IN RE: **John Alden Life Insurance Company**	)))))	**CONSENT AGREEMENT** **Docket No. INS 03-426**

This document is a Consent Agreement, authorized by 10 M.R.S.A. § 8003(5)(B), entered into by and among John Alden Life Insurance Company (hereafter also "John Alden"), the Superintendent of the Maine Bureau of Insurance (hereafter "the Superintendent"), and the Office of the Attorney General. Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of Health Plan Improvement Act, 24-A M.R.S.A. Chapter 56-A, Insurance Rule Chapter 850 and the Unfair Claims Practices Act, 24-A M.R.S.A. 2164-D.

I

FACTS

1. The Superintendent is the official charged with administering and enforcing Maine's insurance laws and regulations. On April 9, 2003 a policyholder filed a complaint with the Superintendent against John Alden regarding the rescission of the policyholder's short-term policy.
2. John Alden Life Insurance Company is a licensed Maine health insurer, license # LHF 724. John Alden short-term policies issued in Maine are administered by Fortis Insurance Company (Fortis), and John Alden is directly responsible for the actions of Fortis in administering its policies.
3. Policyholder purchased a John Alden short-term policy that was to become effective June 12, 2002 and continue until August 1, 2002, when Policyholder would become eligible for health insurance through a new employer.
4. Policyholder was hospitalized in July of 2002 with viral pericarditis, and underwent surgery to have fluid drained from the infected area. Policyholder incurred medical bills of approximately $20,000, which were submitted to John Alden for payment.
5. John Alden sent a letter to Policyholder dated February 12, 2003 denying all of the claims and rescinding the policy. The rescission was based on John Alden's assertion that Policyholder had an obligation to disclose medical services received in 2000, and that if John Alden had been aware of those services, the policy would not have been issued. The letter stated, in part:

   "Medical records received indicate that you received consultation, diagnosis or treatment for a condition prior to your effective date that would have made you ineligible for our plan. On our application, the fifth question asks:

   Within the last 5 years have you ever received any medical or surgical consultation, diagnosis, or treatment including prescription medication for heart or circulatory system disorder including heart attack or chest pain…"

6. Policyholder sent a letter of appeal to John Alden dated February 28, 2003, stating in part:

   "I have just received your letter today stating that you are indeed not going to honor your commitment to me because you feel I did not answer the question about whether I received, consultation, been treated or diagnosed for heart disease etc. etc. properly. I have no pre-existing conditions, which you should have been able to figure out by my medical records. All testing that I did have proved to be negative and benign. That means to me that, thankfully, there is nothing wrong with me. So why would I ever consider that I did have a condition. Furthermore, my illness this past summer was in no way connected to anything else."

7. John Alden denied Policyholder's appeal on March 24, 2003 and did not offer a second level of appeal, stating in part:

   "Our Health Management Services department reviewed the filing, including the medical records. According to the medical records received from [Policyholder's health care providers], you should have answered 'yes' to question five. The records indicate you received medical treatment, consultation and diagnosis for heart palpitations, a heart disorder, including medications and diagnostic testing during the five years prior to the effective date. Therefore your policy was appropriately rescinded."

8. Policyholder provided John Alden with a letter from the treating physician dated March 30, 2003, stating in part:

   "[Policyholder] has been under my care since 1985. Apparently [Policyholder's] medical coverage under short-term medical policy #….has been rescinded on the basis of my medical records. I would like to appeal this decision on the following basis.

   Prior to June 12, 2002, [Policyholder] complained of palpitations which were clearly related to a generalized anxiety disorder; [Policyholder] had a completely negative cardiac work-up, including echocardiogram and Holter monitor in early 2000. [The] palpitations resolved on anti-anxiety meds.

   In early July of 2002, [Policyholder] presented to the office, emergency room and underwent multiple hospitalizations for an acute pericarditis. This was felt to result from a viral process. This problem is totally unrelated to the palpitations in the aforementioned anxiety disorder. Copies of multiple histories and physical as well as discharge are included and highlighted which prove the acute onset of this medical process.

   Please rethink your decision to rescind coverage for [Policyholder]. Clearly the medical problems are unrelated and the acute nature of [Policyholder's] pericarditis should be covered under the new policy."

9. Policyholder's medical records during 2000, some of which were cited by John Alden as a basis for rescission, indicate that Policyholder was diagnosed with G.A.D. [generalized

anxiety disorder]. The medical records indicate that [Policyholder] was advised by the treating physicians that a heart disorder was not present.

10. John Alden's May 16, 2003 letter to the Bureau in response to Policyholder's complaint stated that it was unable to reverse its decision, citing several dates on which Policyholder was seen and treated for palpitations.
11. Bureau staff wrote to John Alden on May 20, 2003 requesting that John Alden provide a second level appeal as required by Rule Chapter 850, and stating in part:

    "The only reasonable construction [of] 'heart of circulatory disorder' is that Fortis would not reject an application unless such disorder is documented…please consider that, as [Policyholder's physician] points out in [Policyholder's] March 30, 2003 appeal letter…, [Policyholder's] medical records evidence no heart or circulatory disorder."

12. John Alden's June 5, 2003 letter to Bureau again listed the medical records cited in its May 16, 2003 letter, but did not acknowledge or address Policyholder's contention that question 5 was answered correctly because the diagnosis indicated a stress disorder rather than a heart disorder. In addition, the June 5, 2003 letter stated:

    "Pursuant to our review of this extensive history, we continue to maintain our position that since [Policyholder's] medical records document [Policyholder] having received diagnostic testing and medication for heart palpitations and heart arrhythmia prior to the effective date, [Policyholder] failed to answer Question Five correctly on [Policyholder's] application.

    Please also note that it is our position that Bureau Rule 850 does not apply in this instance because no policy has been in force; therefore, there is no contractual relationship between [Policyholder] and John Alden Life Insurance Company."

13. Bureau staff wrote to John Alden on July 31, 2003, stating in part:

    "Whatever review has occurred, it was not in compliance with Bureau of Insurance Rule 850(9), containing the requirements for second level grievance review.

    Pursuant to Rule 850(9), we ask Fortis to immediately offer full second level grievance review to [Policyholder]."

14. In its August 18, 2003 response to the Bureau, John Alden refused to comply with the grievance procedure requirements of Rule 850, stating in part:

    "…rescission of coverage would not meet the definition of an 'adverse determination' and it would also not qualify as a dispute regarding claims. Finally, it is our position that due to the fact that coverage was rescinded based on a material misrepresentation by the insured during the application process there is no contractual relationship between the insured and carrier.

Please note that the second review by a Medical Director that was afforded in this instance was extended as part of our internal administrative process. It was not provided pursuant to any statutory or legal obligation."

15. On January 30, 2004, as a result of Policyholder's complaint and Bureau intervention, John Alden agreed to reverse its prior rescission, reinstate the policy, and pay the outstanding claims.

II

MAINE LAW

16. Title 24-A M.R.S.A. § 2411 provides that a health insurance policy may not be rescinded based on statements in the application unless the statements were fraudulent and material to the acceptance of the risk. In order to show that a statement in the application was fraudulent, a carrier must prove by clear and convincing evidence that the statement was false and that the applicant knew or should have known that the statement was false.
17. The Health Plan Improvement Act, 24-A M.R.S.A. Chapter 56-A, § 4303(4) provides, in part:

    24-A M.R.S.A. § 4303(4) Grievance procedure for enrollees. A carrier offering a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denial or other matters by which enrollees are aggrieved.

    A. The grievance procedure must include, at a minimum, the following:

    (4) Provision to the aggrieved party of a written statement upon the conclusion of any grievance process, setting forth the reasons for any decision. The statement must include notice to the aggrieved party of any subsequent appeal or external review rights, the procedure and time limitations for exercising those rights and notice of the right to file a complaint with the Bureau of Insurance and the toll-free telephone number of the bureau; and

    (5) Decision-making by one or more individuals not previously involved in making the decision subject to the grievance.

18. Rule Chapter 850 § 5(S) defines “grievance” to mean:

    A written complaint submitted by or on behalf of a covered person regarding the:

    (1) Availability, delivery or quality of health care services, including a complaint regarding an *adverse determination* made pursuant to utilization review;

    (2) Claims payment, handling or reimbursement for health care services; or

(3) Matters relating to the contractual relationship between a covered person and a health carrier.

19. Rule Chapter 850(9)(C)(1)(a) provides that the person or persons reviewing a first level grievance shall not be the same person or person's who made the initial determination denying the claim or handling the matter that is the subject of the grievance. Rule Chapter 850(9)(D)(2) requires the majority of the second level review panel to be comprised of persons who were not previously involved with the grievance.
20. Rule Chapter 850(9)(C)(1)(b)(i) requires grievance decisions to contain the names, titles and qualifying credentials of the person or persons participating in the first level grievance review process.
21. Rule Chapter 850(9)(C)(1)(b)requires adverse first level grievance decisions to contain (ii)a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts and (iii) the reviewer's decision in clear terms and the reason for the decision.
22. Rule Chapter 850(9)(C)(1)(B)(vii) requires adverse first level appeal and grievance decisions to advise policyholders of any appeal and grievance rights, including the rights specified in Section (9)(D)(3)(c).

    Section 9(D)(3)(c) provides:

    c) A covered person has the right to:
    i.) Attend the second level review;
    ii) Present his or her case to the review panel;
    iii) Submit supporting material both before and at the review meeting;
    iv) Ask questions of any representative of the health carrier; and
    v) Be assisted or represented by a person of his or her choice.

23. The Unfair Claims Practice Act, 24-A M.R.S.A. § 2164-D provides, in part:

    (2) Prohibited activities. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if:

    A. It is committed in conscious disregard of this section and any rules adopted under this section; or

    B. It has been committed with such frequency as to indicate a general business practice to engage in that type of conduct.

    (3) Unfair practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice.

    A. Knowingly misrepresenting to claimants and insured relevant facts or policy provisions related to coverages at issue;

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

E. Refusing to pay claims without conducting a reasonable investigation.

(5) Resolution of Claims. It is an unfair claims practice for any domestic foreign or alien insurer transacting business in this State to fail to deal with insureds in good faith to resolve claims made against policies in insureds without just cause and with such frequency as to indicate a general business practice.

(6) Chapter 56-A. The superintendent shall ensure that the provisions of chapter 56-A and any rules adopted pursuant to that chapter are enforced consistent with this section.

III

CONCLUSIONS OF LAW

24. Policyholder's letter to John Alden appealing the rescission of [Policyholder's] health insurance contract was a "grievance" within the meaning of Rule Chapter 850(5)(S), and Policyholder was entitled to a second level grievance review pursuant to Rule Chapter 850(9)(D).
25. John Alden's actions violated the Health Plan Improvement Act, 24-A M.R.S.A. Chapter 56-A and Rule Chapter 850. In particular:

a. John Alden failed to establish and maintain grievance procedures that meets the requirements of Maine law as required by 24-A M.R.S.A. § 4304(4).

b. John Alden failed to provide Policyholder with notice of the right to a second level grievance review and the rights specified in Rule 850(9)(D)(3)(c).

c. John Alden denied Policyholder the opportunity to present her case at a second level review hearing as required by Rule 850(9)(D)(3)(c).

d. John Alden refused to provide Policyholder with a second level grievance review by one or more persons not previously involved with the compliant as required by Rule 850(9)(D)(2).

e. John Alden advised that Policyholder was entitled to only one level of appeal, and that John Alden's first level appeal decision was final.

f. John Alden failed to provide Policyholder with a first level grievance decision including the names, titles and qualifying credentials of the person or persons participating in the first level grievance review process as required by Chapter 850(9)(C)(1)(b)(i).

26. John Alden violated the Unfair Claims Practices Act, 24-A M.R.S.A. § 2164-D, by doing the following:

    a. John Alden misrepresented the rights of Policyholder by advising that [Policyholder] was entitled to only one level of review.

    b. John Alden failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refusing to pay claims without conducting a reasonable investigation. In particular, Rule Chapter 850(9)(C)(1)(b)(ii) requires adverse grievance decisions to contain "a statement of the reviewer's understanding of the covered person's grievance and all pertinent facts." John Alden understood that the principal reason for the appeal was that Policyholder thought question 5 had been answered correctly because the diagnosis had been for a general anxiety disorder and that the treating physicians had advised that Policyholder did not have a heart disorder. John Alden's first level grievance decision and its responses to the Bureau did not mention or address the diagnosis for "general anxiety disorder." A reasonable investigation of the issues relating to rescission under 24-A M.R.S.A. § 2411 should have included an inquiry regarding whether an applicant with Policyholder's medical history knew or should have known to answer yes to question 5 on the application. In addition, Policyholder was entitled to the opportunity to participate in a second level grievance review hearing and present arguments regarding the medical and legal issues raised by the appeal.

IV

COVENANTS

27. John Alden shall pay a civil penalty of Ten Thousand Dollars and No Cents ($10,000.00) for the violations of the Health Plan Improvement Act and Rule Chapter 850 described in paragraph 24.
28. John Alden shall pay a civil penalty of Ten Thousand Dollars and No Cents ($10,000.00) for violating the Unfair Claims Practices Act, 24-A M.R.S.A. § 2164-D, as described in paragraph 25.
29. John Alden shall submit revised appeal provisions to the Bureau for approval within thirty (30) days of executing this agreement, and shall document that the new provisions have been mailed to all Maine policy holders within sixty (60) days of executing this agreement.

V

MISCELLANEOUS

30. A formal hearing in this matter is waived and no appeal will be made.

31. John Alden acknowledges that this Consent Agreement is a public record within the meaning of 1 M.R.S.A. § 402 and will be available for public inspection and copying as provided for by 1 M.R.S.A. § 408, and will be reported to the NAIC RIRS database.
32. John Alden has been advised of its right to consult with counsel and has, in fact, consulted with counsel before executing this Agreement.
33. The parties to this Agreement understand and agree that nothing herein shall affect any right of interest of any person not a party to this Agreement.
34. Nothing herein shall prohibit the Superintendent from seeking an order to enforce this Agreement, or from seeking additional sanctions in the event that John Alden does not comply with the above terms, or from taking further legal action in the event that the Superintendent receives additional evidence not previously a part of this investigation that further legal action is necessary.

SIGNATURE PAGE

Dated: , 2004

JOHN ALDEN LIFE INSURANCE COMPANY

By: _____

Its: _____
Printed Name and Title

Subscribed and sworn to before me
this _____ day of _____, 2004.

_____
Notary Public

_____
Printed name

_____
Date of commission expiration

Dated: , 2004

MAINE OFFICE OF THE ATTORNEY GENERAL

_____
Thomas C. Sturtevant, Jr.
Assistant Attorney General

MAINE BUREAU OF INSURANCE

Effective
Date: , 2004

_____

Alessandro A. Iuppa
Superintendent