State of Missouri

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION

IN RE:	)	
	)	
Central United Life Insurance Co.	)	**Case No. 090814644C**
Missouri Market Conduct Examination	)	
No. 5013-36-TGT	)	

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ACCEPTING FINAL EXAMINATION REPORT AS FILED

NOW, THEREFORE, Director John M. Huff ("Director") of the Department of Insurance, Financial Institutions and Professional Registration ("Department"), after a hearing, having read the full record, including all the evidence, hereby renders the decision and makes the following findings of fact, conclusions of law and order in accordance with 20 CSR 100-8.018(1)(F):

FINDINGS OF FACT

A. Procedural History

1. Pursuant to § 374.205.3(2) RSMo 2000, on or about September 5, 2008, the Missouri Department of Insurance, Financial Institutions and Professional Registration ("Department"), Division of Insurance Market Regulation ("Division") mailed to Central United Life Insurance Company ("Central United") a Market Conduct Examination Report of the Cancer and Specified Disease Health Insurance Business of Central United dated August 26, 2008 ("August 26, 2008 Report"). *Central United's Prehearing Proposed Findings of Fact, Conclusions of Law and Order* ("Central United's Prehearing Proposed Order"); *Exhibit MM, October 31, 2009 Central United Response to August 26, 2008 Report.*

2. On October 31, 2008, Central United submitted its formal response to the August 26, 2008 Report in accordance with § 374.205.3(2). *Central United's Prehearing Proposed Order; Exhibit MM.*

3. In accordance with 20 CSR 100-8.018(1)(E), the Division forwarded to Central United on July 13, 2009 a Market Conduct Final Examination Report ("Final Report") dated July 10, 2009 and signed by Chief Examiner Michael W. Woolbright. The examination report was

accompanied by a letter that included a notice to the Company of its rights under 20 CSR 100-8.018(1)(F). *Central United's Prehearing Proposed Order.*

4. The time period covered by the Division's examination of Central United was primarily from January 1, 2002 through December 31, 2004. The stated purpose of the examination was "to determine whether the Company complied with Missouri Laws and [Department] regulations in its marketing, underwriting and administration of cancer and specified disease health insurance policies." *Exhibit 1, Final Report,* p. 4.

5. On August 13, 2009, Central United petitioned the Director of the Department to modify the findings of the Final Report and requested a hearing pursuant to 20 CSR 100-8.010(1)(F). By Notice of Hearing and Order, the Director scheduled the hearing for August 24, 2009, to commence at 1:30 p.m., and designated Mary S. Erickson, Senior Enforcement Counsel, as the hearing officer pursuant to 20 CSR 800-1.130.

6. Upon a request by Central United, the hearing officer rescheduled the hearing for August 25, 2009, to commence at 9:00 a.m., at the Department in Room 530 of the Truman State Office Building, 301 West High Street, Jefferson City, Missouri.

7. At the administrative hearing on August 25, 2009, Carolyn H. Kerr and Kevin Jones, appeared on behalf of the Division. Sherry L. Doctorian of Armstrong Teasdale LLP and Dennis R. Bailey of Rushton, Stakely, Johnston & Garrett, P.A., *pro hac vice,* appeared on behalf of Central United.

8. At the hearing, the Division presented the Final Report into evidence as well as the working papers relating to the market conduct examination. When presenting the Final Report, the Division noted that pursuant to § 375.205, findings of fact and conclusions made pursuant to any examination shall be prima facie evidence.

9. Central United presented five witnesses and documentary evidence in response. The Division presented no rebuttal testimony or evidence. Only Central United chose to make an oral closing argument at the hearing.

B. Parties

10. The Division of Insurance Market Regulation of the Department protects the interests of Missouri's insurance buying consumers by ensuring companies are conducting business in compliance with applicable state statutes and regulations. The Division is authorized to conduct an examination of pursuant to §§ 374.202 to 374.207 of any company engaging in the business of insurance in Missouri.

11. At the time of the examination, Central United was a Texas-domiciled insurer. *Exhibit 1, Final Report.*, p. 1. Since that time, Central United has redomesticated to Arkansas. *Motion to Correct the Record,* p. 1. The correct NAIC Number for Central United is 61883, and NAIC Group Number is 1117. *Id.* Central United holds a Certificate of Authority to transact insurance business in Missouri. *Exhibit 1,* p. 6.

C. Findings and Conclusions in Final Report and Evidence

12. Central United sells and administers supplemental cancer insurance policies which are specific benefit, indemnity policies which pay benefits directly to the policyholder as defined in the policy. *Hearing Transcript ("Tr."),* 37 – 38 (Central United witness Lee Ann Blakey). Central United's policies are not major medical or health insurance policies. *Id.*

13. In addition to its own policies, Central United administers the closed block of business it acquired from Commonwealth National Life Insurance Company ("Commonwealth") and Dixie National Life Insurance Company. *Tr. 36* (Blakey); *Tr. 220* (John McGettigan); *Exhibit A, Commonwealth Policy Form CEP350REV; Exhibit H, Dixie Advertisement.*

14. The Central United policies at issue provide for three categories of benefits: scheduled, per diem, and actual charge benefits. The third category of benefits provides for a cash payment to the policyholder in the amount of actual charges for chemotherapy or radiation treatment. *Tr. 43 – 45* (Blakey); *see, e.g., Exhibit A, Commonwealth Policy Form CEP350REV and Exhibit B, Commonwealth Policy Form CEP93ULT.* For example, in Exhibit A, page 5, under "Radiation Therapy", the policy states, in part: "We will pay the actual charges for radiation for the purpose of modification or destruction of abnormal tissue."

15. Central United materially changed how it administers the benefit provisions of guaranteed renewable cancer health insurance policies beginning February 1, 2003. *Exhibit 1, Final Report,* p. 5; *Tr. 106* (Blakey). Specifically, the Final Report states:

> Many of the benefit provisions of the Company's cancer policies are worded to pay benefits based on a health care provider's *actual charge* for covered services. Prior to February of 2003, the Company administered those *actual charge* claims based on the amount health care providers billed for their services. Beginning in February of 2003, the Company administered claims based on a different definition of the term *actual charge*. From that date forward, the Company defined *actual charge* to mean, *"...the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided."* As a result, any benefit payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer.
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> The term *actual charge* was not defined in any of the Company's marketing materials or in any of the cancer policies sold in Missouri until October of 2003. It was not until December of 2003 that all cancer policies the company marketed in Missouri that paid one or more benefits based on a health care provider's *actual charge* included a definition of that term.

Exhibit 1, Final Report, p. 5 (italics in original).

16. The Final Report examined the following areas of Central United's operations: Sales and Marketing, Underwriting, Claims, Complaints/Grievances, Criticism & Formal Request Time Study. *Id.*

17. Central United presented extensive (and redundant) evidence regarding the changes in the medical services industry and its billing practices to demonstrate the differential between a provider's "list charge" and the lesser amount accepted by a provider for full payment. *E.g., witnesses Lee Ann Blakey; Mark Chapman; Dr. Michael Morrisey* (by Affidavit, *Exhibit DD*); *Exhibits F, G, Q, R, S, FF, and HH.*

18. Central United ultimately admits that "Central United failed to notice until early 2003" the transformation of the billing practices. *Exhibit MM, October 31, 2009 Central United Response to August 26, 2008 Report; Tr. 107* (Blakey).

19. Central United presented unchallenged evidence that the medical services industry has evolved tremendously since the 1980s. *Central United's Proposed Order,* ¶ 23; *Tr. 48* (Blakey); *Exhibit DD, Affidavit of Michael A. Morrisey, Ph.D.*

20. John McGettigan, Senior Vice President and General Counsel of Central United testified that prior to the February, 2003 change, Central United relied on whatever the policyholders turned in with their claims for the payment of actual charges benefits, such as statements of account, claim forms, computer printouts. *Tr. 221.* Prior to February, 2003, the policyholder would send Central United "whatever document they received from the provider." *Tr. 49* (Blakey).

21. In January, 2003, Central United determined that it "needed to begin asking for EOBs [Explanation of Benefits] from our policyholders so that we could see the amount the providers agreed to accept and were paid in full for the chemo and radiation benefits." *Tr. 220; 223.*

22. Central United failed to present any evidence contradicting or rebutting the fundamental finding of the Final Report: Central United changed its policy administration regarding payment for actual charges benefits by requiring proof of payment accepted by the provider. Although Central United's evidence explains perhaps **why** it instituted the change, the extensive evidence of Central United regarding the gradual evolution of medical billing and reimbursement is immaterial and irrelevant to the ultimate issue in the Final Report: Central United unilaterally, and without prior notification, attempted to modify in-force, guaranteed renewable policies.

23. In February, 2003, Central United posted on its website a revised claim form and notice to its policyholders advising them of its change in how it was going to administer claims. *Tr. 53* (Blakey); *Exhibit 4, Claim Form.* This notice was also attached to Central United's claim forms beginning in February, 2003. *Id.* As of February 1, 2003, Central United required policyholders to submit as part of their claim "any Explanation of Benefit Statements, Medicare Summary, or statements of account showing the charges paid by you or on your behalf." *Id.* A similar notice was sent to all policyholders and to Central United's producers in July, 2003. *Id.; Exhibits 2 and E, "Important Notice".* The record establishes that while a few policyholders who

filed a claim after February, 2003, used a form with the notice, Central United waited six months before sending notice to all policyholders of its change.

24. The only written communication from the company to its agents regarding this change was sent to them sometime in July 2003. That communication consisted only of a copy of the Notice form that had been sent to the policyholders on July 3, 2003. *Exhibit 1, Final Report, p. 7.* Therefore, between February 1, 2003 and July, 2003, Central United marketed an ambiguously worded policy form, CP3000AMO, through misinformed agents. *Id.; Exhibit 7, Policies.*

25. The term "actual charge" was not explained or defined in any of Central United's Missouri policy forms, advertising or marketing material until October 2003, when Central United attempted to change the language of the existing Central United policies and newly issued policies by issuing an endorsement to the policies which contained a written definition of "actual charge." Endorsement Form CP3ACEND was attached to Policy Form CP3000AMO beginning on or about October 16, 2003. *Exhibit 1, Final Report*, p. 12; *Exhibit 7, Policies.*

26. Central United marketed Policy Form CP3000AMO until December 2003, but never revised the marketing or solicitation materials referencing that policy form to include a written definition of "actual charge" or an explanation of how Central United was administering claims after February 2003. *Exhibit 1, Final Report*, p. 12; *Tr. 102* (Blakey); *Exhibit 3.*

27. No other Central United cancer policies that paid a benefit based on a health care provider's "actual charge" included a written definition of the term "actual charge". *Tr. 45* (Blakey); *Central United's Post-Hearing Proposed Findings of Fact, Conclusions of Law and Order*, (Central United's Post-Hearing Proposed Order), ¶ 18.

28. Lee Ann Blakey testified on behalf of Central United that Central United did not change its internal definition of actual charges. *Tr. 51.* This testimony is inconsistent with the fact that Central United, after February 2003, issued notices specifying that policyholders must submit documents "showing the charges paid by you or on your behalf", *Exhibit E*, and issued new endorsements in October, 2003 containing the definition of actual charge. *Exhibit 1, Final Report.* The testimony is also inconsistent with the fact Central United had for years paid the list price of the providers. *Central United Post-Hearing Proposed Order,* ¶ 27. No notice would have been required to the policyholders if Central United had not changed its interpretation and administration of the actual charges benefits.

29. Central United's February 2003 change in how it administered the benefit provisions of its guaranteed renewable cancer and specified disease health insurance policies impacted, and continues to impact, the benefits paid for claims under the following policies issued and assumed by Central United (*Exhibits 5 and 7*):

a. Central United Policy Forms:
    i. CP-1003-MO
    ii. CP3000AMO
b. Dixie National Life Insurance Company ("Dixie") Policy Forms:
    i. CP-1003

ii. CP-1004
iii. CP-1005

c. Commonwealth National Life Insurance Company ("Commonwealth") Policy Forms:

i. CEP-350-MAX-COMB
ii. CEP-93ULT
iii. CEP-93CONV

30. Nowhere in the following listed advertisements or marketing materials providing for actual charge benefits and in no advertisement or marketing materials of policies that Central United assumed from or administered for Dixie or Commonwealth did Central United disclose that the payment a policyholder would receive would be impacted by the policyholder's primary insurance coverage:

a. Form CP-1005-Rev.3/88, which advertised Policy Form CP-1005;
b. Form NCP-2-(Rev.9/92), which advertised Policy form CP-1004;
c. Form BCEP-94, which advertised Policy Form CEP-93ULT;
d. Form CP-1003-GN-7/96, which advertised Policy Form CP-1003; and
e. Forms CP300A 0102-MO and CP300A-CC-0202 (AR, IL, MO), which advertised Policy Form CP3000.

Exhibit 1, Final Report, pp. 6 – 10; Exhibits 5 & 6, Advertising materials; Exhibits H & I, Dixie advertisement.

31. Lee Ann Blakey testified that the amount paid by Central United for an actual charge benefit would depend on the policyholder's major medical policy in that the actual charge amount paid may be different. *Tr. 104.* Hence, Central United's advertisements claiming such language as "**Pays in addition to all other insurance**" (*e.g., Exhibit* G, bold in original) and "**pays regardless of other insurance you may have!**" (*e.g., Exhibit J*, bold and underline in original), fails to inform that the actual charges benefits do, in fact, depend on the level of coverage provided by the policyholder's "other insurance".

32. In December, 2003, Central United began to use and market a new policy form which contained a written definition of "actual charge." *Exhibit 1, Final Report.*

33. In its Proposed Findings of Fact, Conclusions of Law and Order, Central United does not assert that Sections III (Claim Practices), IV (Complaints) or V (Criticisms & Formal Request Time Study) of the Final Report should be rejected or modified. *Central United's Post-Hearing Proposed Order,* p. 28.

34. Central United failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably have been completed within this time, in violation of 20 CSR 100-1.040 (as amended, 20 CSR 100-1.050). *Exhibit 1, Final Report,* p. 15.

35. Central United failed to advise claimants of the acceptance or denial of 57 claims within 15 working days of receipt of all forms necessary to establish the nature and extent of the claims, in violation of 20 CSR 100-1.050(1)(A). *Id.* at 15 – 16.

36. Central United improperly reduced a policyholder's benefits, in violation of 20 CSR 100-1.020(1). *Id.* at 16.

37. Central United failed to include one complaint in it its Company Complaint Log, in violation of 20 CSR 300-2.200(3)(D) (as amended, 20 CSR 100-8.040(3)(D). *Id.* at 18.

38. Central United failed to respond to three criticisms and one formal request within 10 calendar days after receipt. *Id.* at 19.

39. Central United presented evidence that employees of the Department's Consumer Affairs Division corresponded with consumers and Central United where the consumer complained regarding the amount of paid benefits by Central United. *Exhibit W, October 21, 2003 Carol Harden letter to consumer complainant; Exhibit X, August 29, 2005 Harden letter to consumer complainant; Exhibit Y, August 26, 2005 Mary Kempker letter to consumer complainant; Exhibit Z, September 13, 2005 Harden letter to Central United; Exhibit AA, August 9, 2005 Central United letter to Harden.*

40. Carol Harden testified for Central United pursuant to a subpoena issued by the hearing officer. In 2004, Carol Harden was employed by the Department in the Consumer Affairs Division, Consumer Services Section, as a consumer services specialist. *Tr. 195 – 95* (Harden). At that time, Harden reported to Mary Kempker who was the Director of the Division of Consumer Affairs. *Id.* at 195.

41. John McGettigan, Senior Vice President and General Counsel of Central United, testified: "Our company received those letters [from Harden and Kempker] and relied on the Department's statements in the letters that the company was paying claims accurately by paying the actual charge." *Tr. 229.* McGettigan's testimony regarding reliance is not credible. The correspondence in Exhibits W through Z occurred months, or even years, after Central United changed its administration of actual charge benefits in its policies on February 1, 2003. Additionally, Central United received the notice of the Division's market conduct examination in October, 2004, for an exam covering January 1, 2002 through December 31, 2004. *Tr. 243*(McGettigan); *Exhibit 1, Final Report,* p. 4.

42. Harden testified that Consumer Services, [within the Division of Consumer Affairs] cannot require an insurer to do anything. *Tr. 214.* If Consumer Services feels that an insurer is not in compliance, it can refer the matter to Market Conduct [Division of Insurance Market Regulation]. *Id.*

III. CONCLUSIONS OF LAW

A. Jurisdiction and Authority

43. The Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration has the duty to administer Chapter 354 and Chapters 374 to 385 RSMo, including the supervision, regulation and discipline of insurance companies authorized to operate and conduct business in Missouri.

44. The authority of the Division within the Department to perform a market conduct examination includes, but is not limited to §§ 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009

45. The jurisdiction of the Director to initiate and administer this proceeding is found in § 374.205.3 RSMo 2000 and 20 CSR 100-8.018.

46. The Director had authority pursuant to 20 CSR 800-1.130 to appoint a hearing officer to conduct the hearing requested by Central United under 20 CSR 100-8.018(1)(F). Once the hearing is completed, the hearing officer shall recommend findings of fact, conclusions of law and a final order to the Director. The Director shall dispose of the matter. 20 CSR 800-1.130; *see also* § 374.205 and 20 CSR 100-8.018(1)(F) and (G).

47. After a hearing under 20 CSR 100-8.018(1)(F), "the director shall issue final examination findings; and"

> (G) Within thirty (30) days of the end of the period allowed for the receipt of an acceptance or comments by the company or following a hearing, the director shall fully consider and review the report, together with any written comments and any relevant portions of the examiner's work papers and enter an order:
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> 1. Accepting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation, or prior order of the director, the director may issue an order for any legal or regulatory action as the director deems appropriate, provided that this order shall be a confidential internal order directing the department to take certain action, or the company and the division may negotiate a consent order, curative order, or settlement agreement. Any such order or agreement shall be final once issued or approved by the director;
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> 2. Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional documents, data, information, and requiring the submission of either a new report or a supplemental report; or
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> 3. For an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documents, data, information, and testimony.

* * *

(3) All orders entered pursuant to subsection (1)(G) shall be accompanied by findings and conclusions resulting from the director's consideration and review of the examination report, relevant examiner work papers, and written submissions, rebuttals, or comments, if any submitted by the company. A finding issued under subsection (1)(F) shall not be considered a final order. Any order issued under paragraph (1)(G)1. shall be considered a final administrative decision and may be appealed pursuant to section 374.055, RSMo, Chapter 536, RSMo, and 20 CSR 800-1.100 and shall be served upon the company by certified mail, together with a copy of the final examination report. Within thirty (30) days of the issuance of the final findings, as outlined in subsection (1)(G), the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the final report and related orders.

20 CSR 100-8.018(1)(F), (G) and (3).

47. "Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action." § 374.205.2(5).

48. Section 375.445 RSMo 2000 states:

1. When upon investigation the director finds that any company transacting business in this state has conducted its business fraudulently, is not carrying out its contracts in good faith, or is habitually and as a matter of business practice compelling claimants under policies or liability judgment creditors of the insured to either accept less than the amount due under the terms of the policy or resort to litigation against the company to secure payment of the amount due, and that a proceeding in respect thereto would be in the interest of the public, he shall issue and serve upon the company a statement of the charges in that respect and a notice of a hearing thereon.
2. If after the hearing the director shall determine that the company has fraudulently conducted its business as defined in this section, he shall order the company to cease and desist from the fraudulent practice and may suspend the company's certificate of authority for a period not to exceed thirty days and may in addition order a forfeiture to the state of Missouri of a sum not to exceed one thousand dollars, which forfeiture may be recovered by a civil action brought by and in the name of the director of insurance. The civil action may be brought in the circuit court of Cole County or, at the option of the director of insurance, in another county which has venue of an action against the person, partnership or corporation under other provisions of law. The director of insurance may also suspend or revoke the license of an insurer or agent for any such willful violation.

49. Section 375.934 states that it is an unfair trade practice for any insurer to commit any practice defined in § 375.936 if:

(1) It is committed in conscious disregard of §§ 375.930 to 375.948 or of any rules promulgated under those section.
(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

§ 375.934 RSMo 2000.

50. Pursuant to § 975.936, any of the following practices, if committed in violation of § 375.934 are defined as unfair trade practices in the business of insurance:

(6) "Misrepresentations and false advertising of insurance policies", making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission, or comparison which:

(a) Misrepresents the benefits, advantages, conditions, or terms of any policy;

* * *

(13) Any violation of section 375.445.

§375.936 RSMo 2000.

51. Section 376.777.7(3) RSMo 2000 states:

(3) The director of the department of insurance, financial institutions and professional registration shall approve only those policies which are in compliance with the insurance laws of this state and which contain such words, phraseology, conditions and provisions which are specific, certain and unambiguous and reasonably adequate to meet needed requirements for the protection of those insured. The disapproval of any policy form shall be based upon the requirements of the laws of this state or of any regulation lawfully promulgated thereunder.

52. Section 376.780 states:

1. Other policy provisions. No policy provision which is not subject to section 376.777 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to sections 376.770 to 376.800.

2. Policy conflicting with sections 376.770 to 376.800. A policy delivered or issued for delivery to any person in this state in violation of sections 376.770 to 376.800 shall be held valid but shall be construed as provided in sections 376.770 to 376.800. When any provision in a policy subject to sections 376.770 to 376.800 is in conflict with any provision of sections 376.770 to 376.800, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 376.770 to 376.800.

53. Rule 20 CSR 400-5.700(5)(A)1 states:

(5) Advertisements of Benefits Payable, Losses Covered or Premiums Payable.

(A) Deceptive words, phrases or illustrations are prohibited.

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of this information or use of these words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied or does not remedy misleading statements or omissions of pertinent fact. No advertisements may employ devices which create undue fear or anxiety in the minds of its readers judged by the standards in section (4).

B. Conclusions of Law Relating to the Final Examination Report

54. Central United has the burden of demonstrating that the Final Report should be modified or rejected, as requested. 20 CSR 100-8.018(1)(F). Central United has not met its burden.

55. Central United's attempt to change the terms of its policy, #CP3000AMO, with Endorsement Form CP3ACEND, was ineffective. Central United's policies were guaranteed renewable and could not be unilaterally modified by Central United without the policyholders' consent and an exchange of consideration. Central United violated § 375.934 by engaging in unfair trade practices as defined in § 375.936, by committing the violations defined in § 375.936(13) with such frequency to indicate a general business practice to engage in that type of conduct.

56. Central United's unilateral imposition of a new contractual term and change in its claims administration for "actual charge" policies is fraudulent, amounts to a failure to carry out its contracts in good faith, and compels claimants to accept less than the amount due under the terms of their policy, in violation of § 375.445 and in violation of § 375.936(13).

57. Central United's change in its interpretation of the term "actual charge" and the manner in which Central United was administering claims effective February 2003 highlighted an ambiguity in Central United's policy forms. When there is an ambiguity in an insurance contract, the contract must be construed in favor of the policyholder. *Jones v. Mid-Century Ins. Co.*, 2009 WL 1872113, at *2 (Mo. June 30, 2009).

58. Section 376.777.7(3), RSMo, prohibits ambiguities in individual health insurance policies. For the policy forms to comply with §§376.777.7(3) and 376.780.2, RSMo, Central United was under an obligation to interpret the undefined term "actual charges" in the manner

most favorable to the insured. By adopting and implementing the less favorable interpretation and claims administration procedures for those policies where "actual charges" was undefined, Central United violated § 376.780 by delivering policies Central United implicitly agrees are not in conformance with § 376.777.7(3).

59. Because Central United changed how it administered claims so that the amount paid on a claim depended on the amount the provider accepted as payment in full from the policyholder's "other insurance," rather than the billed amount, the policyholder's benefit under the Central United policy was adversely affected by any "other insurance" he or she may have in addition to the Central United policy. As a result of the change in the manner in which Central United administered its claims, any benefit payments that were based on a provider's "actual charge" were limited to whatever lower amount the provider agreed to accept from the policyholder's primary health plan, Medicare, or other third party payer.

60. Central United's failure to disclose that the policyholder's actual charges benefits were affected by "other insurance" made Central United's marketing and advertising of its policy forms incomplete, deceptive, ambiguous and a misrepresentation of the benefits, advantages, conditions, or terms of the policies, in violation of §375.936(6) and 20 CSR 400-5.700(4) and (5)(A)1. Where the advertisements claimed that the benefits would be "in addition to" or "regardless" of other insurance, it is reasonable for an consumer to believe that they would be required to pay what a doctor bills, or what they would actually be charged in the absence of other insurance.

61. Central United's marketing and advertising of ambiguously worded policy forms between February 1, 2003, and July 1, 2003, through uninformed producers constitutes a violation of § 375.934 by engaging in unfair trade practices as defined in § 375.936, by committing the violations defined in § 375.936(6) with such frequency to indicate a general business practice to engage in that type of conduct.

62. Missouri law prohibits any insurance company transacting business in Missouri from conducting its business fraudulently, carrying out its contracts in bad faith, or compelling insured to accept less than the amount due under the terms of their policy. § 375.445. Central United engaged in such conduct which constitutes a violation of § 374.445 and is an unfair trade practice pursuant to § 375.934, committed with such frequency to indicate a general business practice to engage in such conduct. § 376.936(13), RSMo.

63. Central United assumed the block business of Dixie in 1996 and of Commonwealth in 1997. Central United's failure, when purchasing these blocks of business, to recognize the change in medical billing and reimbursement cannot be shifted to the shoulders of its policyholders.

64. Central United's witnesses Blakey, Chapman, and Morrisey testified that the changes in medical billing, dating back to at least the 1980s, necessitated the changes in the administration of actual charges benefits. This testimony does not address the fact that Central United did not attempt to change its administration of actual charges benefits until 2003.

decide how the Director of the Department should apply Missouri insurance law to Central United Life's conduct in the state of Missouri. Nowhere in the *Skelton Final Judgment* does the Alabama state circuit court attempt of extend subject matter jurisdiction over the regulatory authority of the Director, Department or Division. The *Skelton* court lacks jurisdiction over the enforcement of Missouri's insurance law against an insurer licensed to do business in Missouri.

78. Second, the Director, Department and/or Division were not parties to the *Skelton* Alabama circuit court action and no litigation occurred in *Skelton* on the issue of personal jurisdiction over the Director, Department or Division. *Miller v. Dean*, 2009 WL 981113 (Mo. App. W.D. April 14, 2009). Moreover, Central United fails to offer a basis for a Missouri state official or governmental entity to be sued and subject to personal jurisdiction in an Alabama state court in a private, class action proceeding. Finally, the fact the Central United's policyholders in Missouri may be bound by the Alabama court's judgment does not assist the insurer in a Missouri administrative proceeding. Simply put, the Missouri policyholders may have no power to require Central United to do anything to the contrary of the judgment of the Alabama court, but the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration does, where permitted by Missouri insurance law.

79. In Paragraph 88 of its Post-Hearing Proposed Order, Central United contends that "[b]y simply concluding ambiguity because [Central United] allegedly changed its practices to process claims based on more accurate EOB information rather than provider list prices the Report fails to apply an appropriate legal standard." Contrary to that contention, however, the record is replete with evidence of ambiguity regarding the meaning of the term "actual charge". If the term was unambiguous, Central United would not have issued endorsements for their older policies and begun marketing new policies with the term defined. If the term was unambiguous, Central United would not have administered the claims on its own and the Commonwealth and Dixie policies as it did for years prior to February 1, 2003, and then abruptly change claims administration. Also, if the term was unambiguous, no new statutes would be needed in various the states defining the term actual charges. *See* Exhibit E (new state statutes) with *Exhibit MM, October 31, 2008 Response of Central United to the August 26, 2008 Report.*

80. Furthermore, several lawsuits have been filed around the country regarding the term at issue. District courts in Alabama and Louisiana have found that the phrase "actual charges" is unambiguous "when given its ordinary and plain meaning in the context of the policy" and that it means "the amount that the insured is legally obligated to pay." *Claybrook v. Central United Ins. Co.*, 387 F.Supp.2d 1199, 1204 (M.D.Ala.2005); *Jarreau v. Central United Ins. Co.*, 2006 WL 2086011, * 1 (M.D.La.2006) (questioned by *Guidry v. American Public Life Ins. Co.*, 512 F.3d 177, 182 (5th Cir. 2007), and *Ward v. Dixie Nat'l Life Ins. Co.*, 257 Fed.Appx. 620, 630 (4th Cir. 2007)). Conversely, the Fifth Circuit and Fourth Circuit have found the phrase "actual charges" as used in a supplemental cancer insurance policy to be ambiguous. *Guidry*, 512 F.3d at 182; *Ward*, 257 Fed. Appx. at 627. The Western District of Oklahoma has also found that the undefined phrase "actual charges" is ambiguous in a limited benefit health insurance policy. *Metzger v. American Fidelity Assurance Co.*, 2006 WL 2792435 at *4-5 (W.D. Okla. Sept. 26, 2006). The Northern District of Mississippi has also held that "the term 'actual charges' as used but not defined in the subject policy means the amount of money the provider typed on the bills and sent to the insured and insurer." *Conner v. American Public Life Ins. Co.*, 448 F.Supp.2d

762, 766 (N.D. Miss. 2006). And very recently, the District Court of Arizona found the term actual charge to be ambiguous and could be interpreted in different ways. *Pierce v. Central United Life Ins. Co.*, 2009 WL 2132690 (D.Ariz. July 15, 2009).

81. In a similar vein, Central United points to the definition of "actual payment" in 20 CSR 400-2.065(1) to support its interpretation of actual charge benefits in its policies. *Central United Post-Hearing Proposed Order*, ¶ 98.c. That regulation states:

> (A) "Actual payment," the real total dollar amount actually paid or to be paid in fact, by a health insurer, or by the health insurer and the insured when the insured is responsible for some part of the cost, to a health services provider for a health service(s) pursuant to a health plan. Annual adjustments in amounts paid to providers which are based on referral rates, quality or cost effectiveness measurements, or other similar contractual provisions may be excluded from the calculation of actual payments, at the option of the health insurer.

82. This citation does not avail Central United for two reasons: (1) the phrase "actual payment" is not at issue in this matter and simply because the word "actual" appears in the phrase, it does not render the phrase sufficiently similar to the term actual charges to provide any guidance, and hence, is irrelevant; and (2) if the term "actual charges" is not ambiguous and is not a term of art as Central United contends, Central United would not need to rely on the definition of a different phrase in a different context to aid in defining the term.

ORDER

Based upon the substantial and competent evidence in the record and presented at the hearing in this matter, and having read the full record including the Final Examination Report, transcript, written submissions and comments, and all evidence submitted by the parties in this matter, including any relevant portions of the examiner's work papers,

IT IS HEREBY ORDERED that the Final Examination Report of Central United Life Insurance Company (NAIC #61883), Examination #5013-36-TGT, dated July 10, 2009, is hereby accepted as filed, pursuant to 20 CSR 100-8.018(1)(F).

65. Central United failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably have been completed within this time, in violation of § 375.1007(3) and 20 CSR 100-1.040 (as amended 20 CSR 100-1.050(4), eff. 7/30/08)).

66. Central United failed to advise claimants of the acceptance or denial of 57 claims within 15 working days of receipt of all forms necessary to establish the nature and extent of the claims, in violation of § 375.1007(3) and 20 CSR 100-1.050(1)(A).

67. Central United improperly reduced a policyholder's benefits, in violation of 20 CSR 100-1.020(1).

68. Central United failed to include one complaint in it its Company Complaint Log, in violation of § 375.936(3) and 20 CSR 300-2.200(6), (as amended 20 CSR 100-8.040(6), eff. 7/30/08)).

69. Central United failed to respond to three criticisms and one formal request within 10 calendar days after receipt, in violation of § 374.205.2(2) and 20 CSR 300-2.200(6), (as amended 20 CSR 100-8.040(6), eff. 7/30/08)).

C. Resolution of Other Legal Issues

70. In its Proposed Order, Central United would have the Director declare Section II of the Final Report as invalid because:

> [T]he Director is estopped to assert and apply an interpretation of actual charges as meaning billed charges and to penalize Central United on that basis due to prior authorized statements and acts of Department agents and employees, upon which Central United relied. The Report attempts to find violations for Central United's payment of "actual charges" claims based the amount actually paid for a service. However, the evidence indicates that agents and employees of the Department made prior statements and took action in direct contradiction to the findings and conclusions in Section II of the Report . . . .

Central United Post-Hearing Proposed Order, ¶ 95. Central United then lists the correspondence between employees of the Division of Consumer Affairs and Central United Life and consumer complainants (policyholders). Central United goes on to claim that it "relied upon these statements and actions of the Department[,] that its reliance was reasonable under the circumstances and that [Central United] will be injured if the contradictions contained in Section II of the Report are permitted." *Id.*, ¶ 96.

71. The case law in Missouri amply demonstrates the persistent prevalence of the general principle of no estoppel against the government and a recitation of such case law will not be repeated here. The requirements for applying estoppel to government agencies is set forth in *Bailey v. City of Goodman,* 69 S.W.3d 154 (Mo. App. 2002).

> A party asserting estoppel must prove all required elements of estoppel in order to prevail. These elements are 1) a statement or act by the government entity inconsistent with the subsequent government act; 2) the citizen relied on the act; and 3) injury to the citizen. In addition, the governmental conduct complained of must amount to affirmative misconduct.

Id. at 157 (internal citations omitted). Equitable estoppel may run against the state, but only where there are exceptional circumstances and a manifest injustice will result. *Prince v. Division of Family Services,* 886 S.W.2d 68, 73 (Mo. App. 1994). Equitable estoppel is not applicable if it will interfere with the proper discharge of governmental duties, curtail the exercise of the state's police power or thwart public policy, and is limited to those situations where public rights have to yield when private parties have greater equitable rights. *State ex rel. Capital City Water Co. v. Missouri Public Service Comm'n,* 850 S.W.2d 903, 910 (Mo. App. 1993); *compare Twelve Oaks Motor Inn, Inc. v. Strahan,* 110 S.W.3d 404, 408 (Mo. App. S. D. 2003) (court estopped the government from denying the timeliness of an appeal of a tax assessment where the government had erroneously informed the taxpayer as to the deadline for filing the appeal and where the timely appeal of the tax assessment, did not involve a substantive public policy) *with Fraternal Order of Police Lodge No. 2 v. City of St. Joseph,* 8 S.W.3d 257, 263-264 (Mo. App. W. D. 1999) (appellants failed to meet their burden of proving affirmative misconduct and the case dealt with substantive public policy regarding the solvency of the police pension fund).

72. Central United has not proven the required elements of estoppel against the Director, Department or Division. As a matter of fact and law, nothing in the correspondence is a representation or assurance to either the consumer or Central United upon which they could reasonably rely. Central United does not and cannot assert "affirmative misconduct" by the Director, Department or Division. This is especially true where Central United decided before February, 2003 to change its actual charge claims procedures, which is nine months **before** the earliest correspondence, Exhibit W. No injury could have resulted to Central United based upon the correspondence because it had already changed its procedures and was notifying policyholders. As stated in the Findings of Fact, John McGettigan's testimony that Central United relied upon the correspondence of the Department's employees is not credible.

73. The Director, Department, and Division are charged with enforcing the insurance laws of the state of Missouri. Estoppel will interfere with the proper discharge of governmental duties and thwart public policy of protecting Missouri insurance consumers. There is a case directly on point to Central United's argument. In *Traders Mutual Fire Insurance Company v. Leggett,* 284 S.W.2d 586 (Mo. 1955), an insurance company argued that past knowledge and implicit approval by the insurance department of the insurance company's business precluded the insurance department's attempt to enjoin such business:

> It is claimed, by reason of its annual reports and the department's examinations, that the department long had knowledge of the fact that the company was writing automobile insurance and that the department's knowledge and actions in these respects constituted an administrative construction of the statutes and the company's charter and should be given some weight indicative of the company's power to write that class of insurance. But aside from the meagerness of the record and the inconclusiveness of the facts shown, the knowledge or tacit

> consent of the department would not make the company's act of writing automobile insurance lawful if in point of fact the writing of such insurance was unauthorized and unlawful.

Id. at 588 – 589.

74. In its Post-Hearing Proposed Order, Paragraph 83, Central United argues that the Final Report must be rejected because it contradicts the final judgment in a class action proceeding styled *Cora Skelton and Stephen McKnight v. Central United Life Insurance,* Civil Action No. CV-2008-900178 in the Circuit Court of Mobile County, Alabama ("*Skelton*"), Exhibit C. Central United cites to Article IV, § 1 of the United States Constitution which states, in pertinent part: "Full Faith and Credit shall be given in each State to the public Acts, Records, and judicial Proceedings of every other State."

75. Central United goes on to state that the parallel provision of Missouri state law is located in section 490.130, RSMo, and that "full faith and credit" applies to state administrative bodies as much as to state courts, citing *V.M.B. v. Missouri Dental Board*, 74 S.W.3d 836, 841 (Mo. App. W.D. 2002). Central United claims the effect of the *Skelton* judgment given Full Faith and Credit here is that all of the Missouri policyholders alleged by the Department to have been subject to unfair practices relating to "actual charges" have been compensated and have released all claims against Central United relating to these matters. The meaning of "actual charges" has been adjudicated as between the parties to these policies and all claims relating thereto released by the policyholders. Central United quotes part of the *Skelton* Final Judgment:

> All future claims for actual-charge benefits, submitted by Settlement Class members who did not exclude themselves from the Settlement[1], will be processed and paid actual charges benefits for chemotherapy/ radiation/blood based upon the monetary amount that Central United can determine was the amount paid by or on behalf of the insured, beneficiary or policyholder and accepted as payment in full by the healthcare provider. Central United may require an Explanation of Benefits ('EOB') or proof of loss documentation from the policyholders primary insurance company or Medicare in order to determine that monetary amount.

76. Central United's arguments are misplaced and the full faith and credit clause of the United States Constitution, or as codified in Missouri under § 490.130, has no application to this proceeding. Full faith and credit, as applied to judgments of a state court, makes "that which has been adjudicated in one state res judicata to the same extent in every other." *Magnolia Petroleum Co. v. Hunt*, 320 U.S. 430, 438, 64 S.Ct. 208, 213 (1943); *overruled on other grounds by Thomas v. Washington Gas Light Co.*, 448 U.S. 261, 100 S.Ct. 2647 (1980).

77. Missouri courts give full faith and credit to judgments of sister states except where it can be shown that there was no jurisdiction over the subject matter or over the person or where the judgment was obtained by fraud. *Big Tex Trailer Mfg. v. Duff Motor Co., Inc.*, 275 S.W.3d 384, 386 (Mo. App. W.D. 2009). First, the Alabama court has and had no power to

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[1] Central United's footnote: Only four (4) Missouri policyholders opted out of the class settlement judgment.

SO ORDERED, SIGNED AND OFFICIAL SEAL AFFIXED THIS 27th DAY OF AUGUST, 2009.

John M. Huff
Director

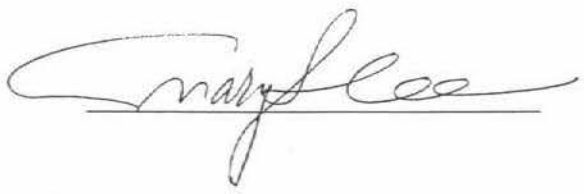
CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing document was forwarded by facsimile, hand-delivery, and certified mail, this 27th day of August, 2009 to:

Sherry L. Doctorian, Esq.
Armstrong Teasdale LLP
3405 West Truman Blvd., Suite 210
Jefferson City, MO 65109

And hand delivered to:

Carolyn H. Kerr, Esq.
Senior Attorney
Insurance Market Regulation Division
Department of Insurance, Financial Institutions
and Professional Registration



State of Missouri

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION

IN RE:	)	
	)	
Central United Life Insurance Co.	)	**Case No. 090814644C**
Missouri Market Conduct Examination	)	
No. 5013-26-TGT	)	

ORDER

This matter comes before the Hearing Officer on the Motion to Correct the Record filed by the Division of Insurance Market Regulation ("Division"), Department of Insurance, Financial Institutions and Professional Registration on August 26, 2009. Counsel for Central United Life Insurance Company ("Central United") has been notified and does not object to the record being modified to reflect accurate information regarding Central United.

For good cause shown, the Division's Motion is hereby granted and Exhibit 1 submitted by the Division at the August 25, 2009 hearing in this matter, is modified in accordance with the Division's Motion as follows:

Exhibit 1 is the Final Market Conduct Examination Report of Central United, dated July 10, 2009, and signed by Michael W. Woolbright on July 10, 2009. Exhibit 1 contained the incorrect NAIC Number, NAIC Group Number, and the state of domicile of Central United.

Exhibit 1 and the record are modified to reflect that Central United's NAIC Number is 61883 and NAIC Group Number is 1117. Central United is currently domiciled in the State of Arkansas. When the examination was originally called and began, Central United was domiciled in Texas, and the company has since redomesticated to Arkansas.

SO ORDERED.

8/27/09
Date

Mary S. Erickson, Hearing Officer
Missouri Department of Insurance, Financial Institutions & Professional Registration

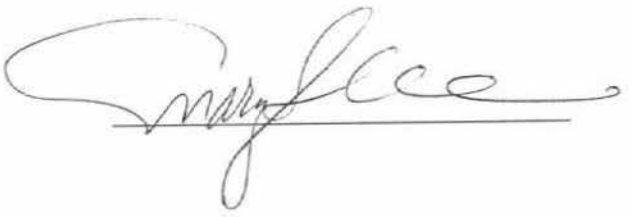
CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the foregoing document was forwarded by facsimile and U.S. mail, postage prepaid, this 27th day of August, 2009 to:

Sherry L. Doctorian, Esq.
Armstrong Teasdale LLP
3405 West Truman Blvd., Suite 210
Jefferson City, MO 65109

And hand delivered to:

Carolyn H. Kerr, Esq.
Senior Attorney
Insurance Market Regulation Division
Department of Insurance, Financial Institutions
and Professional Registration



STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

MARKET CONDUCT

FINAL EXAMINATION REPORT

OF THE

CANCER AND SPECIFIED DISEASE
HEALTH INSURANCE BUSINESS

OF

CENTRAL UNITED LIFE INSURANCE COMPANY

NAIC NUMBER: 65323

NAIC GROUP CODE: 2398

10700 NORTHWEST FREEWAY, THIRD FLOOR
HOUSTON, TEXAS 77092

STATE OF DOMICILE: TEXAS

July 10, 2009

REPORT NUMBER: 5013-36-TGT

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FOREWORD

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration. In performing this examination, the Missouri Department of Insurance, Financial Institutions and Professional Registration selected a small portion of the Company's operations for review. As such, this report does not reflect a review of all practices and all activities of the Company. The examiners, in writing this report, cited errors made by the Company. The final examination report consists of three parts: the examiners' report, the response of the Company, and administrative actions based on the findings of the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration.

Wherever used in this report:

- "CUL" or "Company" refers to Central United Life Insurance Company;
- "CSR" refers to the Code of State Regulations;
- "DIFP" or "Department" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "NAIC" refers to the National Association of Insurance Commissioners;
- "RSMo" refers to the Revised Statutes of Missouri.

SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, §§374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, §447.572, RSMo grants authority to the DIFP to determine Company compliance with the Uniform Disposition of Unclaimed Property Act.

The Company examined was Central United Life Insurance Company.

The time period covered by this examination is primarily from January 1, 2002, through December 31, 2004, unless otherwise noted.

The purpose of this targeted examination is to determine whether the Company complied with Missouri laws and DIFP regulations in its marketing, underwriting and administration of cancer and specified disease health insurance policies..

While the examiners reported on errors found in individual files, the examination also focused on the general business practices of the Company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a 10% error tolerance ratio to all operations of the Company, with the exception of claims handling. The error tolerance ratio applied to claims matters was 7%. Any operation with an error ratio in excess of these criteria indicates a general business practice.

The examination focused on review of the cancer and specified disease health insurance business of the company. The examination included, unless otherwise noted, a review of the following areas of the Company's operations: Sales and Marketing, Underwriting, Claims and Complaints/Grievances.

This market conduct examination was performed at the home office of the Company: 10700 Northwest Freeway, Houston, Texas 77092.

EXECUTIVE SUMMARY

The main issues of concern found by the examiners are as follows:

1. CUL materially changed how it administers the benefit provisions of guaranteed renewable cancer health insurance policies beginning February 1, 2003. The change has impacted the benefits paid for claims under many of the policies issued by CUL as well as benefits paid for claims under many of cancer insurance policies that the Company assumed from or administers for Dixie National Life Insurance Company or assumed from Commonwealth National Life Insurance Company.

   Many of the benefit provisions of the Company's cancer policies are worded to pay benefits based on a health care provider's *actual charge* for covered services. Prior to February of 2003, the Company administered those *actual charge* claims based on the amount health care providers billed for their services. Beginning in February of 2003, the Company administered claims based on a different definition of the term *actual charge*. From that date forward, the Company defined *actual charge* to mean, *"...the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided."* As a result, any benefit payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer. This change resulted in:

   A. A reduction to the amount of benefits payable,
   B. An increase in the number of consumer complaints,
   C. Increased litigation against the Company,
   D. More time consuming claims processing because the company had to ask claimants to provide EOBs from their primary health plan or their Medicare benefits summary, and,
   E. Unfair discrimination against equally situated policy owners due to differences among their primary health plans.

   The term *actual charge* was not defined in any of the Company's marketing materials or in any of the cancer policies sold in Missouri until October of 2003. It was not until December of 2003 that all cancer policies the company marketed in Missouri that paid one or more benefits based on a health care provider's *actual charge* included a definition of that term.

2. The Company and the DIFP have both received consumer complaints because of the Company's slow payment of claims. Claims investigation and claims payment time studies outlined in this report clearly demonstrate that slow payment of claims is an issue of concern. Consumer complaint files indicate that the changed definition of the term *actual charge*, slow payment of claims (to which that changed interpretation would contribute), and premium rate increases made up the majority of the complaints against the Company during the time frame covered by this examination.

SECTION I

I. SALES AND MARKETING PRACTICES

This section details the examination findings regarding sales and marketing practices. The items reviewed were the Certificate of Authority, product marketing and advertising materials and agent training materials.

A. Company Authorization

Missouri law limits the entities that may sell insurance and the types of insurance they may sell. These limitations exist to protect consumers and ensure that they receive fair treatment from insurers. After an insurer has submitted an application and complied with all requirements to conduct insurance business in Missouri, the DIFP grants a license called a Certificate of Authority.

During the time period covered by the examination, Central United Life Insurance Company had authority to transact business in the following lines of insurance:

* Life, Annuities and Endowments
* Accident and Health

B. Marketing Practices

Missouri law requires that an insurer be truthful and provide adequate disclosure when marketing its insurance products. This includes assuring that its advertisements do not omit information if that omission has the capacity, tendency, or effect of misleading or deceiving potential customers as to the extent of any policy benefits payable. The examiners reviewed Company marketing practices including advertising and agent training materials, to determine whether those materials and marketing practices complied with Missouri law.

The examiners found the following issue in this review:

Many of the cancer insurance policies the Company issued in Missouri, as well as cancer policies issued in Missouri that it assumed from or administered for other insurers, contain benefit provisions that pay benefits based on a health care provider's *actual charge* for covered services. None of the marketing materials used in the solicitation or sale of those policies defined or explained the term *actual charge*.

Before February 1, 2003, the Company, as well as those companies from which it had assumed such policies, administered claims based on *actual charge* meaning the amount billed by the health care provider. From that date forward any benefit

payments that were based on a provider's *actual charge* were limited to whatever lower amount the provider agreed to accept from the insured person's primary health plan, Medicare or other third party payer.

Based on information provided by the Company, it continued to market policy form CP3000AMO until December 2003, although that policy form and its related marketing materials did not define *actual charge* or explain the limiting nature of that terminology. A notice in that regard was not sent to existing policyholders until July 3, 2003.

The company did not begin attaching endorsement form CP3ACEND to new issues of this form to add the definition of *actual charge* until October 16, 2003. Marketing materials used in the solicitation of this policy, however, were never revised.

The only written communication from the company to its agents regarding this change was sent to them sometime in July 2003. That communication consisted only of a copy of the Notice form that had been sent to policyholders on July 3, 2003.

Therefore, between February 1, 2003, and July 1, 2003, the Company marketed an ambiguously worded policy form through misinformed agents (form CP3000AMO).

Reference: § 375.936(6), RSMo, and 20 CSR 400-5.700(5)(A)1.

C. Advertising

No advertisement for cancer policies providing *actual charge* benefits that were issued by the company prior to October 2003, and no advertisement of such policies that the company assumed from or administers for Dixie National Life Insurance Company or assumed from Commonwealth National Life Insurance Company, define or explain the term *actual charge*. Furthermore, the advertising materials did not explain that, after February 1, 2003, the actual amount of benefits payable depended on the claimants' "other" insurance rather than the billed charges.

Review of advertisements from these companies for policies in force during the time frame of this examination, and that pay one or more benefits based on *actual charges*, found the following:

1. Dixie National Life Insurance Company – The Company was able to produce two advertisements used by this company:

   a. Form CP-1005-Rev.3/88 - This ad advertised policy form CP-1005. Under the heading Additional Benefits are six bullet items. The first and last bullet items, "***Pays in addition to all other insurance**" and "***Pays directly to you**", are the only bullet items in bold type.
   b. Form NCP-5-(Rev.9/92) - This ad advertised policy form CP-1004. White text on a black background at the bottom of the third page of this ad, in bold type and in the largest font on the page, reads: "·PAYS IN ADDITION·". Below that, also in

bold type but in a slightly smaller font, reads: "**to any other insurance, private or governmental, including Medicare, and directly to you or whomever you designate. No reduction in benefits at any age.**"

The two sentences in bold type in each of these ads imply that benefits of the policy are not affected in any way by other insurance a claimant may have. This characterization of the policy's benefits fail to inform the purchaser that the actual level of benefit does, in fact, depend on the policyholder's "other insurance." Because CUL changed its application of "actual charge," so that the amount paid on a claim depends on the amount the provider accepted as payment in full from the policyholder's "other insurance," rather than the billed amount (as it was paying prior to February 1, 2003), the policyholder's benefit under the CUL policy was adversely affected by any other insurance he or she may have in addition to the CUL policy.

A person with experience in the field of health insurance may understand that each sentence addresses a separate issue. However, because of the overall style and appearance of this ad, an ordinary, prudent consumer would believe that these two sentences should be read together to mean that benefits of the policy are not reduced due to any other insurance they may have no matter how old they become.

This failure to fully inform the customer or potential policyholder of the effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700(5)(A)1

2. Commonwealth National Life Insurance Company – The Company was able to produce four advertisements used by this company. Form BCEP-94 advertised policy form CEP-93ULT. On the lower half of page 3 of this ad, below the bolded, large type heading, "**Why does this outstanding policy deserve your consideration**" are six bullet point items in bold type. The second bullet point states: "**It <u>pays regardless</u> of other insurance you may have!**"

   This advertisement directly conflicts with the Company's new interpretation of *actual charge*. This advertisement clearly illustrates the intention of the issuing company to pay *actual charge* benefits based on the amount of a provider's bill for covered services.

   Reference: §375.936(6) (a), RSMo.

3. Central United Life Insurance Company – The Company provided two advertisements of its policies:

a. Form CP-1003-GN-7/96. At the bottom of the second page, in the second largest font that appears on the page and in bold type, is the same wording as described in 1b, above, although in black type on a white background: "**PAYS IN ADDITION" to any other insurance, private or governmental, including Medicare, and directly to you or whomever you designate. No reduction in benefits at any age.**"

A person with experience in the field of health insurance may understand that the two sentences address separate issues. However, because of the overall style and appearance of this ad, an ordinary, prudent consumer would have believed that these two sentences should be read together to mean that benefits of the policy are not reduced due to any other insurance they may have no matter how old they become.

Additionally, this characterization of the policy's benefits fail to inform the purchaser that the actual level of benefit does, in fact, depend on the policyholder's "other insurance." This failure to fully inform the customer or potential policyholder of the effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700(5)(A)1

b. Form CP-1004-GN-7/96 - The front cover page of this ad includes a list of six items that describe what the policy pays. The second item in this list states, "*PAYS* in addition to any other policy you might own."

This ad implies that benefits of the policy are not affected in any way by other insurance a claimant may have. Again, the Company's failure to fully inform the customer or potential policyholder of the actual effect of "other insurance" on the level of coverage provided by the CUL policy had the capacity, tendency, or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the CUL policy.

Reference: §375.936(6)(a), RSMo, and 20 CSR 400-5.700 (5)(A)1

A review of advertisements the company used after January 1, 2003, to market policies that provide one or more benefits based on the *actual charge* for a covered service found the following:

1. Outlines of Coverage form CP 3000AMO-OC – This outline of coverage was used in the sale of cancer policy form AP3000AMO after the date the Company changed how it defines *actual charge*. These outlines of coverage do not define or explain the term *actual charge*.

2. CP3000A 0102-MO – The following statement appears in bold type on the bottom of page 2 of this brochure, in a font that is consistent with the font used for other text on that page: **"PAYS IN ADDITION to any other insurance, private or government, including Medicare, and directly to you or whomever you designate."** The brochure does not include a definition or explanation of the term *actual charge*.

3. CP3000A-CC-0202 (AR, IL, MO) – Language at the top of page 2 is substantially similar to language in form CP3000A 0102-MO, as shown above.

Reference: 20 CSR 400-5.700(5)(A)1

SECTION II

II. UNDERWRITING PRACTICES

This section of the report details the examination findings regarding underwriting practices.

To minimize the duration of the examination, while achieving an accurate evaluation of the issues of concern examiners limited their review to a review of policy forms.

A. Forms and Filings

The examiners reviewed policy form documents and related forms to determine if the Company complied with Missouri law and requirements for the filing, approval and content of policy forms and related forms. Those forms were also reviewed to ensure that the contract language used is not ambiguous and is adequate to protect the consumer.

The examiners found the following errors in this review:

No cancer insurance policy forms that the Company issued or renewed in Missouri from the beginning of the period covered by this examination (1/01/02) through October 16, 2003, that based one or more benefits on the provider's *actual charge* for covered services, contained a definition of the term *actual charge*. Policies the Company sold or that it assumed from Dixie National Life Insurance Company and Commonwealth National Life Insurance Company had been sold and administered such that *actual charges* meant the amount the provider billed for the covered service. The intent of these companies to pay *actual charge* benefits based on the amount billed by the provider is clear upon review of those forms and related advertising.

When any of these insurers chose to further limit the amount of policy benefits payable for a covered service, whether the benefit provision was worded to pay based on the *actual charge or usual and customary* charge these companies did so by placing specific dollar limits on the maximum amount payable, or, in the case of benefits for surgery, by limited benefits to a surgical fee schedule.

Prior to February 2003, there was no ambiguity in such policies issued by the Company, or in like policies assumed from or administered for Dixie National Life Insurance Company and Commonwealth National Life Insurance Company, because claims filed for *actual charge* benefits were consistently adjudicated on the basis of the health care provider's billed charge. That was no longer the case when the Company implemented its decision to change how it defined the term *actual charge* beginning February 1, 2003.

The Company sent "IMPORTANT NOTICE REGARDING CANCER CLAIMS" to all owners of *actual charge* policies on July 1, 2003. This was the first communication from the Company to policyholders concerning its new interpretation of *actual charge*. That notice explained the Company's new interpretation of *actual charge* and informed policyholders that, because of this change, Explanation of Benefit forms (EOBs), Medicare Benefit Summaries or similar documents would be required as part of proofs of loss to show the amount of money a provider agreed to accept as full payment for covered services.

In addition, the policy forms that provide one or more benefits based on a provider's *actual charge*, but do not contain a definition of that term, have become ambiguous and no longer meet the standards under which they had been approved, as set forth in §376.777.7, RSMo. The Company continued to market policy form CP3000 AMO until December 2003.

New issues of policy form CP3000 AMO were not amended or revised to include a definition of *actual charge* until endorsement form CP3ACEND was mailed to existing Central United Life Insurance Company policy holders on October 16, 2003, and attached to new issues of that policy form from that date forward.

Pursuant to the provisions of §376.780, RSMo, "A policy delivered or issued for delivery to any person in this state in violation of sections 376.770 to 376.800 shall be held valid but shall be construed as provided in sections 376.770 to 376.800. When any provision in a policy subject to sections 376.770 to 376.800 is in conflict with any provision of sections 376.770 to 376.800, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of sections 376.770 to 376.800."

Finally, the company had no contractual right to change in-force policies by endorsement, using form CPA3CEND without the signed consent of policy owners. All of those policies were guaranteed renewable. Each policy owner was entitled to maintain their policy in force as issued, so long as they paid the required premium.

Reference: §§375.445, 376.777.7, and 376.780, RSMo.

For all of the reasons stated above the Company should re-process, and pay, based on the provider's billed charge, all claims filed on all such policies issued before October 16, 2003, for which benefits were payable based on the provider's *actual charge* unless:

1. The Company can show that the policy under which claim was filed has contained a definition of the term actual charges since the date of issue, that definition is consistent with the way the claim was adjudicated, and any amendments to the policies were agreed to by the policy owners; or

2. Claims for *actual charge* benefits were paid based on the provider's billed charges.

The following lists, for each company, the form numbers of the policy forms that were issued in Missouri to claimants of one or more of the 200 claims files reviewed during this examination Each of these policies provide one or more benefits based on a provider's actual charge but none of these policies define or explain that term:

1. Central United Life Insurance Company –

   Forms: CP-1003-MO, CP3000 AMO and CP-1004-GN-7/96

2. Dixie National Life Insurance Company –

   Forms: CP-1003, CP-1004 and CP-1005

3. Commonwealth National Life Insurance Company –

   Forms: CEP-350-MAX-COMB
   CEP-93ULT
   CEP-NP93-MO
   CEP-93CONV
   CEP-120-REV-487 *
   CEP-200-GP/NGP-MO *

* Although both of these policies pay *actual charge* benefits for various inpatient services such as drugs, attending physician visits, private duty nursing services and inpatient and outpatient lab services, these benefits are subject to very limited daily or per occurrence dollar limits.

Cancer Insurance Policy Claims Time Studies

Field Size: 11,374
Sample Size: 200
Type of Sample: Random

1. Acknowledgement Time Study

Insurers are required to acknowledge receipt of notification of a claim within 10 working days.

Working Days	Number of Claims	Percent
0-10	200	100%
Over 10	0	0%
Total		100%

Examiners found no errors in this review.

2. Investigation Time Study

The company failed to complete its investigation of 29 claims within 30 days after notification of the claim, although the investigations could reasonably be completed within this time.

Calendar Days	Number of Claims	Percent
0-30	171	85.5%
Over 30	29	14.5%
Total		100%

Error Ratio: 14.5%

Reference: 20 CSR 100-1.040 (as amended 20 CSR 100-1.050)

Note: Each of the 29 above referenced claims is also among the exceptions noted in the following Determination Time Study.

3. Determination Time Study

The Company failed, in 57 of the 200 claims sampled, to advise claimants of the acceptance or denial of their claim within 15 working days of receipt of all forms necessary to establish the nature and extent of those claims

Working Days	Number of Claims	Percent
0-15	143	71.5%
Over-15	57	28.5%
Total		100%

Error ratio: 28.5%

Reference: 20 CSR 100-1.050(1) (A)

B. General Handling Practices

The examiners reviewed Company claim processing practices to determine adherence to its contract provisions and compliance with Missouri law and regulations.

The following are the results of this review:

1. The company offered policy holders the option to accept an endorsement to their policies that reduced benefits for chemotherapy and radiation by 50%. This endorsement was offered in lieu of a pending rate increase.

   The owner of policy form 72 19305 elected to accept the endorsement, but not until after the date expenses were incurred for chemotherapy. The company improperly reduced benefits 50% although services were received prior to the endorsement's effective date.

   The company acknowledged this error and remitted a check for $13,727 to the policy holder for the actual amount due, plus interest.

   Reference: 20 CSR-100-1.020(1)

3. The Company provided examiners with copies of the claim files for claims that had been denied because claimants failed to provide a copy of a Medicare Benefit Summary or an EOB from the insured's primary health plan. Upon review of those files, it appeared to examiners that some claimants submitted documents that provided sufficient information for the Company to have determined its liability for the *actual charge* benefits covered by the policies.

   Request # 23 asked the Company to review 10 of those claim files to determine if sufficient information had been provided to have allowed payment of those claims. CUL reviewed those files and reconsidered and paid the following four claims.

	Block #	Policy #	Claimant #	Claim #	Date Paid	Amount Paid
2	72	13487	OO2	6001	3/29/2006	$8,909
3	83	A05118400	OO1	6001	3/29/2006	$8,400
4	83	A05128220	OO1	6001	3/27/2006	$478
5	83	A05415830	OO1	6001	3/27/2006	$1,590

SECTION IV

IV. COMPLAINTS

This section of the report details the examination findings regarding complaints and grievances against the Company. Missouri law requires insurers to maintain a register of all complaints/grievances received and to retain the documentation on the handling of these complaints. The examiners reviewed 32 complaints submitted directly to the Company or through the DIFP for calendar years 2002, 2003 and 2004. No errors were found in that review.

However, one complaint was found in the Company's claim files that were not included on the Company's Complaint Log.

Reference: 20 CSR 300-2.200(3)(D) (as amended, 20 CSR 100-8.040(3)(D), eff. 7/1/08)

SECTION V

V. CRITICISM & FORMAL REQUEST TIME STUDY

This study reflects the amount of time taken by the Company to respond to criticisms and requests submitted by the examiners.

A. Criticism Time Study

Calendar Days	Number Criticisms	Percentage
0-10	4	57%
Over 10	3	42%
Total	7	100%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
0 -10	25	96%
Over-10	1	4%
Total	26	100%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Central United Life Insurance Company (NAIC #2398-65323), Examination Number 5013-36-TGT. This examination was conducted by Jim Mealer, and Jim Casey. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated August 26, 2008. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Michael W. Woolbright 7/10/09

Michael W. Woolbright Date
Chief Market Conduct Examiner

CENTRAL UNITED LIFE

John McGettigan
General Counsel

October 31, 2008

Via Hand Delivery
Carolyn Kerr, Esq.
Missouri Department of Insurance, Financial
Institutions and Professional Registration
Truman State Office Building
301 West High Street, Room 530
Jefferson City, MO 65102

Re: Central United Life Insurance Company
Missouri Market Conduct Examination Report

Dear Ms. Kerr:

Thank you for allowing us additional time to respond to the Market Conduct Examination Report of the Cancer and Specified Disease Health Insurance Business of Central United Life Insurance Company (Central United). Please accept this as Central United's response to the examination report submitted to Central United by the Department of Insurance Financial Institutions and Professional Registration (DIFP) dated August 26, 2008.

Over the past several years, we have provided the DIFP with a number of documents, cases and other materials related to the issues discussed herein. In view of the fact that nowhere in the examination report is there any reference to any of these materials, the events reflected by them or the support they lend to our position, we are concerned that some or all of these materials may not been available to all DIFP personnel involved in the examination process. We have attached a few of the materials we previously submitted to the DIFP for your reference. We would also be pleased to provide you with copies of any materials referred to in this response if you are unable to locate them in the DIFP's files.

A. The DIFP Agreed with Central United in Prior Communications

Before addressing the report itself, I would like to summarize a number of important events relating to our communications with the DIFP leading up to the issuance of the examination report on August 26, 2008. After Central United modified its claim handling procedure in February 2003 involving the payment of benefits under the chemotherapy and radiation provisions in its cancer policies where the benefit is based on the "actual charge", Central United corresponded with the DIFP. On October 23, 2003, Carol Harden copied Central United on a letter she

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wrote to a policyholder about the payment of actual charges benefits. Quoting from Ms. Harden's letter, she stated "In other words, if the provider billed $50 and accepted $30 as payment in full from your primary carrier, than Central United should use the $30 as the amount of the claim under their policy". Based on this letter, we understood that the Missouri Department of Insurance agreed with Central United's position that policyholders should be paid actual charges benefits equal to the amount the healthcare provider was paid in full for the covered services. Ms. Harden's October 23, 2003 letter is attached as Exhibit A.

Approximately two years after receiving Ms. Harden's October 23, 2003 letter, we corresponded with the Missouri Department of Insurance in August 2005 regarding a policyholder complaint concerning the payment of actual charges benefits ("the August 2005 Position Paper"). We believe this letter sets forth in sufficient detail why Central United's payment of actual charges is proper. We attach, again, the August 2005 Position Paper with all exhibits (Exhibit B). We incorporate this position paper into this response.

After we exchanged communications, we were copied on a letter written by the Missouri Department of Insurance dated August 29, 2005 enclosing our August 2005 Position Paper to the policyholder. Attached, as Exhibit C, is Carol Harden's August 29, 2005 letter. Contrary to the examination report, in this letter, the Department states it does not have the "statutory authority to determine if the insurance company's interpretation is correct or legally sound".

On October 26, 2005, the Director of Consumer Affairs copied us on another letter to a policyholder which is attached as Exhibit D. As shown in this letter, the Missouri Department of Insurance agreed with Central United's payment of actual charges benefits and stated:

> "the Company may establish the actual charge by using the allowable charge accepted by the physician if participating with other carriers. In other words, if your provider accepted a certain amount from BCBS for a procedure, nothing prohibits Central United Life from using this amount as the allowable amount.

A copy of the Missouri Department of Insurance correspondence dated October 26, 2005 is attached as Exhibit D.

Suffice it to say, based on the written communications received from the Missouri Department of Insurance, starting in October 2003 and continuing until October 2005, Central United believed that the Missouri Department of Insurance concurred with Central United's modification of its claim handling procedure to request EOBs to determine the proper amount of benefits to be paid when the benefits are based on the "actual charge".

The Missouri Department of Insurance conducted a Market Conduct Exam in early 2006. On April 4, 2006, Central United representatives met with Mike Woolbright and Doug Ommen of the Missouri Department of Insurance to discuss Central United's payment of actual charges benefits in connection with the ongoing exam. Following this meeting at the Missouri Department of Insurance, Central United sent the Department additional legal authorities and judicial decisions supporting Central United's payment of actual charges benefits, including:

1. April 7, 2006 - Central United supplied the Department with 20CSR100-2.300. In a letter to Mike Woolbright, we brought this regulation, promulgated in 1995, to the department's attention in that it addresses the actual charges issue. Subsection (1)(A) defines actual payment as "the real total dollar amount actually paid or to be paid in fact, by a health insurer." This is precisely the same definition Central United uses when determining the amount to pay a provider. Central United seeks to pay the real dollar amount actually charged by the provider. To do otherwise results in inequities to other policyholders, not to mention, inequities in calculating data for policies in force.

2. September 20, 2006 - Letter to Jim Mealer enclosing four federal district court opinions where the court ruled that the term "actual charges" as used in the cancer insurance policies was unambiguous and it is proper for the policyholder be paid benefits equal to the amount actually charged for the treatment.

3. 2007-2008 - Central United sent letters to the Missouri Department of Insurance regarding two policyholder complaints, again reiterating Central United's position on payment of actual charges benefits and enclosing legal authorities in support of its position.

Central United incorporates all of the above communications into this response.

We provide this outline of the timeline of events for the last five plus years to show that dating back to August 2003, Central United had received communications showing that the DIFP had agreed with Central United's position on payment of actual charges benefits. Central United reasonably relied on DIFP's communications in reaching this understanding. In other words, at no time from 2003 until the issuance of the August 26, 2008 examination report did the DIFP advise Central United that it opposed Central United's payment of actual charges benefits.

Moreover, during the past two and a half years (when Central United heard very little from the DIFP), there have been a few federal cases involving other companies that have not received the same favorable results as Central United has in past "actual charges" cases. During this same time period we know that South Carolina legislature, at the request of the South Carolina Department of Insurance,

recently passed legislation requiring cancer insurance companies to pay actual charge benefits on the true transaction price i.e., the amount actually paid in full.

Four states have now passed laws defining the term actual charges to mean the amount paid by or on behalf of the policyholder as payment in full. The four states are: Texas, Arkansas, Georgia and South Carolina. Enclosed are copies of the state statutes (Exhibit E).

Also enclosed is a Bulletin issued by the South Carolina Department of Insurance (Exhibit F) on August 28, 2008 which is directly on point in support of Central United's interpretation and administration of actual charges benefits. In this Bulletin, the South Carolina Department of Insurance instructs insurers who have issued supplemental cancer policies in South Carolina containing the term "actual charge" that they may not pay any claim or any benefit in excess of the amount the health care provider agreed to accept, pursuant to a network or other agreement with a health insurer, as payment in full for the goods or services provided to the insured. This is exactly how Central United pays actual charges benefits.

As for the examination report's conclusion on page 9 section II, that the "Company should re-process and pay, based on the providers' billed charge, all claims filed on such policies issued before October 16, 2003, for which benefits were payable based on the providers' *actual charge*" (excluding policies that define actual charge or for claimants that were paid based on the providers' statement amount), Central United respectfully states that the very language of this conclusion indicates that the DIFP does not fully understand how these policies or medical reimbursements operate in today's world. It may be that we will simply agree to disagree on the issue of how actual charges benefits should be determined and paid and if we cannot resolve this issue with the DIFP, we understand that we can move forward through the administrative and judicial process if it is within the purview and jurisdiction of the DIFP to make rulings on the ordinary meaning of undefined terms in insurance policies.

B. Class Action Settlement Resolves the Pending Issues

We would like to point out, however, that the resolution of the issue of payment of actual charges benefits *could* be forthcoming in the form of a nationwide class action settlement that may render any further administrative or judicial proceedings on the issue moot. Exhibit G is a copy of the notice of proposed class action settlement in Skelton vs. Central United for your records. All policyholders in Missouri who own or have owned the policies in question since 2003 (and all who submitted claims for "actual charge" benefits) were mailed the class action notice of this proposed settlement. Four Missouri policyholders opted out of the settlement. A two-day hearing on the fairness of this settlement was conducted before Circuit Judge Stout on July 14 - 15, 2008 in Mobile, Alabama.

On October 9, 2008, the Skelton court entered an Order approving the proposed class action settlement. A copy of the Final Judgment Approving Class Action Settlement is attached as Exhibit H. Once the time period to appeal the enclosed Order runs, then all Missouri policyholders, current and former, will be bound by the settlement as will be Central United. We respectfully suggest that the DIFP consider taking no further action on the issue of payment of actual charges benefits until such time as it is known whether the settlement is finalized or appealed.

Regardless, we submit that the Skelton class action settlement reflected in Exhibits G and H as a fair and just way to address the issues, as you have characterized them, with all Missouri Central United policyholders—those who have been paid benefits based on the actual charge as well as those Missouri policyholders who have never filed a claim for benefits but who continue to pay premiums. For example, one of the many exhibits introduced at the class action fairness hearing showed that the premium concessions included in the settlement would provide over $36.7 million in projected reduced premium benefits to Central United policyholders nationwide and that the number of policyholders expected to incur claims is 1.2% of the population of in force policyholders.

In Missouri, this means that if Central United is forced to pay actual charges benefits equal to "providers' billed charges,"[1] it would dramatically adversely affect 98.8% of the approximately 1600 in-force Missouri policyholders in the form of higher premiums to the unjust enrichment of the approximate 1.2% in claims status who will receive a "windfall" in the form of higher benefits. Also, an actuarial expert has estimated that most of Central United's Missouri policyholders own a policy which (if the premium concessions are applied) will enjoy a rate freeze until 2011. If you would like a copy of that report (or any of the exhibits introduced by any parties) please let me know as they are, as you would expect, quite voluminous.

You should also know that a similar settlement (although not in our opinion as favorable to policyholders as that reflected in Exhibit H) was reached in a case involving cancer insurance issuer Liberty National Life Insurance who also has cancer policies with "actual charge" provisions. Attached as Exhibit I is a copy of a recent order approving that class settlement. The judge who issued that order (who is different from the judge who ruled on the Skelton case involving Central United) sets forth several reasons why such a settlement is fair to Liberty National policyholders in general. Central United would hope that the Liberty National order would also instructive here as a means to resolve the conflict of paying benefits based on the "provider's billed charges" (the DIFP's term) and thereby burdening the entire population of inforce policyholders with higher future rate increases.

Now Central United will respond to each section of the examination report.

[1] This is the DIFP's term. Central United does not agree that the statement or claim forms healthcare providers generate are true "bills" or that providers even "bill" their patients.

FOREWARD

Central United has no objections to this section.

SCOPE OF EXAMINATION

Central United does not agree that "[a]ny operation with an error ratio in excess of [the above stated percentages] indicates a general business practice". The complexity of the manual nature of the claims process involved for the type of policies in question and the variability and non-transparency of medical reimbursement practices makes adjustment of claims involving cancer treatments more difficult than average and certainly an arbitrary percentage of error of 7% does not take that into consideration.

EXECUTIVE SUMMARY

Central United objects to the "main issues" summarized by the examiner. We object to the examiner's characterizations of Central United's past or present practices. Central United has been providing the DIFP with detailed and comprehensive information, including legal authorities and regulatory opinions, supporting its payment of actual charges benefits since 2003 (for over 5 years), yet the examination report omits any reference to this information and continues to reflect the same misunderstandings regarding the determination of actual charges benefits, medical reimbursement practices and the fallacy that medical providers generate "bills" that reflect a dollar amounts that the policyholder is legally obligated to pay and the medical provider expects to be paid.

Central United objects to the DIFP's contention that beginning in February 2003, the Company began to administer claims based a different definition of the term "actual charge". In addressing this assertion -- and in responding to the examination report as a whole -- we thought it would be helpful to provide an overview of these policies similar to the overviews we have provided in prior communications.

C. Overview of the Limited Benefit, Supplemental Cancer Policies

The examination focuses on limited benefit specified disease cancer policies either sold by Central United or which Central United assumed from Dixie National Life Insurance Company or Commonwealth National Life Insurance Company. These cancer policies are sold as supplemental coverage to the policyholder's primary insurance coverage. The policies pay cash benefits directly to the policyholder. Substantially all of our policyholders have primary medical insurance either through a third party insurer (Blue Cross/Blue Shield; Aetna, etc.) or they have Medicare coverage. The cash benefits are kept by the policyholder to use as the policyholder wishes as the healthcare provider's services are paid by the policyholder's primary health insurance. In the rare instances where the

policyholder does not have primary insurance, the policyholder may use the benefit to pay the provider.

Part one of the Executive Summary implies that all benefit provisions were affected by Central United's 2003 claims handling modification. This is not the case. The cancer policies at issue provide for basically three categories of benefits, two of which do not involve benefits based on the actual charge. Many of the benefits are "scheduled" and are based on a specific dollar amount referenced in the body of the policy. For example, surgical benefits are based on a surgical schedule. Likewise, the Hospital Confinement Benefit pays the policyholder a specified dollar amount for each day the policyholder is in the hospital receiving cancer treatment. Central United does not request EOBs for these non-actual charges benefits as they are based on a specified dollar amount.

For benefits under the cancer policies which are based on the "actual charge," Central United must determine the amount that was, in fact, actually charged by the healthcare provider in order to pay the policyholder the proper amount of benefits. The benefit provisions which are based on the actual charge are the radiation and chemotherapy provisions.

For example, under Central United's CP1003 cancer treatment policy, the radiation benefit states as follows: "We will pay the actual charges for teleradiotherapy, using either natural or artificially propagated radiation, when used for the purpose of modification or destruction of tissue invaded by cancer." See Benefit E on page 6 of the Central United cancer policy which is included as part of Exhibit B. Similarly, under the chemotherapy benefit, the Company is obligated to pay benefits based on "the actual charges for cancericidal chemical substances and the administration thereof for the purpose of modification or destruction of tissue invaded by cancer." See Central United policy at page 6, Benefit E, included as part of Exhibit B.

In February 2003, Central United began requesting appropriate documentation from its policyholders to determine the amounts paid to, and accepted by, the healthcare provider for covered treatments in order to pay our policyholders the actual charge benefit. This documentation often takes the form of Explanation of Benefits ("EOBs") from our policyholders' primary insurers or Medicare summaries. We began requesting these additional documents because we discovered, in January 2003, that our claims department was erroneously utilizing statements, computer print outs or claim forms generated by healthcare providers which did not show the amount they were being paid, in full, for covered treatments and procedures. We began requesting EOBs because the amounts health care providers put on their statements alone do not reflect the amount our policyholders are obligated to pay for services rendered when the policyholder has primary insurance.

D. The Provider's "Billed" Charge is Never "Billed" or Paid

The examiner asserts that before 2003, "the Company administered those actual charge claims based on the amount healthcare providers **billed** for their services. Beginning in February 2003, the Company administered claims based on a different definition of the term *actual charge*." (Emphasis added).

The examiner's assertion is flawed because it assumes that the amounts healthcare providers put on their statements for services are actually "billed" to the policyholders. The examiner seems to be unaware that medical providers do not submit any "bills"[2] to the vast majority of their patients. He is certainly unaware that the policies in question were written during the time when doctors and hospitals generated true bills to patients (and their carriers) showing the same amounts they expected them to pay and which they did pay. These cancer policies are clearly intended to pay the policyholder benefits equal to whatever the transaction amount was for chemotherapy and radiation (the actual charge). In the 70s and early 80s, when the policies were designed and filed with departments of insurance, a doctor or hospital's bill was the best source of the actual charge because that is the amount the policyholder or the policyholder's insurer was actually paying for the services. The medical services industry has evolved greatly since these policies were originally drafted but the position taken by the examiner reflects no acknowledgment of the changes in documentation now utilized by medical providers to seek reimbursement and how they are reimbursed.

Again, medical providers no longer issue bills (a demand for payment of services) to the vast majority of their patients. Over time and gradually, medical providers have stopped issuing true "bills" to the majority of their patients. It was this gradual transformation that Central United failed to notice until early 2003.

Today, most medical providers are prohibited from billing the patients with primary insurance or on Medicare for more than co-pays by contract or by law or by medical ethics (or a combination of all three). *See, e.g.*, Council on Ethical and Judicial Affairs, CODE OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION, Current Opinions with Annotations, 6.05 at pg 167 (2006-2007 Ed). Yet the DIFP continues to assert that Central United should pay benefits, which are supposed to be based on the "actual charges," in amounts that would be illegal and unethical for the provider to bill the patient, were never billed to the patient and which bear no relation to the amounts expected to be paid at the time services were rendered. These "billed amounts" are a commonly used misnomer for what really are the provider's "list prices" they place on their claim forms or itemized statements. Leading health economists throughout the country literally scoff at the

[2] Laypeople understand that "bills" reflect amounts that are expected to be paid. To laypeople "charges billed by the medical provider" with respect to their treatment by that medical provider are not hypothetical amounts which the provider may file with an insurance carrier and which neither the insurer nor the patient is obligated to pay.

suggestion that the "list prices" of medical providers in 2003 forward could be considered the "actual charge" because the "list prices" are not the transacted amount.

The DIFP is not to be criticized for failing to grasp the concept that there is no "billed amount" to most patients over the co-pay or deductible a patient may be required to pay.[3] The medical reimbursement system is very complex. However, after reviewing this issue since 2003, the DIFP should now acknowledge the realities of the medical billing and reimbursement system. Central United would encourage the DIFP to sit down with any health economist at the University of Missouri and ask them if they know Dr. Glenn Melnick of USC and/or Dr. Michael Morrisey of UAB. Both these well respected health economists would tell you exactly this: The amounts healthcare providers place on their statements or claim forms (the "list prices") the DIFP contends Central United should pay in actual charges benefits are not real in any economic sense and are never billed to the vast majority of patients. "List prices" are, in a real sense, only the medical provider's opening bid in negotiations with insurance carriers. Medical providers often intentionally inflate the list price amounts while not ever expecting to be paid or charge that amount. A higher list price is used as part of the medical providers' negotiating process over fee schedules and to make sure their "list prices" always exceed the maximum amount any third-party payor would actually approve for the service. Literally, almost no one ever really pays the amounts the providers list in their statements or claim forms submitted to third party payors because they are not the real charge. It is in this context that Central United tries to determine the "actual charge" in a particular transaction involving chemotherapy, radiation and, as will be noted below, air transportation as this is the language used in the cancer policies.

In further objection Central United would rely upon the numerous documents and letters it has already provided the DIFP setting forth the above information in detail. If you wish to see any of the contracts, statutes or ethical publications referenced above, please let us know.

As will be discussed in more detail later in this response, Central United does not agree that any of the items listed in A-E of the Executive Summary resulted from Central United modifying its claims handling procedure to request proper documentation to pay actual charges benefits. Specifically, Central United responds to A-E as follows:

A. Central United paid actual charges benefits to its policyholders equal to the amount paid by or to the healthcare provider as payment in full. Therefore, actual charges benefits were properly paid; they were not reduced.

[3] Actual charges benefits include deductibles and co-pays as those amounts are paid to the provider.

B. After Central United modified its claims handling procedure, we received seven (7) complaints from Missouri policyholders (based on our review of our complaint log) during 2003. The majority of these complaints concerned policyholders questioning why we started asking them to supply us with EOBs from their primary insurance carrier when, in the past, we had not requested these documents. For the years 2004 through 2007, our complaint log shows we received one (1) complaint over this four year period. Based on these numbers Central United does not agree with the Department's contention that policyholder complaints "increased" as a result of Central United's modification of its claims handling procedure.

C. Central United has never had any litigation in the state of Missouri involving the payment of actual charges benefits.

D. Central United is entitled to obtain proper documentation to pay claims under the proof of loss sections of its cancer policies. Central United policyholders generally understand the necessity of submitting EOBs from their primary health insurers or Medicare summaries as this information is needed to ascertain the amounts actually paid for covered cancer treatments. Central United believes it should be entitled to request the EOBs from its policyholders so that so that it can pay the proper amount of benefits under the actual charge provisions. To help expedite the submission of this documentation, Central United: (i) revised its claim form on February 12, 2003 to notify its policyholders to submit EOBs, (ii) sends letters to policyholders advising them what information is needed when a policyholder does not submit complete information, and (iii) sent all policyholders "The Important Notice Regarding Cancer Claims" in July 2003, a copy which is attached as Exhibit J.

E. As will be described in greater detail below, Central United believes that paying actual charges benefits equal to the amount healthcare providers are paid in full is the most fair and non-discriminatory way to determine benefits in light of the wide varying list price amounts that healthcare providers place on their statements.

Central United objects to the DIFP's assertion that Central United received consumer complaints as a result of "slow payment of claims". As explained above, these policies pay benefits directly to the policyholder if the policyholder receives certain specified treatments or procedures. Central United must rely on its policyholders to submit proper documentation consisting of the medical providers itemized statements so it can determine the treatments received along with Explanation of Benefits from the policyholders' primary insurance carrier to determine the amount the medical provider actually charged. Central United is entitled to these documents under the policies' proof of loss provisions. Central United does not agree that by requesting proper documentation it "slowed" claim

payments. Central United additionally objects to the DIFP's characterization that Central United's modification of its claims handling procedure was a "change in definition of the term actual charge".

I. Sales and Marketing Practices

A. Company Authorization

Central United has no objections about this section.

B. Marketing Practices

The Dixie National, Commonwealth National, and Central United cancer policies which are the subject of the examination report each provide that the policyholder will be paid a radiation or chemotherapy benefit based on the actual charge for the covered treatment. The marketing materials for these policies clearly state that the radiation and chemotherapy benefits will be paid based on "100% of actual charges" or the "actual charge". Central United does not agree that the phrase "actual charge" should have been defined in the marketing materials because these words are simple, ordinary and clear words that need no definition. The plain and ordinary meaning of the terms "actual charges" is what it is in every other transaction—the amount the provider expects to be paid is paid and accepts as payment in full for treatment rendered. Indeed, we are not aware of any commercial transaction where the amount that is "actually charged" is an amount that is different than (and more than) than what is paid to and accepted by the person rendering the service. In short, we believe the marketing materials use of the phrase "actual charges" are truthful and provide clear and adequate disclosure to the policyholder regarding how they will be paid benefits for covered treatments.

C. Advertising

Central United objects to the DIFP's contention that the advertising materials should have explained that the amount of benefits payable depend upon the policyholder's "other insurance" rather than the "billed" charges.

The radiation and chemotherapy benefits at issue are not based on the "provider's bill charges"—the policy specifically states benefits are based on the actual charge. No where in the policy is the term "billed charges" used. As explained throughout this response, Central United opposes the Department's contention that benefits should be based on the "billed charges". Furthermore, Central United objects to the Department's assertion that the chemotherapy and radiation benefits payable depend on claimant's "other insurance".

The DIFP lists a number of advertisements for Dixie National (paragraph C1), Commonwealth National (paragraph C2), and Central United (paragraph C3). The DIFP makes essentially the same argument regarding the substantially same

statement contained in these advertisements. The DIFP contends that the statement "**PAYS IN ADDITION**" or "**PAYS IN ADDITION TO ALL OTHER INSURANCE**", or "**PAYS DIRECTLY TO YOU**" or some similar variation thereof has the capacity or tendency to deceive purchasers or potential purchasers of the exact nature and extent of the benefits payable under the various policy forms.

The subject cancer policies pay benefits directly to the policyholder in addition to any other insurance the policyholder may have. The policy **does** pay benefits regardless of other insurance and the benefit amounts are not reduced when a policyholder reaches a certain age. As such, the advertisement phrases cited by the Department do not have the effect of misleading or deceiving purchases of the policy.

Central United does not understand the DIFP's argument that the cited advertising phrases somehow fail to inform a purchaser that the benefits depend on a policyholder's "other insurance". By paying actual charges benefits equal to the amount the healthcare provider is paid in full, Central United is not coordinating benefits and paying the policyholder an amount above the amount paid by the primary insurance carrier. If the DIFP is somehow arguing that Central United is coordinating benefits and only paying policyholders actual charges benefits above the amount paid to the policyholders' healthcare provider by their primary insurance carrier, this is not the case.

Paying actual charges benefits equal to the amount the healthcare provider is paid in full does not mean Central United is utilizing a policyholder's "other insurance" to "reduce benefits" as the DIFP contends. Rather, Central United is simply paying its policyholder the full amount of benefits they are entitled to under the policy. To reiterate Central United prior arguments, to suggest that policyholders should be paid benefits equal to whatever amount a provider may place on their statement (what the DIFP calls the "billed amount") even though the medical provider has no expectation that it will be paid this amount is, in Central United's opinion, an unsupported and illogical argument.

Central United disagrees that the Commonwealth National advertisement which states "**it pays regardless of other insurance you may have!**" means actual charges benefits will be paid based on the amount "the provider's bill". To the contrary, this advertisement is clear: the Commonwealth policy pays benefits to a policyholder whether the policyholder has other insurance or no insurance. Also, as discussed in great detail herein, medical providers do not "bill" the patients for their services.

Central United urges the same arguments in response to the DIFP's assertions regarding that Central United advertisements set forth in paragraph 3a and 3b. Central United avers that the advertising provision cited by the DIFP did not have the capacity, tendency or effect of misleading or otherwise deceiving purchasers or potential purchasers as to the exact nature and extent of the benefits payable under the cancer policies.

The DIFP comments that the outline of coverage and brochure for the CP3000 policy form do not define the term actual charge. For the reasons stated above, Central United does not agree that the term "actual charge" needs to be defined. The plain, ordinary, everyday meaning of actual charge means the amount a person is expected to pay and does pay for a service. Please see Central United's prior arguments, above.

Central United does not agree that the CP4000 brochure does not disclose to readers how actual charge benefits will be paid by the Company. The CP4000 policy form, designed in 2004, includes a clear explanation of how actual charge benefits will be determined. Central United believes this brochure clearly advises its policyholders how benefits which are based on the actual charge will be paid.

II. Underwriting Practices

Central United incorporates all of its prior arguments in previous sections in opposition to the findings expressed by the DIFP in this section. In addition, Central United provides the following additional information in response:

A. Forms and Filings

Central United objects to the DIFP's contention that it was error for the subject cancer policies to not include a definition of the term actual charge. As explained in detail in prior sections of this response, the term actual charge needs no definition. Central United also objects to the DIFP's contention that Dixie National and Commonwealth National intended to pay actual charge benefits equal to the so-called provider "billed amount". Neither the policy forms nor the related advertising support this contention. The term "billed amount" is not used in the policy forms or advertisements. As discussed in detail herein, when these policies were designed in the late 1970's and 1980's by Dixie National and Commonwealth National, the medical provider's actual charge - what providers expected to receive and what patients were legally obligated to pay - was the same amount as the provider's list price. Central United assumed the Dixie National and Commonwealth National cancer policies prior to when medical providers list price amounts became significantly higher than the amounts the providers accepted as payment in full. The DIFP's contentions in regard to the intent of these companies is unfounded considering the facts regarding the advent and development of Medicare and managed care resulting in medical providers agreeing to accept-- and expecting no more--than what was in essence a contracted amount for their services.

Central United again objects to the contention that it "changed" the definition of the term actual charge beginning February 1, 2003. As explained herein, effective February 1, 2003, Central United modified its claim handling procedures to request proper documentation from its policyholders in response to the evolving changes in how medical providers were being paid, in full, for their services.

Central United also disagrees with the DIFP's characterization that the "Important Notice Regarding Cancer Claims" sent to all actual charge policyholders on July 21, 2003 was a communication concerning "its new interpretation of actual charge". To the contrary, the Important Notice was sent to inform policyholders that Central United had modified its claims handling procedure to properly ascertain the amount medical providers were actually charging so it could properly pay benefits to its policyholders. The purpose of the Important Notice was to advise policyholders that they should submit Explanation of Benefits ("EOBs") from their primary insurance company so Central United could determine what the medical providers were actually charging. Central United sent the Important Notice to expedite the payment of cancer claims. See Exhibit J, Important Notice.

Central United does not agree that by modifying its claims handling procedure to obtain proper documentation from its policyholders, it misrepresented the benefits and terms of the cancer policies. Instead, Central United believes this modification was needed to pay its policyholders the proper amount of benefits under the radiation and chemotherapy provisions of the cancer policies.

E. Paying "Billed Charges" Would Result in Wide Varying Benefit Payments

The examiner suggests that Central United should pay benefits equal to the provider's list price (the billed charge amount) because this would "guarantee" that two similarly situated policyholders who go to the same medical provider would be paid the same amount of benefits. The examiner's logic is flawed because it assumes that all medical providers "bill" the same amount for the same treatment. As discussed herein, medical providers' list price amounts have no basis in reality or in fact. The dollar amounts medical providers place on their statements or "bills" vary significantly from medical provider to medical provider. (Please see our lengthy discussion with examples of wide varying provider list price amounts in our August Position Paper). Therefore, if benefits are based on a medical provider's list price amount, as the examiner contends, then one policyholder would be paid substantially greater benefits than another policyholder depending on the medical provider who treated the policyholder and the amount the medical provider chooses to write down as his "list price".

The cancer policies do not dictate where the policyholder is required to get medical treatment. It simply provides that the policyholder will be paid benefits equal to the actual charge for chemotherapy and radiation. To illustrate our point that medical providers have huge discrepancies between the list price amounts, we are providing list price data on Rituxan®, a common chemotherapy drug. This chemotherapy has a wide varying provider's list price amount nationwide. For example, the provider list price amount in Monongahela, Pennsylvania is $9,124 per unit whereas in Corry, Pennsylvania, the list price is $222.00 per unit. In Birmingham, Alabama, the list price for Rituxan® varies from a low of $1,600 per treatment to a high of $37,600 per treatment (twenty times greater). However, for Blue Cross-Blue Shield insureds, all doctors with Preferred Medical Doctor agreements in Birmingham are paid $3,725 per unit for Rituxan, regardless of the

doctor's list price. If BC/BS pays the doctor the agreed upon contract amount of $3,725 for a dosage of Rituxan®, and the doctor accepts this amount as payment in full, Central United pays this same amount, $3,725, directly to its policyholders to spend as they wish as their doctor was fully paid by their insurance carrier. If Central United is required to pay actual charges benefits equal to the medical providers' list price amounts (as the DIFP suggests) and not based on the amount the providers actually charge, policyholders would be paid widely varying amounts of benefits, depending on how much the medical providers arbitrarily inflate their list price amount.

We also refer the DIFP to the August Position Paper (Exhibit B) where we provide information showing the wide varying "list price" amounts that medical providers put on their statements for the same exact treatments.

Significantly, the examiner fails to acknowledge that the policy also has an "actual charge" benefit for air transportation (a non-medical benefit). Certainly, it should be common knowledge that the "actual charge" for a plane ticket is not the same for every passenger on the same flight. Those with AAA, AARP or other memberships receive contractual discounts. Those who book through certain internet travel agencies pay a lower ticket price. Those who booked well in advance of their fight receive different prices than those who book the day before takeoff as the prices for the seats change almost by the hour. Literally, persons sitting next to each other on a flight can pay vastly different amounts for their transportation. By the DIFP's logic, Central United would have to pay every policyholder the same amount for the transportation benefit provided for in the policy for the same flight even if each policyholder paid different amounts for their tickets. This would not be fair to the policyholders. Further, it makes no sense and it would not comport with policy language requiring Central United to pay, as the transportation benefit, the "actual charge" for each ticket. See Central United policy included under Exhibit B, page 7, Transportation Benefit.

Central United policyholders with primary insurance coverage or on Medicare (close to 100% of Central United policyholders have major medical coverage or are on Medicare) are free to spend the Central United benefit payments (based upon what their providers actually charged) on groceries and other expenses just as these supplemental policies were designed as their medical treatments have been paid for by their medical insurance. Central United pays its policyholders benefits equal to the actual charge of the medical treatment or the airline ticket, based on the language in the cancer policy.

III. CLAIMS PRACTICES

Central United responds to the findings in the Claims Practices section as follows.

A. Claims Time Studies

1. Acknowledgment Time Study

The subject cancer policies are sold as supplemental policies to the policyholder's primary insurance. The cancer policies pay benefits for certain treatments, procedures and services rendered to the policyholder in connection with their cancer treatment. In processing claims, Central United must rely on its policyholders to submit a claim with sufficient information so that Central United can investigate, process, and pay the benefits the policyholder is owed under the policy. Central United does not have a direct relationship with the policyholder's healthcare provider so it must rely on the policyholder to obtain additional required documentation from the medical provider and submit such documentation to Central United. Central United then manually reviews submitted documentation and if information is lacking, Central United contacts the policyholder to request the policyholder to obtain documentation (itemized statements, medical records, pathology reports, etc.). Usually, the policyholder has to obtain the needed information from the policyholder's medical provider. Once the required documentation is complete, Central United processes and pays its policyholder benefits owed under the policy.

Central United strives to acknowledge receipt of policyholder claims shortly after the claim is received. Central United has no objections to the Acknowledgement Time Study section.

2. Instructions and Reasonable Assistance Time Study

As explained above, the payment of benefits under the subject cancer policies is a manual process. Upon receipt of a claim, if Central United determines additional documentation is needed, Central United requests the additional documentation from its policyholder.

Central United cannot comment on the examiner's error ratio because Central United does not have the benefit of reviewing the information relied upon by the examiner. However, Central United strives to timely provide instruction and assistance to its policyholders so that they can comply with the proof of loss sections in the cancer policies and submit needed documentation to pay the benefits owed.

3. Investigative Time Study

Central United repeats its response to numbers 1 and 2 above in response to the Investigative Time Study.

4. Determination Time Study

Again, Central United strives to timely pay claims upon receipt of a complete claim file. Upon receipt of a complete claim file, if the claim is not payable under the policy, Central United strives to notify the policyholder of the denial as soon as possible. Central United does not have the benefit of the information presented by the examiner for the number of claims paid after fifteen days so Central United cannot comment on the specific claims. However, Central United attempts to and believes it has good business practices in place to investigate, process, and pay (or deny where applicable) claims.

B. Unfair Settlement

Central United does not have the specific information relied on by the DIFP concerning its contention that Central United denied 201 claims because they were filed after one year and ninety days following the date of service. Central United points out that it understands a "claim" consists of individual demand or request for payment or action under an insurance contract. As such, Central United understands that the 201 "claims" consist of requests for payment. Many of the non-timely claims consist of requests for payment for treatments or procedures that are not benefits under the policy; furthermore, many of the claims consist of duplicate claims. Central United also points out that it does not have the benefit of knowing the claims the DIFP contends were denied as non-timely.

Even though Central United does not have the specific data upon which the DIFP bases its findings, Central United believes that for those claims for which a benefit was allowed under the policy, Central United's decision to deny the claims because they were submitted after the following deadline was justified. The policy contract, itself, provides for a deadline to submit claims. Central United followed the policy language. In addition to having the contractual right to deny the untimely claims, Central United believes its actions were justified based on the reasons set forth in the exam report under numbers 1-5.

C. General Handling Practices

Central United believes no response is needed to this subsection.

IV. COMPLAINTS

Central United does not have any response.

V. CRITISISM & FORMAL REQUEST TIME STUDY

Central United thinks the DIFP's percentages under the Formal Request Time Study are in error. Central United thinks the 0-10 days percentage should be 96% and not 4%.

We appreciate the opportunity to respond to the examination report.

Very truly yours,

John E. McGettigan

Enclosures
JEM/lc

cc: Sherry Doctorian, Armstrong Teasdale, LLP