controlling entities were Fortis AG, located in Belgium, and Fortis AMEV. Effective April 1, 1998, Time Insurance Company changed its name to Fortis Insurance Company (Fortis). Effective January 1, 1999, Fortis AG was renamed Fortis (B) and Fortis AMEV was renamed Fortis (NL). Prior to March 1999, FIC had two subsidiaries: Fortis

Benefits Insurance Company (FBIC) and United Family Life Insurance Company (UFLIC). After that date, these became "sibling" affiliated companies of FIC through a dividend transaction. On September 27, 2001, certain changes in the ownership structure occurred. Fortis (B) was replaced by Fortis SA/NV, a Belgian company and Fortis (NL) was replaced by Fortis N.V., a Netherlands company. These two companies own 100% of Fortis Utrecht, a Netherlands company. Fortis Utrecht owns 75% of Fortis N.V. and Fortis Insurance N.V. owns 100% of Fortis, Inc.

The company is a domestic insurer that writes individual business, short term medical insurance, student health insurance, and small group health coverage. The company offers coverage through preferred provider network plans, one of which is the Private healthcare Systems, Inc. (PHCS) network. The company's parent company has an ownership interest in PHCS. The company reported that it had 22,130 PPO enrollees with 13,072 policies written during 2002.

In 2002 Fortis Insurance Company ranked 15th in the individual accident and health insurance business with .2% of the market. It ranked 20th as a small employer health insurance writer with 1.0 % of the business.

National Direct Business to Wisconsin Direct Business Summary

2002	**Life Insurance Premiums**	**Annuity Considerations**	**A&H Insurance Premiums**	**Deposit Type Funds**
Wisconsin	$ 5,566,153	$203,700	$ 52,806,748	$ 2,933,465
National	75,474,341	800,614	1,046,519,747	34,654,607
Wisconsin As a % of National	*7.3%*	*25.4%*	*5.0%*	*8.4%*

2001	**Life Insurance Premiums**	**Annuity Considerations**	**A&H Insurance Premiums**	**Deposit Type Funds**
Wisconsin	$ 6,468,170	$ 57,437	$ 46,136,307	$ 2,632,796
National	82,837,096	652,070	902,011,363	29,346,663
Wisconsin As a % of National	*7.8%*	*8.8%*	*5.1%*	*8.9%*

The majority of the premium written by the company in 2001 and 2002 was for accident and health coverage.

The following tables summarize the premium written and benefits paid in Wisconsin for 2002 and 2001:

Wisconsin Premium and Benefits Paid Summary

2002			
Line of Business	**Premium Written**	**% of WI Total**	**Benefits Paid**
Group Policies	$33,647,818	63.7	$19,930,177
Federal Employees Health Benefits	0	0	0
Credit (Group & Individual)	0	0	0
Collectively Renewable Policies	440	0.1	0
Other Individual Policies	19,158,490	36.2	11,620,400
Total	$52,806,748		$31,550,576

2001			
Line of Business	**Premium Written**	**% of WI Total**	**Benefits Paid**
Group Policies	$26,950,981	58.4	$15,895,230
Federal Employees Health Benefits	0	0	0
Credit (Group & Individual)	0	0	0
Collectively Renewable Policies	400	0.1	0
Other Individual Policies	19,184,926	41.5	10,848,210
Total	$46,136,307		$26,743,440

Complaints

The Office of the Commissioner of Insurance received 211 complaints against Fortis between January 1 2002, through December 31, 2003. A complaint is defined as a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent. The company ranked 4th on the 2002 complaint summary for individual accident and health insurance, with 66 complaints and a complaint ratio of .34 compared to a Wisconsin average of .10 complaints per $100,000 of written premium. The company ranked 26th on the 2002 complaint summary for group accident and health insurance, with 12 complaints and a complaint ratio of .05 compared to a Wisconsin average of .04 complaints per $100,000 of written premium. The majority of the complaints involved claim

handling issues, primarily claim denials and UCR determinations. Thirty one percent of the complaints involved the company's PPO products.

The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

2003						
Reason Type	**Total**	**Underwriting**	**Marketing and Sales**	**Claims**	**Policyholder Service**	**Other**
Coverage Type	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Individual A&H	78	19	2	49	1	7
Group A&H						
PPO	42	4	1	34	3	
Other	7	2	1	2	2	
Total	127	25	4	85	6	7

2002						
Reason Type	**Total**	**Underwriting**	**Marketing and Sales**	**Claims**	**Policyholder Service**	**Other**
Coverage Type	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Individual A&H	81	23	5	40	3	10
Group A&H	5	2		3		
PPO	25	10		14	1	
Other	14	2	3	10		
Total	126	37	8	67	4	10

Grievances

The grievance report for 2001 indicates Fortis received 18 grievances. Six or 33.3% were reversed. The company did not submit detailed information adequate to determine what the majority of the grievances filed with the company in 2001 related to. The grievance report for 2002 indicates Fortis received 712 grievances. 353 or 49% were reversed. The majority of the grievances filed with the company in 2002 were related to plan administration. The significant increase in grievances from 2001 to 2002 is attributable to the manner in which the company was calculating the number of grievances received. The following table summarizes the grievances for the company for the last two years:

2002	
Category	**No.**
Access to Care	0
Continuity of Care	0
Drug & Drug Formulary	11
Emergency Services	0
Experimental Treatment	1
Prior Authorization	51
Not Covered Benefit	158
Not Medically Necessary	24
Other	9
Plan Administration	0
Plan Providers	0
Request for Referral	0
Total	254

Year	Plan Administration	Benefit Denial	Total
2002	0	254	254
2001	0	228	228

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine whether the company's practices and procedures comply with Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2002, through December 31, 2003. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of the company's operations in the areas of producer licensing, small employer group health insurance, individual accident & health insurance, policyholder services, grievances, complaints, underwriting and rating, claims, marketing/sales & advertising, electronic commerce, privacy and managed care.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. CURRENT EXAMINATION FINDINGS

Producer Licensing

The examiners reviewed the company's responses to OCI's producer licensing interrogatories, agency and producer licensing agreements, the company's procedures and practices related to producer licensing, listings, terminations and training and a sample of agent licensing files.

The examiners requested from the company a listing of all Wisconsin agents that represented the company as of the date the listing was run. The agent listing data provided by the company was compared with the agent database maintained by OCI. The examiners found that the company's agent database included 47 agent records in which the license number for active and terminated agents submitted by the company did not match the agent license number in the OCI agent database. The examiners found that company's agent database included 36 agent records where the Social Security number submitted by the company did not match the Social Security number of the agent in OCI's agent database.

The examiners found that the company's agent database include five agent records by either license or Social Security number that did not appear in OCI's database as ever being listed to represent the company. The company attributed the mismatch to various "keying" errors and a failure to update the system on its part but maintained that no business was accepted from these agents. The examiners also found that the company did not reconcile its agent records with the OCI's annual billing statement. Section 628.11, Wis. Stat., requires an insurer to report to the commissioner all appointments, including renewals of appointments, and all terminations of appointments of insurance agents to do business in Wisconsin. Section Ins 6.57 (5), Wis. Adm. Code, provides that no insurer shall accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent listed with that insurer.

1. **Recommendation:** It is recommended that the company revise its producer licensing procedures to include periodic audits of its agent data base for accuracy of information and to annually reconcile its agent listing records with the annual renewal billing statement received from OCI to ensure that the company does not accept business from agents not listed to represent the company in order to document compliance with s. 628.11, Wis. Stat., and s. Ins 6.57 (5) Wis. Adm. Code.

The examiners found that the company's agent database include six agent records that showed the agents as having active listings but that were shown as terminated in OCI's agent database. The company confirmed that all six agents were terminated as inactive per the OCI database and that the company had failed to update its agent database accordingly. The company reported, however, that it did not accept any business from the agents after termination. Section Ins 6.57 (2), Wis. Adm. Code, requires an insurer to notify the OCI prior to or within 30 days of the termination of appointment of an individual intermediary.

2. **Recommendation:** It is recommended that the company revise its producer licensing procedures to ensure that the company notifies the OCI of agent terminations from the company as required by s. 628.11, Wis. Stat., and s. Ins 6.57 (2), Wis. Adm. Code.

The examiners reviewed a random sample of 100 active and terminated agent licensing files. The examiners found that 41 of the terminated agent files reviewed did not contain the required written notice to the agent regarding termination. Section Ins 6.57 (2), Wis. Adm. Code, requires insurers to send written notice to terminated agents advising the agent that he or she is no longer listed as a representative of the company and may not act as a representative of the company. The notice must also include a demand for the return to the company of all indicia of agency.

3. **Recommendation:** It is recommended that the company revise its producer licensing procedures to ensure that agents terminated for any reason are sent the notice required by s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

The examiners reviewed the company's response to OCI's small employer interrogatories, its written policies and procedures for small group business, rating practices, underwriting standards, applications, waiver and disclosure forms and a sample of small employer files for business issued during the period of review.

The examiners found that the company used a brochure for small employer group business entitled, "Employer Administrative Guide," that stated that newborns or acquired dependents may be added without evidence of insurability for medical and dental coverage provided written or verbal notification is received by Fortis within 31 days of the birth or the date of legal dependence. The examiners also found that the "Employer Administrative Guide," contained information regarding the ERISA appeal process but did not include information regarding the grievance process that applies to Wisconsin insureds. The company reported that the guide did not contain state specific information as it was used in states other than Wisconsin. Section 632.895 (5), Wis. Stat., regarding coverage of newborn infants, provides for 60 days of coverage after the date of birth. Section 632.896 (6), Wis. Stat., regarding mandatory coverage of adopted children, provides that the insurance policy shall cover adopted children of the insured and children placed for adoption with the insured, on the same terms and conditions, including exclusions, limitations, deductibles and copayments, as other dependent children. Section Ins 18.03 (3), Wis. Adm. Code, describes the provisions of the grievance procedure that must be utilized by an insurer offering coverage to Wisconsin insureds, including the right to appear in person before the grievance panel to present written or oral information.

4. **Recommendation:** It is recommended that the company either discontinue using the brochure entitled, "Employer Administration Guide," in Wisconsin or revise information in the brochure to comply with the requirements of ss. 632.895 (5) and 632.896, Wis. Stat.

5. **Recommendation:** It is recommended that the company revise the information in its brochure entitled, "Employer Administration Guide" for Wisconsin insureds to comply with the grievance requirements of s. Ins 18.03 (3), Wis. Adm. Code.

The examiners found during the review of the company's small employer rating practices that the company used occupation as a case characteristic when determining rates for small employer groups. Section 635.02, Wis. Stat., prohibits using the case characteristics of a group when determining rates.

6. **Recommendation:** It is recommended that the company revise its small employer rating procedures and discontinue including occupation as a case characteristic when calculating small employer group rates in compliance with the requirements of s. 635.02, Wis. Stat.

7. **Recommendation:** It is recommended that the company identify those groups that were rated incorrectly as a result of this practice, recalculate the rates charged, and issue refunds where necessary in order to comply with s. 632.02, Wis. Stat.

The examiners found that the company reported in its 2002 Small Employer Insurer Actuarial Certification that it issued rates for 33 groups in 2001 that were outside of the rate band. Five groups were below the rate band and twenty-eight groups were above the rate band. The examiners found that the company had not followed up on and recalculated rates for these groups in order to comply with s. Ins 8.52 (3), Wis. Adm. Code.

8. **Recommendation:** It is recommended that the company recalculate the rates for the 33 identified groups that were issued rates in 2001 outside of the rate band, and make refunds where necessary in order to comply with the requirements of s. Ins 8.52, Wis. Adm. Code

The examiners requested from the company a list of small employer quotes made by the company during the period of review in order to select a sample to verify the timeliness of quotes. The examiners found that the company maintained records of quote requests but only recorded the receipt date of a quote request in those situations where the case needed to be reviewed by its underwriting department. Section 601.42, Wis. Stat., requires a company to provide information to OCI in reasonable form as requested by OCI.

9. **Recommendation:** It is recommended that the company revise its procedures for providing quotes for small employer business to include recording the dates

the requests for price quotes are received in order to comply with s. 601.42, Wis. Stat.

The examiners found that the company required that a small employer, as defined by s. 635.02 (7), Wis. Stat., must be in business for a period of 6 months before the employer was eligible to apply for and be issued a group health insurance policy. The company reported that it has been imposing this restriction since 1997. Section 635.19, Wis. Stat., requires an insurer that offers a health benefit plan in the small group market to accept any employer in the state that applies for such coverage.

10. **Recommendation:** It is recommended that the company cease requiring that a small employer be in business for any minimum period of time before being eligible to apply for and to have issued a group health insurance policy in order to comply with the requirements of s. 635.19, Wis. Stat.

The company reported that it had minimum participation requirements for dependents to issue new coverage to small employer groups as referenced in the company's "Small Group Wisconsin State Variations Underwriting/Agent's Guide." The examiners found that the company's practice was more stringent than what the rule allowed because it imposed minimum participation requirements for dependents. The company maintained that this was allowable since s. Ins 8.46 (2), Wis. Adm. Code, has no guidelines with respect to dependent participation. Section Ins. 8.46 (2), Wis. Adm. Code, sets forth the most stringent participation requirements a small employer insurer may impose for new groups and in force policies. The participation requirements in the rule pertain only to eligible employees in the group and do not include dependent participation.

11. **Recommendation:** It is recommended that the company revise its minimum participation requirements for new groups by deleting the minimum participation requirements for dependents to comply with the requirements of s. Ins 8.46 (2), Wis. Adm. Code.

The examiners reviewed a sample of 50 small employer group files where coverage was issued during the period of review. The examiners found that the disclosure notice used by the company referred to a small employer as having 2-25 employees. Section 635.02 (7), Wis.

Stat., defines "small employer" as with respect to a calendar year and a plan year, an employer that employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employees on the first day of the plan year. Section Ins 8.44 (2), Wis. Adm. Code, requires that an insurer send a notice with newly issued policies explaining the circumstances under which the protections of s. 635, Wis. Stat., will cease to apply.

12. **Recommendation:** It is recommended that the company revise the disclosure notice used to satisfy the requirements of s. Ins 8.44 (2), Wis. Adm. Code, to correctly state the number of employees that constitute a small employer group as defined by s. 635.02 (7), Wis. Stat.

Electronic Commerce

The examiners reviewed the company's responses to OCI's electronic commerce interrogatories and the company website www.fortis.com. The company's use of the internet varied depending on the product being marketed. Beginning in June 2003, the company began a very limited internet marketing effort for its individual medical business. At that time the company entered into an agreement with Answer Financial Inc. (AFI) of Encino, California. AFI is a licensed Fortis agent that operated a call center staffed with agents and also displayed Fortis product information and quotes on its website www.answerfinancial.com. Regarding the small group products, the company's websites and links were designed primarily to be used by agents and employees for informational purposes providing product information and network availability. For its specialty products, including short term medical, the company had a fully developed e-commerce site and sells these products on-line to consumers on a direct basis.

The company did not have a single department or position responsible for overseeing its internet activities. Each department controlled its own sites and the IT Inet application services department provided assistance to all departments.

The company allowed agents to establish a link from individual agent websites to the Fortis specialty products internet program ("Program") and to the Fortis specialty products websites for short term medical and/or student select ("SP website"). The company required its agents to sign its specialty products agent internet agreement that included a provision on prior approval of advertising used on the agent's individual website. The examiners found that the company did not have a process in place to monitor individual agent websites for compliance but rather relied on its managing general agents to supervise and monitor agents. The examiners also found that responsibility for oversight of agent websites was not included in the company's managing general agent contracts. Section Ins 3.27 (27), Wis. Adm. Code, makes an insurer responsible for the content form and method of dissemination of all advertisements related to the insurer's products regardless of who creates or uses the advertisement.

13. **Recommendation:** It is recommended that the company implement a process to monitor websites of individual agents that contain material pertaining to the company and its products to ensure compliance with all of the requirements of s. Ins. 3.27, Wis. Adm. Code.

Policyholder Service & Complaints

The examiners reviewed the company's responses to OCI's policyholder service & complaints interrogatories and its complaint handling procedures.

The examiners requested data on complaints received from Wisconsin insureds during the period of review. The examiners found that the company did not have a "formal" definition of a complaint. When an insured called with a complaint, the company instructed the caller to put the complaint in writing. The telephone call regarding the complaint was recorded in the company's Cosmic database as were other policyholder telephone calls and were maintained for a period of seven years. The company was unable to run a report off the Cosmic database to produce a list of complaints received and the examiners were, therefore, unable to review a sample of these complaints. Section Ins 18.01 (2), Wis. Adm. Code, defines "Complaint" means any expression of dissatisfaction expressed to the insurer by the insured, or an insured's authorized representative, about an insurer or its providers with whom the insurer has a direct or indirect contract. Section Ins 18.06 (1), Wis. Adm. Code, requires an insurer that offers a health benefit plan to maintain a record of each complaint received for a period of three years and make these records available for review by OCI during examinations.

14. **Recommendation:** It is recommended that the company revise its procedures to include a formal definition of complaint that complies with the definition in s. Ins 18.01 (2), Wis. Adm. Code.

15. **Recommendation:** It is recommended that the company revise the manner in which it keeps records of complaints so that it can make its complaint records available to OCI for review in order to comply with the requirements of s. Ins 18.06 (1), Wis. Adm. Code.

Grievances & Independent Review

The examiners reviewed the company's responses to OCI's grievance and IRO interrogatory, its written grievance procedures and practices, procedures for handling independent review requests from Wisconsin insureds, grievance experience reports and a sample of grievance files.

Grievances

The examiners found that the company sorted grievances into two categories, "administrative" and "UR/case management." It defined an administrative grievance as involving issues such as benefit limitations, exclusions, pre-existing conditions, and reasonable and customary charges. Administrative grievances were handled by the company's correspondence department. The company defined a UR/case management grievance as involving issues of benefit denials based on medical necessity determinations. This category of grievance was handled by the company's health management department. The company reported that until March 8, 2004, it used a two level grievance appeal process that required an individual to request that a grievance proceed to the second level of review if the grievance was not resolved to the individual's satisfaction at the initial level of review. The examiners found that the company's grievance process requires that the grievant submit a second written request before the grievance is referred to the grievance committee, which does not comply with s. Ins 18.03 (3), Wis. Adm. Code, until the grievance reached this second level of appeal. The company reported that as of May 1, 2003, all UR/case management grievances were handled in a one step process in compliance with Wisconsin requirements. The company reported that as of March 8, 2004, all administrative grievances were handled in a one step process in compliance with Wisconsin requirements.

16. **Recommendation:** It is recommended that the company revise its internal grievance procedure and manuals to comply with all of the requirements of s. Ins 18.03 (3), Wis. Adm. Code.

The examiners found that the company's internal grievance procedure limited the period of time for filing a grievance to 60 days from the date the insured received notification of the determination of a "standard appeal/reconsideration." Section Ins 18.03, Wis. Adm. Code, regarding Wisconsin's grievance procedure does not provide for restricting the length of time for filing a grievance.

The examiners found that the company referred grievances involving quality of care issues to it contracted networks and did not refer the grievances to its grievance committee. Section Ins 18.03, Wis. Adm. Code, provides that an insurer that offers a health benefit plan shall investigate each grievance. A grievance is defined as any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured. Section Ins 18.06, Wis. Adm. Code, provides that each record of each complaint and grievance submitted to the insurer shall be kept and retained for a period of at least 3 years. It also provides that the insurer submit a grievance experience report to the commissioner each year, including information on all grievances received during the previous calendar year.

17. **Recommendation:** It is recommended that the company refer all grievances involving quality issues to its grievance committee, and include these grievances in its annual grievance experience report submitted to the OCI in order to comply with ss. Ins 18.03 and Ins 18.06, Wis. Adm. Code.

18. **Recommendation:** It is recommended that the company revise its written grievance procedures and manuals to remove the provision that limits an insured's right to file a grievance to 60 days from the date the insured receives notification of an initial appeal determination in order to comply with s. Ins 18.03 (3), Wis. Adm. Code.

The examiners reviewed a random sample of 50 grievances received during the period of review. The examiners found three grievance files where the company had not sent

acknowledgement letter to the grievant within 5 business days of the receipt of the grievance by the company. The examiners also found eleven grievance files where acknowledgement letters were not sent at all. Section Ins 18.03 (4), Wis. Adm. Code, provides than an insurer offering a health benefit plan shall, within 5 business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance.

19. **Recommendation:** It is recommended that the company improve its grievance procedures to ensure that grievances are acknowledged with a letter to the grievant within 5 business days of receipt as required by s. Ins 18.03 (4), Wis. Adm. Code.

The examiners found twenty nine grievance files where the company had not sent resolution letters to the grievant and the disposition of the grievance was not apparent. Section 632.83 (3) (d), Stats., provides that the insurer's internal grievance procedure include notification to each grievant of the disposition of his or her grievance and of any correction action taken on the grievance.

20. **Recommendation:** It is recommended that the company revise its grievance procedures to ensure that all grievants, regardless of resolution, are sent a notification of the disposition and corrective action taken as required by s. 632.83 (3) (d), Wis. Stat.

The examiners found one grievance file where the company had not resolved the grievance within 30 days of receipt and had not sent a letter to the grievant explaining why more time was needed to resolve the grievance. Section Ins 18.03 (6), Wis. Adm. Code, provides that an insurer shall resolve a grievance within 30 calendar days of receiving the grievance, or if the insurer is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days, if the insurer provides a written notification to the insured and the insured's authorized representative.

The examiners found 12 grievance files where the company had not notified the grievant of the right to appear in person before the grievance committee and the date of the grievance meeting. Section Ins 18.03 (3) (a), Wis. Adm. Code, provides that an insurer have

method whereby the insured who filed the grievance, or the insured's authorized representative, has the right to appear in person before the grievance panel to present written or oral information. Section Ins 18.03 (3) (b), Wis. Adm. Code, provides that an insurer provide written notification to the insured of the time and place of the grievance meeting at least 7 calendar days before the meeting.

21. **Recommendation:** It is recommended that the company improve its grievance procedure to ensure that grievants are notified of the right to appear at the grievance meeting and the time and place of the meeting in order to comply with s. Ins 18.03 (3) (b), Wis. Adm. Code.

Prior to 2002, Fortis was only reporting to OCI those grievances that were not resolved in the grievant's favor at the initial level of appeal and proceeded to a second level of appeal that involved review by the grievance committee. Section Ins 18.06, Wis. Adm. Code, and s. 632.83 (2) (c), Wis. Stat., requires that an insurer offering a health benefit plan to submit a grievance experience report to the commissioner by March 1 of each year providing information on all grievances received during the previous calendar year. The manner in which the company reported its grievances to OCI prior to 2002 does not comply with these requirements.

22. **Recommendation:** It is recommended that the company revise its procedures for submitting its annual grievance report to OCI to ensure that the reporting process complies with all of the requirements of s. Ins 18.06, Wis. Adm. Code, and s. 632.83 (2) (c), Wis. Stat.

Independent Review (IRO)

The examiners found that the company had developed and implemented policies and procedures to notify insureds of the right to request and obtain an independent review each time it made an adverse determination or an experimental treatment determination. The company reported that all claims that could result in an adverse determination were referred to its health management services department for review and to determine whether to pay or deny the claim. When the review resulted in an adverse determination or an experimental treatment

determination, a notice was sent to the insured that included an explanation of the right to request an independent review.

The examiners found that the company had developed and implemented written policies and procedures for notifying OCI and the independent review organization (IRO) when it received a member's request for an independent review and for submitting all relevant documents to the IRO within the required timeframes. The examiners also found that the company had internal procedures to comply with the determination of the IRO.

The examiners interviewed the company's appeal coordinator regarding its independent review process and identified and reviewed three files in which an insured had requested an independent review. No exceptions were noted regarding the company's IRO process.

Marketing, Sales & Advertising

The examiners reviewed the company's responses to OCI's marketing, sales, and advertising interrogatories, its marketing, sales and advertising activities and advertising file. The company had a marketing department that was divided into small group and individual medical marketing. The company's specialty products department (short term medical) was responsible for its own marketing. The marketing departments were responsible for marketing and advertising and for sales generated by the Fortis health call center. The sales department was responsible for sales generated by independent agents. The company did not have any telemarketing contracts with outside vendors.

The examiners reviewed a random sample of 50 advertisements from the company's advertising file. The examiners found that 25 advertisements did not include a record in the advertising file of the manner and extent of use of the advertisement and that none of the advertisements reviewed indicated the policy number associated with the advertisement. The company reported that most of its advertisements were not for state specific products and therefore a record of the manner and extent of use and associated policy number was not maintained. The company did maintain a record of the manner and extent of use of its advertisements related to Wisconsin small employer health insurance products that satisfy the regulation. The examiners found that the company did not have written procedures regarding the maintenance of its advertising files. Section Ins 3.27 (28), Wis. Adm. Code, requires an insurer to maintain an advertising file with copies of all advertisements. The advertising file must include a record of the manner and extent of use of each advertisement as well as the policy number associated with the advertisement.

23. **Recommendation:** It is recommended that the company revise the manner it maintains its advertising file to comply with the requirements of s. Ins 3.27 (28), Wis. Adm. Code.

24. **Recommendation:** It is recommended that the company develop written procedures regarding the maintenance of the advertising file in order to comply with s. Ins 3.27 (28), Wis. Adm. Code.

Underwriting & Rating

The examiners reviewed the company's responses to OCI's new business & underwriting interrogatories, underwriting manuals, rating manuals, applications, premium, lapse and termination notices, and a sample of applications for individual accident & sickness coverage issued and denied during the period of review. The company had separate underwriting departments for its small employer group health and individual health products. The findings in this section are related to the individual health product only.

The examiners' interrogatory review found that when the application for individual accident and sickness products indicated applicant was replacing existing coverage, the company did not provide to the applicant a replacement notice. The examiners also found during their file review that three files did not contain a replacement notice signed by the applicant. Section Ins 3.29 (6), Wis. Adm. Code, requires that in situations where an applicant for individual accident and sickness is replacing existing coverage, the insurer or its agent must provide the applicant, at the time of application, with a notice advising the applicant of the consequences of replacing the existing coverage.

25. **Recommendation:** It is recommended that the company develop and use the replacement notice required by s. Ins 3.29 (6), Wis. Adm. Code, and that the content of the notice comply with all of the disclosure requirements of s. Ins 3.29 (7), Wis. Adm. Code.

The examiners reviewed a random sample of 50 individual policies issued during the period of review. The examiners found that the company had accepted eight applications from and paid commissions to two agents who were not listed with the company. Section 628.11, Wis. Stat., provides than an insurer shall report to the commissioner all appointments, including renewals of appointments, and all terminations of appointments of insurance agents to do business in Wisconsin. Section Ins 6.57 (5), Wis. Adm. Code, provides that no intermediary shall submit an application for insurance directly to an insurer or solicit insurance on behalf of a particular insurer or enter into an agency contract unless the agent is listed with that insurer.

26. Recommendation: It is recommended that the company improve its procedures to ensure that it does not accept business from nor pay commissions to agents not listed with the company in order to comply with s. Ins 6.57 (5), Wis. Adm. Code.

The examiners found that the company accepted two applications signed by someone other than the writing agent. The name of the writing agent appeared on the "licensed agent name" line and the name of another person appeared on the "licensed agent's signature" line. The company reported that these applications resulted from its relationship with State Farm Mutual Insurance Company agents. The company reported that State Farm agents had sales assistant personnel who were licensed insurance agents and were appointed on behalf of the company (Fortis). The two applications in question were signed by a sales assistant of a State Farm agent. The company stated that it required that the agent of record sign the application. The examiners found that the applications were inconsistent with the company's procedures for accepting business from State Farm agents, and did not comply with s. 628.34 (1), Wis. Stat.

27. Recommendation: It is recommended that the company process applications consistent with its internal procedures and that it review and provide additional information to State Farm agents regarding the company's requirement that the agent of record sign the application in order to comply with s. 628.34 (1), Wis. Stat.

The examiners reviewed a random sample of 50 applications for individual accident and sickness policies where coverage was declined due to medical underwriting. The examiners found that four files did not document that the company had sent letters to the applicants declined due to medical underwriting considerations, which included the required HIRSP notice and information. Section 632.785, Wis. Stat., requires that if an insurer declines an applicant for coverage due to medical underwriting considerations, the insurer must provide the applicant with information regarding eligibility requirements for the Health Insurance Risk Sharing Plan (HIRSP).

28. Recommendation: It is recommended that the company revise its procedures to provide the required HIRSP notice and information to individual accident & sickness applicants who are declined coverage due to medical underwriting considerations in compliance with s. 632.785, Wis. Stat.

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claim procedure manuals, internal audit reports, and explanation of benefit (EOB) and remittance advice (RA) forms. ANSI codes and claim payment methodology. and a sample of 300 paid and denied claims filed during the period of review.

The company's prescription drug benefits were processed through two vendors, Express Scripts and Medco Health. The examiners found that the EOB forms used by Express Scripts and Medco Health did include information for insureds regarding the right to file a grievance. Section Ins 18.03 (2), Wis. Adm. Code, requires that each time an insurer offering a health benefit plan denies a claim, the affected insured must be advised of their right to file a grievance. The examiners also found that EOB forms used by Express Scripts and Medco Health did not substantially comply with the requirements of s. Ins 3.651 (4), Wis. Adm. Code, in that the EOB's codes did not use American national standards institute (ANSI) codes as claims adjustment reason codes.

29. **Recommendation:** It is recommended that the EOBs used by the company's prescription drug vendors be revised to include information on the right to file a grievance in order to comply with the requirements of s. Ins 18.03 (2), Wis. Adm. Code.

30. **Recommendation:** It is recommended that the company establish a written procedure to ensure that vendors who utilize their own explanation of benefit forms (EOBs) are made aware of the requirements of s. Ins 3.651 (4), Wis. Adm. Code, and use of ANSI codes as claim adjustment reason codes in their EOBs.

The examiners reviewed a random sample of 150 paid and 150 denied claims and found that eight claims did not include in the remittance advice (RA) to health care providers ANSI codes as claim adjustment reason codes. Section Ins 3.651 (3), Wis. Adm. Code, requires that RA for each claim include "claim adjustment reason codes", which are defined as ANSI codes.

31. **Recommendation:** It is recommended that the company institute a process for periodically testing and auditing its claim system programs to ensure that its

tables accurately report ANSI codes on Remittance Advice (RA) forms for health care providers in order to comply with s. Ins 3.651 (3), Wis. Adm. Code.

The examiners reviewed a random sample of 50 paid claims for chiropractic services. The examiners found that the company had not paid interest on two chiropractic claims not paid within 30 days of receipt. Section 628.46, Wis. Stat., requires that claims not paid within 30 days of receipt when an insurer has all the necessary information to establish its liability, are subject to interest at a rate of 12% per annum.

32. **Recommendation:** It is recommended that the company improve its claims processing procedures to ensure that interest is paid on claims that are not paid within 30 days of receipt of sufficient information to establish liability as required by s. 628.46, Wis. Stat.

The examiners found that the company did not have written procedures in place for handling requests from insureds for information regarding claim payment methodology. The examiners also found that the company did not provide insured's the specific amount allowable for a specific procedure on a prospective basis, rather the company advised the insured if the amount the provider was charging was within or over the UCR amount. Section Ins 3.60 (6), Wis. Adm. Code, requires an insurer that settles claims based on a specific methodology including usual, customary and reasonable charges (UCR), to provide insureds with certain information concerning the methodology used upon the insured's request. Section Ins 3.60 (6) (a) 2., Wis. Adm. Code, specifically requires insurers to provide the insured with the amount allowable under the insurer's guidelines for determination of the eligible amount of a provider's charge for a specific health care procedure or service in a given geographic area.

33. **Recommendation:** It is recommended that the company develop written procedures on how to handle requests from insureds for UCR information and that the company disclose to insureds the information required by s. Ins 3.60 (6) (a) 2., Wis. Adm. Code.

The examiners reviewed a sample of 50 denied claims for chiropractic services. The examiners found that the company could not produce evidence regarding four denied

chiropractic that the denied claims were reviewed by a chiropractor and letters of explanation sent to the insured and treating chiropractor as required by s. 632.875 (2) and (3), Wis. Stat.

34. **Recommendation:** It is recommended that the company revise its claim processing procedures to ensure that denied chiropractic service claims are reviewed and handled as required by s. 632.875 (2) and (3), Wis. Stat.

Privacy and Confidentiality

Section 610.70, Wis. Stat., regarding medical records privacy, became effective June 1, 1999, and created restrictions on insurers regarding their collection and release of personal medical information that correspond with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements. Chapter Ins 25, Wis. Adm. Code, became effective July 1, 2001, to address the provisions of Gramm Leach Bliley, and is based on the National Association of Insurance Commissioners (NAIC) privacy of consumer financial and health information model regulation.

The examiners reviewed the company's responses to OCI's privacy of consumer financial and information interrogatory, company training manuals and procedures for employees regarding treatment of personally identifiable information, the company's privacy notice, enrollment and disclosure informational forms and privacy agreements for employees. The examiners also interviewed the company's privacy officer.

Implementation of the company's privacy standards through its privacy project was overseen by the company's HIPAA program board chaired by the general counsel. Board members included the chief executive officer, the chief financial officer, the chief administrative officer, the chief information officer, the chief marketing officer and the senior vice president of human resources. The company's senior general counsel served as the privacy officer and was responsible for oversight of the company's privacy policy.

The company reported that certain employees had off-site access to personally identifiable enrollee financial or health information. The majority of employees with off-site access capabilities used laptop computers to perform job duties after business hours or while traveling, and a small number of company employees worked full time out of their homes under a telecommuting agreement. All employees with off-site access to the company's databases had print capability. The Fortis telecommuting agreement provided that telecommuting employees treat confidential enrollee information as confidential. However, the agreement did

not provide requirements for the destruction of printed documents. Company employees that had off-site access to company databases but did not work under a formal telecommuting arrangement were not subject to any formal requirements regarding the destruction of documents printed off-site that contained personally identifiable enrollee financial or health information.

35. **Recommendation:** It is recommended that the company draft and implement agreements for all employees with off-site access to company databases that provide for the proper destruction of printed documents containing confidential enrollee financial or health information to ensure compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code

The company reported that it provided enrollees with an initial privacy notice at the time of delivery of the certificate or policy, that an annual privacy notice was mailed to enrollees each year, and that a revised privacy notice was mailed to enrollees upon material change in the company's privacy policies. However, the company did not have in place written policies and procedures that establish when and in what manner the initial, annual, and revised privacy notices were provided to enrollees. Section Ins 25.10 (1), Wis. Adm. Code, provides that an insurer shall provide an initial notice of privacy policies and practices not later than when the insurer establishes a customer relationship. Section Ins 25.13 (1) (a), Wis. Adm. Code, provides that an insurer shall provide notice to customers that accurately reflects its privacy policies and practices with regard to nonpublic personal financial information not less than annually during the continuation of the customer relationship. Section Ins 23.20, Wis. Adm. Code, provides that an insurer shall not provide any nonpublic personal financial information other than described in the initial privacy notice unless it delivers to the consumer a revised privacy notice.

36. **Recommendation:** It is recommended that the company develop and implement internal policies and procedures for providing enrollees with an initial privacy notice to ensure compliance with s. Ins 25.10 (1), Wis. Adm. Code.

37. **Recommendation:** It is recommended that the company develop and implement internal policies and procedures for providing enrollees with an annual privacy notice to ensure compliance with s. Ins 25.13 (1) (a), Wis. Adm. Code.

38. **Recommendation:** is recommended that the company develop and implement internal policies and procedures for providing enrollees with a revised policy notice whenever there is a material change to its privacy practices to ensure compliance with s. Ins 25.20, Wis. Adm. Code.

The company reported that it used its standard underwriting authorization form at the time of application for both group and individual health insurance products. The form authorized the disclosure of information regarding HIV testing and treatment. Section 631.90 (3) (a), WIs. Stat., and s. Ins 3.53, Wis. Adm. Code, provide that no group insurer may request information on HIV testing or treatment.

39. **Recommendation:** It is recommended that the company revise its underwriting authorization form to exclude from the authorization the disclosure of information relating to HIV testing and treatment, as required by s. 631.90 (3) (a), Wis. Stat., and s. Ins 3.53, Wis. Adm. Code.

The company's privacy policy & procedure #2.3 provided standards for the retention of personal medical information. However, it did not provide that copies of recorded personal medical information include the source of the information if the source was a health care provider or a medical institution, as required by s. 610.70 (3) (e), Wis. Stat. The company stated that it was its established practice to mandate inclusion of the information. The company agreed to update its privacy policy & procedure #2.3 to include the requirement.

Managed Care

The provisions of 2001 Wisconsin Act 16 (SB 55) and the 2001-2003 Biennial Budget amended the provisions of ch. 609, Wis. Stat. Effective on September 1, 2001, ch. 609, Wis. Stat., was amended to replace the term "managed care plan" with the term "defined network plan," throughout the chapter. The act relaxed some of the requirements applicable to preferred provider plans, but only if preferred provider plans did not require or impose financial incentives related to referrals for access to a participating or non-participating provider. In addition, a preferred provider plan that imposed material exclusions, deductibles, maximum limits or other conditions that are uniquely applied to out of network provider services, and that results in significant limits on out of network benefits compared to in-network benefits, is a defined network plan. The act provided that a preferred provider plan that was also a defined network plan was required to meet statutory requirements. At the time of the examination, Wisconsin had not created and amended language in its regulations to correspond with the statute. The examination was limited to an overview of the company's compliance with managed care requirements.

The examiners reviewed the company's response to the managed care interrogatory, its policies and procedures regarding plan administration, compliance program, credentialing and recredentialing administrative and clinical oversight for all activities.

The examiners determined that the plans offered by the company met the definition of "preferred provider plan" but are not "defined network plans." The plans provided for direct access to providers by enrollees without referral and the policy forms and certificates did not include significant limits on out of network benefits compared to in-network benefits.

The company reported that it contracted with seven PPO networks, including Associates for HealthCare, Health Care Network of Wisconsin, PHCS, Preferred One, Prevea, Select Care and Touchpoint.

The company had a quality management program that operated within its health management department. It also had a quality improvement committee that was comprised of the medical directors, the vice-president of health management, the director of operations, the director of development & integration and the health management audit coordinator. The committee developed and approved the company's quality improvement plan on an annual basis.

Although PPO plans are exempt from the requirement of s. 609.34, Wis. Stat., that require defined network plans to have a medical director, the company had a chief medical officer position that was responsible for the development of all clinical protocols, the review and approval of utilization review policies and procedures, and directing quality assurance activities.

PPO plans are also exempt from the requirements of s. 609.32 (2), Wis. Stat., that requires defined network plans to develop a process for selecting and approving participating providers. The company reported that it delegated this function to its seven contracted networks. The network credentialing plans were reviewed by the company under its Fortis health credentialing oversight plan created by the network management and legal departments in 2002.

The examiners reviewed the company's practices and procedures regarding enrollee access to care. The company reported that its network contracts included a provision that required the networks to provide an adequate selection of specialty and non-specialty providers in all geographic service areas. In addition, each contracted network had developed written access standards regarding numbers and types of providers within a particular travel distance parameter. The company required the networks to submit reports on a monthly basis of the number and types of current providers but it did not audit these reports.

The examiners reviewed the provider directories provided to plan enrollees. The company reported that the company did not provide directories to enrollees. Rather, the seven contracted networks developed their own directories and provided them to enrollees on an

annual basis. The company did perform hard copy directory updates for two of its contracted networks, Touchpoint and PHCS. In addition, a provider directory was maintained electronically for each of the networks and these were updated anywhere from daily to every six weeks depending on the network.

The examiners requested a list of all providers terminated within three months of the beginning of the examination to verify that the terminated providers had been deleted from the networks electronic provider directories as current providers. The examiners chose a random sample of 50 terminated providers and verified that the providers had been deleted from the electronic directories.

The examiners reviewed the company's plan administration procedures and practices. The company did not have a remedial process in place to address quality problems as required by s. 609.32 (1m), Wis. Stat. The company reported that its contracted networks were responsible for maintaining a procedure for remedial action to address quality problems and take corrective actions. The company maintained that provisions in the network contracts satisfy the laws requirements. Specifically, the contract required the network to immediately notify the company of any adverse decision against a provider including malpractice actions, medical disciplinary proceedings, peer review and grievance proceedings, and the suspension loss or change of status of accreditation, license or medical staff privileges. If the company became aware of a quality problem it provided the network with the information and the network reported back to the company how the problem was resolved. Section 609.32 (1m), Wis. Stat., regarding procedure for remedial action, requires that preferred provider plans shall develop a procedure for remedial action to address quality problems, including written procedures for taking appropriate corrective action.

40. Recommendation: It is recommended that the company develop and institute a remedial action plan to address quality problems, including written procedures for taking appropriate corrective action in order to document compliance with s. 609.32 (1m), Wis. Stat.

The company did not have a process for notifying the Wisconsin Medical Examining Board (MEB) of disciplinary actions involving participating providers as required by s. 609.17, Wis. Stat. The company reported that it delegated to its contracted networks the duty of credentialing and monitoring participating providers. Section 609.17, Wis. Stat., regarding reports of disciplinary action, requires that every preferred provider plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

41. Recommendation: It is recommended that the company develop and institute a process for notifying the Medical Examining Board of any disciplinary actions taken against a participating provider in order to document compliance with s. 609.17, Wis. Stat.

The examiners found that the company did not have a procedure that required that grievances and complaints involving quality of care issues to be reviewed by the quality assurance committee. Section Ins 9.40 (4), Wis. Adm. Code, provides that all insurers, including preferred provider plans, shall establish and maintain a written policy governing the activities of the quality assurance committee. It also requires that the preferred provider plan shall require all complaints, appeals and grievances relating to quality of care to be reviewed by the quality assurance committee.

42. Recommendation: It is recommended that the company develop and implement a written policy requiring that all complaints, appeals and grievances relating to quality of care be reviewed by the quality assurance committee in order to comply with s. Ins 9.40 (4), Wis. Adm. Code.

The company, as an insurer offering preferred provider plans, is required to have a compliance plan that complies with s. Ins 9.42, Wis. Adm. Code. The company maintained that it had a "compliance" process consisting of an attorney in the legal unit reviewing new Wisconsin insurance laws and regulations to assess the impact on existing processes. The attorney also reviewed current laws when compliance problems were discovered and referred the matters to the compliance implementation team if changes in procedures or processes were

required. The compliance implementation team reviewed the requirements with the area of the company affected by the changes and directed implementation of the changes. The compliance implementation team subsequently audited the affected area of the company to ensure that the changes had been implemented. The examiners review of the company's compliance plan and the company's practices found that the plan was not adequate to satisfy the requirements of s. Ins 9.42, Wis. Adm. Code.

43. Recommendation: It is recommended that the company develop and implement a compliance plan that satisfies all of the specific requirements of s. Ins 9.42, Wis. Adm. Code.

The examiners found that the company did not have a compliance program in place that included regular internal audits, including regular audits of any contractors or subcontractors who perform functions relating to compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Wis. Stat., this subchapter or any applicable sections including but not limited to s. Ins 9.07, Wis. Adm. Code, as required by s. Ins 9.42 (3), Wis. Adm. Code.

44. Recommendation: It is recommended that the company develop a process for conducting regular internal audits, including regular audits of any contractors or subcontractors who perform functions related to compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Wis. Stat., and s. Ins 9.07, Wis. Adm. Code, in order to document compliance with s. Ins 9.42 (3), Wis. Adm. Code.

Company Operations/Management

The examiners reviewed the company's responses to OCI's company operations and management interrogatories, and its network and provider agreements. The company was asked to provide a sample copy of agreements with preferred provider networks, medical groups, individual practice associations and each provider category. The company did not contract directly with individual providers rather; it contracted with seven different provider networks: Prevea, Touchpoint, Associates for Healthcare, Health Care Network (HCN), PHCS, Select Care and Preferred One.

The examiners reviewed a sample of 25 executed agreements between the contracted networks and individual providers. The examiners found 13 provider agreements that did not have grievance and complaint referral provisions as required by s. Ins 18.03 (2) (1) 2, Wis. Adm. Code. The company reported that it had no control over the provisions in the agreements between contracted networks and individual providers.

The company's legal department was responsible for updating network contracts to comply with current laws and requirements. The networks were responsible for amending their contracts with participating health care providers. The company maintained that through its contracts with its vendors, it requires its network partners to include provisions in their contracts with individual providers that comply with applicable Wisconsin state laws and regulations. However, due to the fact that the network contracts directly with providers not only on the company's behalf, but also on the behalf of many other payors, it was not able to direct the networks' amendment process with contracted providers.

45. Recommendation: It is recommended that the company revise its procedures and provide oversight of the network contracting process with individual providers through a random audit process to ensure that these contracts comply with the requirements of Wisconsin insurance laws and regulations, including but not limited to s. Ins 18.03 (2) (c) 2., Wis. Adm. Code.

IV. CONCLUSION

The examination involved a targeted review of Fortis Insurance Company's practices and procedures for the period from January 1, 2002, through December 31, 2003. The examination report makes 45 recommendations. The recommendations primarily involve claims grievances, managed care, privacy and underwriting.

V. SUMMARY OF RECOMMENDATIONS

Producer Licensing

Page 8 1. It is recommended that the company revise its producer licensing procedures to include periodic audits of its agent data base for accuracy of information and to annually reconcile its agent listing records with the annual renewal billing statement received from OCI to ensure that the company does not accept business from agents not listed to represent the company in order to document compliance with s. 628.11, Wis. Stat., and s. Ins 6.57 (5), Wis. Adm. Code.

Page 8 2. It is recommended that the company revise its producer licensing procedures to ensure that the company notifies the OCI of agent terminations from the company as required by s. 628.11, Wis. Stat., and s. Ins 6.57 (2), Wis. Adm. Code.

Page 8 3. It is recommended that the company revise its producer licensing procedures to ensure that agents terminated for any reason are sent the notice required by s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

Page 9 4. It is recommended that the company either discontinue using the brochure entitled, "Employer Administration Guide," in Wisconsin or revise information in the brochure to comply with the requirements of ss. 632.895 (5) and 632.896, Wis. Stat.

Page 10 5. It is recommended that the company revise the information in its brochure entitled, "Employer Administration Guide" for Wisconsin insureds to comply with the grievance requirements of s. Ins 18.03 (3), Wis. Adm. Code.

Page 10 6. It is recommended that the company revise its small employer rating procedures and discontinue including occupation as a case characteristic when calculating small employer group rates in compliance with the requirements of s. 635.02, Wis. Stat.

Page 10 7. It is recommended that the company identify those groups that were rated incorrectly as a result of this practice, recalculate the rates charged, and issue refunds where necessary in order to comply with s. 632.02, Wis. Stat.

Page 10 8. It is recommended that the company recalculate the rates for the 33 identified groups that were issued rates in 2001 outside of the rate band, and make refunds where necessary in order to comply with the requirements of s. Ins 8.52, Wis. Adm. Code.

Page 10 9. It is recommended that the company revise its procedures for providing quotes for small employer business to include recording the dates the requests for price quotes are received in order to comply with s. 601.42, Wis. Stat.

Page 11 10. It is recommended that the company cease requiring that a small employer be in business for any minimum period of time before being eligible to apply for and have issued a group health insurance policy in order to comply with the requirements of s. 635.19, Wis. Stat.

Page 11 11. It is recommended that the company revise its minimum participation requirements for new groups by deleting the minimum participation requirements for dependents to comply with the requirements of s. Ins 8.46 (2), Wis. Adm. Code.

Page 12 12. It is recommended that the company revise the disclosure notice used to satisfy the requirements of s .Ins 8.44 (2) Wis. Adm. Code to correctly state the number of employees that constitute a small employer group as defined by s. 635.02 (7), Wis. Stat.

Electronic Commerce

Page 14 13. It is recommended that the company implement a process to monitor websites of individual agents that contain material pertaining to the company and its products to ensure compliance with all of the requirements of s. Ins 3.27, Wis. Adm. Code.

Policyholder Service & Complaints

Page 15 14. It is recommended that the company revise its procedures to include a formal definition of complaint that complies with the definition in s. Ins 18.01 (2), Wis. Adm. Code

Page 15 15. It is recommended that the company revise the manner in which it keeps a record of complaints so that it can make its complaint records available to OCI for review in order to comply with the requirements of s. Ins 18.06 (1), Wis. Adm. Code.

Grievance & Independent Review

Page 17 16. It is recommended that the company revise its internal grievance procedure and manuals to comply with all of the requirements of s. Ins 18.03 (3), Wis. Adm. Code.

Page 17 17. It is recommended that the company refer all grievances involving quality issues to its grievance committee, and include these grievances in its annual grievance experience report submitted to the OCI in order to comply with ss. Ins 18.03 and Ins 18.06, Wis. Adm. Code.

Page 17 18. It is recommended that the company revise its written grievance procedures and manuals to remove the provision that limits an insured's right to file a grievance to 60 days from the date the insured receives notification of an initial appeal determination in order to comply with s. Ins 18.03 (3), Wis. Adm. Code.

Page 18 19. It is recommended that the company improve its grievance procedures to ensure that grievances are acknowledged with a letter to the grievant within 5 business days of receipt as required by s. Ins 18.03 (4), Wis. Adm. Code.

Page 18 20. It is recommended that the company revise its grievance procedures to ensure that all grievants, regardless of resolution, are sent a letter explaining the disposition of the grievance as required by s. 632.83 (3) (d), Wis. Stat.

Page 19 21. It is recommended that the company improve its grievance procedures to ensure that grievants are notified of the right to appear at the grievance meeting and the time and place of the meeting in order to comply with s. Ins 18.03 (3) (b), Wis. Adm. Code.

Page 19 22. It is recommended that the company revised its procedures for submitting its annual grievance report to OCI to ensure that the reporting process complies with all of the requirements of s. Ins 18.06, Wis. Adm. Code, and s. 632.83 (2) (c), Wis. Stat.

Marketing, Sales & Advertising

Page 21 23. It is recommended that the company revise the manner in which it maintains its advertising file to comply with the requirements of s. Ins 3.27 (28), Wis. Adm. Code.

Page 21 24. It is recommended that the company develop written procedures regarding the maintenance of the advertising file in order to comply with s. Ins 3.27 (28), Wis. Adm. Code.

Underwriting & Rating

Page 22 25. It is recommended that the company develop and use the replacement notice required by s. Ins 3.29 (6), Wis. Adm. Code, and that the content of the notice comply with all of the disclosure requirements of s. Ins 3.29 (7), Wis. Adm. Code.

Page 23 26. It is recommended that the company improve its procedures to ensure that it does not accept business from nor pay commissions to agents not listed with the company in order to comply with s. Ins 6.57 (5), Wis. Adm. Code.

Page 23 27. It is recommended that the company process applications consistent with its internal procedures and that it review and provide additional information to State Farm agents regarding the company's requirement that the agent of record sign the application in order to comply with s. 628.35 (1), Wis. Stat.

Page 24 28. It is recommended that the company revise its procedures to provide the required HIRSP notice and information to individual accident & sickness applicants who are declined coverage due to medical underwriting considerations in compliance with s. 632.785, Wis. Stat.

Claims

Page 25 29. It is recommended that the EOBs used by the company's prescription drug vendors be revised to comply with the requirements of s. Ins 18.03 (2), Wis. Adm. Code.

Page 25 30. It is recommended that the company establish a written procedure to ensure that vendors who utilize their own explanation of benefit forms (EOBs) are made aware of the requirements of s. Ins 3.651 (4), Wis. Adm. Code, and use of ANSI codes as claim adjustment reason codes in their EOBs.

Page 25 31. It is recommended that the company institute a process for periodically testing and auditing its claim system programs to ensure that its tables accurately report ANSI codes on Remittance Advice (RA) forms for health care providers in order to comply with s. Ins 3.651 (3), Wis. Adm. Code.

Page 26 32. It is recommended that the company improve its claims processing procedures to ensure that interest is paid on claims that are not paid within 30 days of receipt of sufficient information to establish liability as required by s. 628.46, Wis. Stat.

Page 26 33. It is recommended that the company develop written procedures on how to handle requests from insureds for UCR information and that the company disclose to insureds the information required by s. Ins 3.60 (6) (a) 2., Wis. Adm. Code.

Page 27 34. It is recommended that the company revise its claim processing procedures to ensure that denied chiropractic service claims are reviewed and handled as required by s. 632.875 (2) and (3), Wis. Stat.

Privacy & Confidentiality

Page 29 35. It is recommended that the company draft and implement agreements for all employees with off-site access to company databases that provide for the proper destruction of printed documents containing confidential enrollee financial or health information to ensure compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code.

Page 29 36. It is recommended that the company develop and implement internal policies and procedures for providing enrollees with an initial privacy notice to ensure compliance with s. Ins 25.10 (1), Wis. Adm. Code.

Page 29 37. It is recommended that the company develop and implement internal policies and procedures for providing enrollees with an annual privacy notice to ensure compliance with s. Ins 25.13 (1) (a), Wis. Adm. Code.

Page 30 38. It is recommended that the company develop and implement internal policies and procedures for providing enrollees with a revised policy notice whenever there is a material change to its privacy practices to ensure compliance with s. Ins 25.20, Wis. Adm. Code.

Page 30 39. It is recommended that the company revise its underwriting authorization form to exclude from the authorization the disclosure of information relating to HIV testing and treatment, as required by s. 631.90 (3) (a) Wis. Stat., and s. Ins 3.53, Wis. Adm. Code.

Managed Care

Page 33 40. It is recommended that the company develop and institute a remedial action plan to address quality problems, including written procedures for taking appropriate corrective action in order to document compliance with s. 609.32 (1m), Wis. Stat.

Page 34 41. It is recommended that the company develop and institute a process for notifying the Medical Examining Board of any disciplinary actions taken against a participating provider in order to document compliance with s. 609.17, Wis. Stat.

Page 34 42. It is recommended that the company develop and implement a written policy requiring that all complaints, appeals and grievances relating to quality of care be reviewed by the quality assurance committee in order to comply with s. Ins 9.40 (4), Wis. Adm. Code.

Page 35 43. It is recommended that the company develop and implement a compliance plan that satisfies all of the specific requirements of s. Ins 9.42, Wis. Adm. Code.

Page 35 44. It is recommended that the company develop a process for conducting regular internal audits, including regular audits of any contractors or subcontractors who perform functions related to compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Wis. Stat., and s. Ins 9.07, Wis. Adm. Code, in order to document compliance with s. Ins 9.42 (3), Wis. Adm. Code.

Company Operations/Management

Page 36 45. It is recommended that the company revise its procedures and provide oversight of the network contracting process with individual providers through a random audit process to ensure that these contracts comply with the requirements of Wisconsin insurance laws and regulations, including but not limited to s. Ins 18.03 (2) (c) 2., Wis. Adm. Code.

VI. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

Name	Title
Stephanie Cook	Insurance Examiner
Ken Hendree	Insurance Examiner
Jamie Key	Insurance Examiner
Jerry Zimmer	Insurance Examiner
Barbara Belling	Managed Care Specialist

Respectfully submitted,

Pam Ellefson
Examiner-in-Charge