Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

November 25, 2014

Patrick Carr, President
Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719

Re: Golden Rule Insurance Company NAIC# 62286
Market Conduct Examination Report Closing letter

Dear Mr. Carr:

Attached you will find a fully executed copy of the Stipulation and Consent Order that has been signed by Director Boron. The Department has reviewed your company's proof of compliance and deems it adequate and sufficient. Therefore, the Department is closing its file on this exam. I intend to ask the Director to make the Examination Report available for public inspection as authorized by 215 ILCS 5/132.

If you have any questions, my contact information is listed below.

Sincerely,

Miryam Ramirez
Acting Deputy Director
Consumer Outreach and Protection
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603
Phone: 312-814-2117
E-mail: Miryam.Ramirez@Illinois.gov

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF THE EXAMINATION OF

GOLDEN RULE INSURANCE COMPANY
7440 WOODLAND DRIVE
INDIANAPOLIS, IN 46278-1719

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 132, 401, 401.5, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403, and 5/425) do hereby appoint Victor Negron and Stephen Zellich, each from Examination Resources, LLC, as the Examiners-in-Charge, and Timothy Nutt, William Dow, Beverly Dale, and Michael Morrissey, each from Examination Resources, LLC, as Examiners, to examine the insurance business and affairs of Golden Rule Insurance Company, NAIC #62286, and to make a full and true report to me of the examination made by them of Golden Rule Insurance Company, with a full statement of the condition and operation of the business and affairs of Golden Rule Insurance Company, with any other information as shall in their opinion be requisite to furnish me a statement of the condition and operation of its business and affairs and the manner in which it conducts its business. This will be a targeted exam covering the company's compliance with the Affordable Care Act (ACA). The costs of this examination shall be borne by the company.

The persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Golden Rule Insurance Company.

SEAL OF THE STATE OF ILLINOIS
AUG. 26TH 1818

IN TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed this Seal.

Done at the City of Chicago, this 30th day of April, 2014.

Andrew Boron /mtn

Andrew Boron ***Director***

GOLDEN RULE INSURANCE COMPANY

MARKET CONDUCT TARGET EXAMINATION REPORT

DATE OF EXAMINATION:	March 31, 2014, through May 9, 2014
EXAMINATION OF:	Golden Rule Insurance Company NAIC # 707 62286
LOCATION:	7440 Woodland Drive Indianapolis, Indiana 46278-1719
PERIOD COVERED BY EXAMINATION:	July 1, 2013 through March 27, 2014
EXAMINERS:	Stephen R. Zellich, CIE, FLMI, EIC Patricia S. Hahn

INDEX

I. SUMMARY

1. Rescissions

There were 5 policies/certificates rescinded during the scope period. A total of 5 were reviewed. No violations were found.

2. Declinations

There were 1,622 applications declined during the scope period. A total of 114 were reviewed. In two (2) instances the Company failed to provide a specific reason for declining coverage in writing.

3. Cancellations

There were 1,914 policies/certificates cancelled during the scope period. A total of 107 cancellations were reviewed. No violations were found.

4. Underwriting

There were 9,381 policies/certificates issued during the scope period. A total of 116 were reviewed. In addition, the examination included a review of policies renewed under the transitional policy. The Company did not have any policies renewed under the transitional policy. No violations were found.

5. Paid Claims

There were 17,654 claims paid during the scope period. A total of 109 were reviewed. No violations were found.

6. Denied Claims

There were 3,641 claims denied during the scope period. A total of 108 were reviewed. In one instance the Company failed to pay for covered Preventive Health Service.

7. Appeals and Grievances

There were 45 appeals/grievances during the scope period. A total of 45 appeals were reviewed. No violations were found.

II. BACKGROUND:

Golden Rule Insurance Company is a foreign Life, Health and Accident issuer licensed to conduct business in 40 states and the District of Columbia. The Company became licensed in the State of Illinois on June 17, 1959. The Company is part of the United Health Group. The Company provides individual health and dental insurance plans with optional benefit riders including vision and term life insurance coverage in the State of Illinois.

The Illinois Department of Insurance (DOI) conducted a target market conduct examination of Golden Rule Insurance Company pursuant to Sections 132, 401, 401.5, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403, and 5/425). The examination was performed by Examination Resources, LLC**.** The scope period of the examination was July 1, 2013 through March 27, 2014 for Non Qualified Health Plans (Non-QHP). The onsite examination began March 31, 2014 and ended May 9, 2014.

The purpose of the examination was to review the Company's compliance with the provisions of the Patient Protection and Affordable Care Act (ACA) and Illinois laws and regulations as it relates to rescissions, declinations, cancellations, underwriting, claims, appeals and grievances for business written on QHP and Non-QHP plans in the State of Illinois.

The Company issued 9,381 individual and group Non-QHP policies during the scope period.

The Company did not write any QHP plans.

III. METHODOLOGY:

The market conduct examination places emphasis on an insurer's systems and procedures used in dealing with insureds and claimants. The scope of this market conduct examination was limited to the following general areas.

Compliance with the provisions of the Patient Protection and Affordable Care Act (ACA) and Illinois laws and regulations for business written on QHP and Non-QHP plans in the State of Illinois involving:

1. Rescissions
2. Declinations
3. Cancellations
4. Underwriting
5. Paid Claims
6. Denied Claims
7. Appeals and Grievances

The review of these categories is accomplished through examination of individual underwriting and claim files, written interrogatories and interviews with company personnel. Each of these categories is examined for compliance with Department of Insurance rules and regulations and applicable state laws.

Sample sizes were determined using the Acceptance Samples Table of the NAIC Market Regulation Handbook or by the Audit Command Language (ACL) software. The handbook allows several methods for determining sample sizes. In utilizing ACL to determine the sample sizes, the parameters consisted of a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% in accordance with the handbook.

Rescissions

Rescission is the terminating of any policy retroactively back to the date of its inception. The purpose of the review was to determine compliance with PHS Act § 2712, 42 U.S.C. § 300gg-12 and 45 C.F.R. § 147.128, which require the following:

1. Prohibits an issuer from cancelling or discontinuing coverage retroactively.
2. Exception is an act or omission that constitutes either fraud or intentional misrepresentation of a material fact by the enrollee.
3. An inadvertent misstatement of fact does not constitute fraud.
4. Prospective terminations and terminations due to failure to pay premiums or contributions that may be applied retroactively are not rescissions.
5. Issuer is required to provide thirty (30) days' advance written notice prior to rescinding coverage.
6. An enrollee may appeal the decision under 45 CFR §147.136.

Declinations

Applications that were declined were reviewed to verify compliance with PHS Act § 2705, 42 U.S.C. § 300gg-4 and 45 C.F.R. § 146.121 (group plans) and 45 C.F.R. §147.110 (individual plans), which require the following:

Issuers may not establish any rule for eligibility (including continued eligibility) of any enrollee to enroll for benefits under the terms of the plan or charged more for coverage because of any of the following health factors:

• Health status;

• Medical condition, including both physical and mental illnesses (as defined in 45 C.F.R. § 144.103);

• Claims experience;

• Receipt of health care;

• Medical history;

• Genetic information (as defined in 45 C.F.R. § 146.122(a));

• Evidence of insurability; or

• Disability

Cancellations

Cancellations were reviewed to verify compliance with the PHS Act § 2714; 42 U.S.C. § 300gg-14; 45 C.F.R. § 147.120, 45 CFR 148.122 and 45 CFR 146.152 (HIPAA guaranteed renewability requirements), 215 ILCS 97/30, 215 ILCS 97/50 (Illinois guaranteed renewability requirements), and 215 ILCS 5/356z.12, to ensure cancellations reasons were permissible.

Underwriting

Policies issued were reviewed to verify compliance with the following provisions:

1. Guaranteed Availability - PHS Act § 2702; 42 U.S.C. § 300gg-1; 45 C.F.R. § 146.150 (grandfathered small group); and 45 C.F.R. § 147.104 (individual and group) and 45 CFR 148.122 (grandfathered individual - HIPAA).
2. Pre-Existing Conditions - PHS Act § 2704, 42 U.S.C. § 300gg-3 and 45 C.F.R. § 147.108.
3. Discrimination based on health status - PHS Act § 2705, 42 U.S.C. § 300gg-4 and 45 C.F.R. § 146.121 (HIPAA – group and 45 CFR 147.110 (individual)
4. Lifetime and Annual Limits - PHS Act § 2711; 42 U.S.C. § 300gg-11; and 45 C.F.R. § 147.126.
5. Preventive Health Care - PHS Act § 2713; 42 U.S.C. § 300gg-13; and 45 C.F.R. § 147.130.
6. Dependent Coverage to Age 26 - PHS Act § 2714; 42 U.S.C. § 300gg-14; 45 C.F.R. § 147.120.
7. Patient Protections - PHS Act § 2719A, 42 U.S.C. § 300gg-19a and 45 C.F.R. § 147.138(a)(1), (2), (3) and (4).
8. Wellness Programs - 45 C.F.R. § 146.121.
9. SBC Notices – PHS Act § 2715 and 45 CFR 147.200

10. Appeal Notices – PHS Act § 2719, 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136.

In addition, compliance with transitional policy for non-grandfathered coverage in the small group and individual health insurance market as announced on November 14, 2013, by the Centers for Medicare & Medicaid Services (CMS) was also reviewed. As an option, the transitional policy health insurance issuers may choose to continue certain coverage that would otherwise be cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. CMS further stated that, under the transitional policy, non-grandfathered health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014 and October 1, 2014 will not be considered to be out of compliance with certain market reforms if certain specific conditions are met.

Paid Claims

Paid claims were reviewed to verify compliance with the following provisions:

1. Pre-Existing Conditions - PHS Act § 2704, 42 U.S.C. § 300gg-3 and 45 C.F.R. § 147.108.
2. Nondiscrimination of Health Care Providers - PHS Act § 2706 and 42 U.S.C. § 300gg-5
3. Essential Health Benefits - PHS Act §2707 and 45 CFR §156.115(a)
4. Clinical Trials - PHS Act § 2709 and 42 U.S.C. § 300gg-8
5. Lifetime and Annual Limits - PHS Act § 2711; 42 U.S.C. § 300gg-11; and 45 C.F.R. § 147.126.
6. Preventive Health Services - PHS Act § 2713; 42 U.S.C. § 300gg-13; and 45 C.F.R. § 147.130 (Including cost sharing prohibition)
7. Emergency Services - PHS Act § 2719A; 42 U.S.C. § 300gg-19a and 45 C.F.R. § 147.138(b)

Denied Claims

Paid claims were reviewed to verify compliance with the following provisions:

1. Pre-Existing Conditions - PHS Act § 2704, 42 U.S.C. § 300gg-3 and 45 C.F.R. § 147.108.
2. Nondiscrimination of Health Care Providers - PHS Act § 2706 and 42 U.S.C. § 300gg-5
3. Essential Health Benefits - PHS Act §2707 and 45 CFR §156.115(a)
4. Clinical Trials - PHS Act § 2709 and 42 U.S.C. § 300gg-8
5. Lifetime and Annual Limits - PHS Act § 2711; 42 U.S.C. § 300gg-11; and 45 C.F.R. § 147.126.
6. Preventive Health Services - PHS Act § 2713; 42 U.S.C. § 300gg-13; and 45 C.F.R. § 147.130 (Including cost sharing prohibition)

7. Emergency Services - PHS Act § 2719A; 42 U.S.C. § 300gg-19a and 45 C.F.R. § 147.138(b)

Appeals and Grievances

The Company's appeals program was reviewed to determine whether the appeals and grievance procedures given to enrollees include all the required information and to determine if the Company followed established procedures in compliance with PHS Act § 2719; 42 U.S.C. § 300gg-19; and 45 C.F.R. § 147.136.

IV. SELECTION OF SAMPLE:

Survey	Population	# Reviewed	% Reviewed
Rescissions	5	5	100%
Declinations	1,622	114	.07%
Cancellations	1,914	107	.06%
Underwriting	9,381	116	.01%
Paid Claims	17,654	109	.006%
Denied Claims	3,641	108	.03%
Appeals and Grievances	45	45	100%

V. FINDINGS:

A. Rescissions:

There were 5 policies/certificates rescinded during the scope period. A total of 5 were reviewed. No violations were found.

B. Declinations:

There were 1,622 applications declined during the scope period. A total of 114 were reviewed.

In two (2) instances, the Company failed to provide a specific reason for declining coverage in writing. This is a violation of section 1011 (A)(1) of the Illinois Insurance Code (215 ILCS 5/1011 (A)(1). Both applicants were sent declination letters; however, the letters did not provide a reason for the adverse underwriting decision. Illinois Insurance Code requires the company to provide a specific reason or reasons for the adverse underwriting decision in writing or advise such person that upon written request he or she may receive the specific reason or reasons in writing.

C. Cancellations

There were 1,914 policies/certificates cancelled during the scope period. A total of 107 cancellations were reviewed. No violations were found.

D. Underwriting:

There were 9,381 policies/certificates issued during the scope period. A total of 116 were reviewed. In addition, the examination included a review of policies renewed under the transitional policy. The Company did not have any policies renewed under the transitional policy. No violations were found.

E. Paid Claims:

There were 17,654 claims paid during the scope period. A total of 109 were reviewed. No violations were found.

F. Denied Claims:

There were 3,641 claims denied during the scope period. A total of 108 were reviewed.

In one (1) instance the Company failed to pay for covered Preventive Health Service. This is a violation of Section 2713(a)(4) Coverage of Preventive Health Services. The Company denied paying for labs associated with a routine gynecological examination.

G. Appeals and Grievances:

There were 45 appeals/grievances during the scope period. A total of 45 appeals were reviewed. No violations were found.

STATE OF OHIO)
) ss
COUNTY OF HAMILTON)

Stephen R. Zellich being first duly sworn upon his/her oath, deposes and says:

That he was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Golden Rule Insurance Company, (the "Company"), NAIC #67660.

That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Company business and affairs and the manner in which the Company conducts its business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That she/he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the Company.

Stephen R Zellich
Examiner-In-Charge

Subscribed and sworn to before me
this 16th day of July, 2014.

Rebekah Lynn Brock
Notary Public

Rebekah Lynn Brock
Notary Public, State of Ohio
My Commission Expires 07-22-2018

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

STIPULATION AND CONSENT ORDER

WHEREAS, the Director ("Director") of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Golden Rule Insurance Company, NAIC #62286, ("the Company"), is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 401.5, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Patient Protection and Affordable Care Act (ACA) and the Illinois Insurance Code (215 ILCS 5/1 *et seq.*) and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands the various rights of the Company in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 5/401.5, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, it waives any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS agreed by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Patient Protection and Affordable Care Act (ACA) and the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures to provide a specific written reason when declining coverage as required by 215 ILCS 5/1011(A)(1).

2. Institute and maintain policies and procedures to pay for all covered Preventative Health Services as required by Section 2713(a)(4), Coverage of Preventative Health Services.

3. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above two (2) orders within 30 days of receipt of this Order.

4. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $3,000 to be paid within 30 days of the execution of this Order.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of:

Golden Rule Insurance Company, NAIC# 62286

Signature

MICHAEL L. CORNE
Name

VICE PRESIDENT REGULATORY AFFAIRS
Title

Subscribed and sworn to before me this

13 day of November 2014.

Notary Public

AMANDA GILPATRICK
MY COMMISSION EXPIRES
November 29, 2020
SEAL
SHELBY COUNTY
NOTARY PUBLIC, STATE OF INDIANA

DATE 11-4-14

DEPARTMENT OF INSURANCE
of the State of Illinois:

Andrew Boron
Director