UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

FEDERAL TRADE COMMISSION, Plaintiff, v. **SIMPLE HEALTH PLANS LLC, et al.,** Defendants.	**Case No.: 18-cv-62593-DPG**

DEFENDANT STEVEN DORFMAN'S MEMORANDUM
IN OPPOSITION TO A PRELININARY INJUNCTION

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Pursuant to the Court's Ex Parte Temporary Restraining Order with Asset Freeze, Appointment of a Temporary Receiver, and Other Equitable Relief, and Order to Show Cause why a Preliminary Injunction Should not Issue (the "**Show Cause Order**") [DE 15] and scheduling order [DE 76], Defendant Steven Dorfman ("**Dorfman**") submits this response and memorandum in opposition to the imposition of a preliminary injunction and other relief sought by Plaintiff the Federal Trade Commission (the "**FTC**") at the preliminary injunction hearing scheduled for April 16, 2019 (the "**Preliminary Injunction Hearing**").

For the sake of brevity, Mr. Dorfman respectfully refers the Court to his *Motion to Strike Temporary Restraining Order* [DE 79] as to why the FTC is not authorized to obtain the remedies sought in this proceeding, including disgorgement and restitution, or injunctive relief to restrain the Defendants' assets for the benefit of those remedies, which he fully incorporates herein.

INTRODUCTION

The FTC, as a federal regulatory agency, has been endowed by Congress with specific, ***limited*** enforcement powers. Because of that, like the federal government's mandate in criminal actions, the FTC should maintain the highest standards of integrity in enforcement litigation in federal district courts. That is especially the case where, as here, the FTC submits an *ex parte* request to a district court seeking extraordinary relief including a blanket asset freeze over untraced corporate and personal assets as well as the immediate takeover of a company by a court-appointed receiver without any notice to the interested parties. *See Granny Goose Foods, Inc. v. Bhd. of Teamsters & Auto Truck Drivers Local No. 70 of Alameda Cty*., 415 U.S. 423, 439 (1974) ("the availability of *ex parte* temporary restraining orders reflect the fact that our entire jurisprudence runs counter to the notion of court action taken before reasonable notice and an opportunity to be heard has been granted both sides of a dispute"). However, in this action, the FTC's *ex parte* motion for a temporary

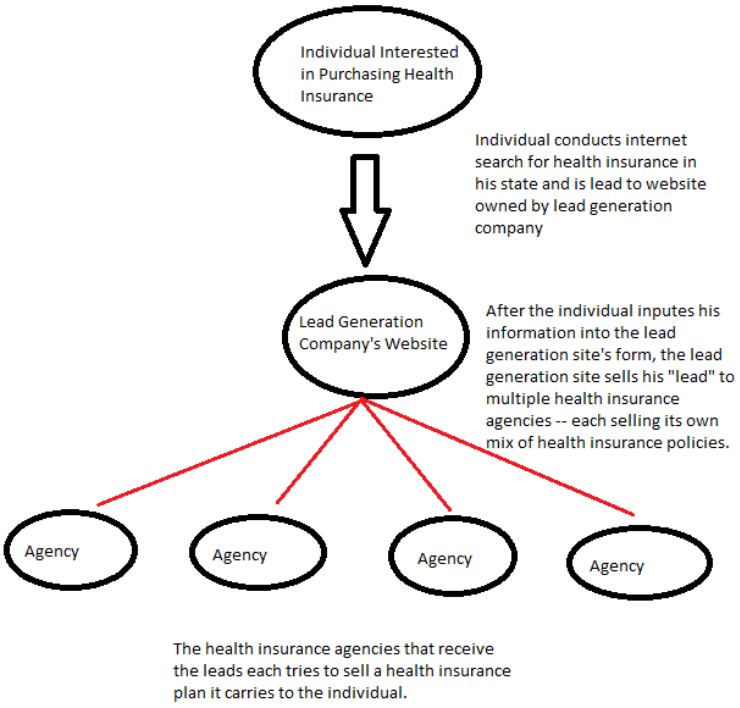
restraining order ("**TRO Motion**") [DE 3] and memorandum in support thereof (the "**TRO Memorandum**")[1] [DE 12] exceeds and constitutes an abuse of the FTC's regulatory authority, the Court's *ex parte* procedures, and the litigants' obligations to accurately disclose all relevant facts, especially when seeking extraordinary relief.

The FTC relied on assumptions, misattributed statements, and out-of-context facts to make a flawed showing that the Defendants deceived their customers into thinking that HBO: (i) sold "comprehensive" health insurance; (ii) sold qualified health plans under the Affordable Care Act; (iii) was an expert on and sold government-sponsored health insurance policies; and (iv) was affiliated with AARP and the Blue Cross Blue Shield Association.

The FTC's errors and misrepresentations to the Court appear to stem from a failure to understand the health insurance industry it seeks to regulate, blurring important distinctions between the various players in the industry and their respective roles, and the process by which consumers search for, identify, and buy health insurance and other healthcare products. Individuals that seek to purchase a health plan or product often start by conducting generic internet searches using search terms such as "health insurance." *See* Paragraphs 37-38; 54-63 of the Declaration of Steven Dorfman attached as **Exhibit "A."** This internet search leads individuals to a variety of independently-owned and operated websites for so-called "lead generation" companies that specialize in connecting consumers to agencies that sell health insurance plans issued by health insurance companies. *Id.* To be connected with health insurance agencies, consumers often input basic biographical information on the lead generation website. *Id.* The lead generation website then immediately sends these "leads" to multiple different agencies that sell health insurance plans and products created and maintained by third party health insurers and administrators. *Id.* Each agency sells a unique array

[1] All citations herein to "PX" are to exhibits to the FTC's TRO Memorandum.

of health insurance plans and products from a different set of health insurers and providers. *Id.* Upon receiving the "lead," the agencies' respective salespeople rush to contact the "lead." *Id.* Salespeople then compete to sell the consumer a health insurance plan or other product marketed and sold by the agency. *Id*. Ignoring the different roles that health insurers, third-party administrators, lead generation companies, and agencies play in the industry, the FTC oversimplifies the industry by lumping all of these independent businesses together and clumsily misattributing the various industry players' representations to unrelated entities. The flow of information and relationship between the players in the process is summarized in the illustration below:



In addition to confusing the fundamental process by which health insurance is marketed and sold, the FTC apparently also fails to appreciate that the numerous corporate Defendants are distinct business entities – further eroding the reliability of the FTC's *ex parte* presentation to the Court. Indeed, throughout its Complaint, TRO Motion, and TRO Memorandum, the FTC repeatedly refers to all of the Defendants as if they are a single entity with identical business models, employees, and

operations. In fact, the Defendants are distinct business entities that were in different lines of business. The only operating Defendants are: Health Benefits One, LLC ("**HBO**"), Senior Benefits One, LLC ("**SBO**"), Innovative Customer Care, LLC ("**ICC**"), and Simple Insurance Leads, LLC ("**SIL**"). Although each of the Defendants is involved in the insurance industry, each has a separate identity and defined businesses: (i) HBO is a health insurance agency focused on brokering limited benefit health insurance plans, short term medical plans, and wellness plans (and which previously sold Affordable Care Act-compliant plans), Dorfman Decl., ¶¶ 48-53; (ii) SBO is a Medicare insurance agency focused on brokering Medicare Advantage plans, Dorfman Decl., ¶¶ 79-84; (iii) ICC is a customer support company that provided customer support for non-affiliated health insurance agencies, Dorfman Decl., ¶¶ 100-102; and (iv) SIL is a lead generation company that gathered applications from individuals interested in purchasing health insurance and distributed those leads to HBO, SBO, and dozens of other unrelated health insurance brokerages, Dorfman Decl., ¶¶ 94-99. Defendant Simple Health Plans, LLC ("**SHP**") never operated and Defendant Health Center Management, LLC ("**HCM**") is merely a holding company that wholly-owned the other corporate Defendants as subsidiaries. Dorfman Decl., ¶¶ 41, 103-107.

The FTC maintains that all of the Defendants acted deceptively by misrepresenting to customers the type of health insurance plan they were purchasing. The FTC is wrong. Putting aside the fact that Defendants ICC, SIL, SHP, and HCM were never in the business of marketing or selling health insurance plans and that there are no allegations with any specificity relating to SBO's conduct, the record reflects that HBO's representations to consumers and contracts were not misleading. In fact, they were replete with express statements advising the customers of the health insurance plans and products that they purchased and that the Defendants did not deceive anyone. Indeed, while finalizing each customer's purchase of a health insurance plan, the customer was either

read or text messaged all of the terms and conditions of the specific plan they were purchasing, setting forth all of the benefits they were entitled to. Dorfman Decl., ¶¶ 64-76. At the end of this disclosure, each customer verified that she understood the terms and conditions of the plan she purchased. *Id; see also,* verification annexed to FTC's consumer-witnesses' declarations (PX6-22).

Despite all of this, it appears that the FTC had a pre-determined view of the corporate Defendants and Mr. Dorfman, and has investigated and litigated this case to vindicate its pre-conceived beliefs – regardless of actual facts. As a result, the FTC's strategy in its *ex parte* submission to the Court was to obtain an uncontested temporary restraining order imposing onerous conditions obstructing the Defendants' ability to contest this action by denying Mr. Dorfman the ability to fund his legal defense and putting the corporate Defendants out of business before they even had an opportunity to respond to the FTC's claims and correct the record. To secure the *ex parte* TRO, the FTC improperly caused the Court to rely on an *ex parte* submission loaded with material falsehoods, half-truths, innuendo, assumptions and omissions. It was a transparent effort to inflame the Court through a one-sided, incomplete version of the material facts bearing on the extraordinary remedies sought. Below are a few examples of the outright falsehoods and omissions in the FTC's *ex parte* papers:

- The FTC asserts that HBO used deceptive third party lead generation websites to market health plans sold by HBO. Specifically, the FTC takes issue with the fact that these websites reflect that they (i) specialize in providing comprehensive health insurance, (ii) are affiliated with Blue Cross Blue Shield Association and AARP, and (iii) are experts on government-sponsored health insurance. *See* TRO Memorandum, 4-11. In reality, HBO had an arms-length business relationship with the lead generation companies, had no way that it could have monitored their independent business activities, and was not responsible

for the content listed on those websites. Dorfman Decl., ¶¶ 54-57. Regardless, the representations that the FTC complains of are *true*. HBO was only one of scores of health insurance agencies that the lead generation websites sent leads to and many of the other health insurance agencies in fact: (i) specialize in providing comprehensive health insurance; (ii) are affiliated with Blue Cross Blue Shield Association and AARP; and (iii) are experts on government-sponsored health insurance. Dorfman Decl., ¶ 58.

- The FTC asserts that HBO deceived its customers into purchasing health insurance products that did not meet their expectations TRO Memorandum, 12-23. In reality, before consummating each transaction, HBO's representatives read or emailed to the customer the complete terms and conditions of the product that the consumer purchased and each consumer verified his or her assent to those terms. Dorfman Decl., ¶¶ 60-63. HBO cannot be held liable for a handful of customers misunderstanding the terms of their coverage despite having those terms clearly explained to them orally and in writing.

What makes the FTC's misrepresentations all the more egregious is that, if the FTC had done even an iota of untainted due diligence, the FTC would have an actual understanding of the Defendants' respective operations and would have avoided destroying multiple profitable businesses, leaving hundreds of individuals unemployed and hundreds of thousands of individuals without access to customer support for the healthcare products that they purchased. Instead, the FTC chose to shoot first and ask questions later based on the hearsay self-drafted declarations by a select few disgruntled customers, out of tens of thousands of satisfied customers, and declarations from two vindictive former low-level employees. Worse yet, ***recordings of the sales calls between HBO and the customer-witnesses*** that the FTC coerced into submitting declarations on behalf of this action ***directly contradict statements in the customers' declarations*** submitted in support of

the TRO. Those recordings, which Mr. Dorfman will present to the Court at the Preliminary Injunction Hearing, highlight that during sales process, HBO representatives advised the consumer-witnesses: (i) that the plans they were purchasing were not (a) ACA-complaint or (b) comprehensive health insurance; and (ii) the benefits they were entitled to and their health insurance plans' terms and conditions. The recordings also highlight that HBO never told customers they were purchasing health insurance issued by the Blue Cross Blue Shield Association or AARP.

Once the TRO was entered, the Receiver took control of the Defendants' assets, and Mr. Dorfman's personal funds were frozen and inaccessible to him. As a result, Mr. Dorfman, who is married has been severely restricted in his ability to use his own money to pay for basic living expenses and for his legal defense. Notably, the FTC has rebuffed Mr. Dorfman's request that the asset freeze be modified so that he can access funds to pay for his family's expenses and for his legal defense. The FTC would prefer that Mr. Dorfman not be able to fund a legal defense and challenge the quality and sufficiency of the investigation in this case.

The Court should not condone the FTC's improvident *ex parte* submission by entering the requested preliminary injunction. More important, as shown below, the factual record and applicable law does not support a preliminary injunction. *First*, the FTC failed to show that there is a likelihood it will prevail on the merits. In its papers, the FTC ignored key facts that contravene its allegations, *i.e.*, that the Defendants did not deceive anyone or engage in unfair trade practices.

Second, the FTC completely fails to support the onerous blanket asset freeze over the corporate Defendants' and Mr. Dorfman's personal assets. The FTC failed to satisfy the threshold inquiry for such an asset freeze: that there is a risk of dissipation of assets. The FTC's argument in support of the risk of dissipation is comprised of false assumptions, misstatements, and innuendo—and nothing more. In attempting to obtain the asset freeze, it seems that the FTC's strategy was to

publish inflammatory allegations and references to "suspicious" transfers to offshore accounts. In reality, the transfers were contractual payments to companies that provided HBO with call center support from Panama and the Dominican Republic – not shells to which Mr. Dorfman sought to secrete assets. Simply put, there is no showing here of a danger of dissipation.

Third, the FTC has not provided support for the extreme remedy of implementing a receiver. In addition to not showing a risk of dissipation of assets, which is an important aspect of the receivership analysis, the FTC cannot justify the severe hardship imposed by the receivership on Mr. Dorfman, and more importantly, on the corporate Defendants' employees and customers who rely on their continued operation. To the extent that the Court determines that oversight of the corporate Defendants is appropriate, a corporate monitorship would clearly suffice.

In sum, the Court should not condone the FTC's thoughtless approach to this case. Granting the proposed preliminary injunction will essentially give the FTC license to continue submitting incomplete and misleading *ex parte* assertions to district courts in order to obtain extreme injunctive relief that exceeds the FTC's statutory authority. Further, granting a preliminary injunction is simply not legally appropriate given the heavy legal burden and the facts of this case. The TRO, entered based on the FTC's improper and misleading *ex parte* submission, has destroyed Mr. Dorfman's reputation and his businesses, resulting in the loss of jobs and damaging the corporate Defendants' customers relying on their ongoing services, and destroyed Mr. Dorfman's finances, as he cannot access most of his personal funds. ***Effectively, the FTC's actions flip the American judicial system on its head by treating defendants as guilty until they prove their own innocence while subject to an asset freeze***. The Court should deny the FTC's motion for a preliminary injunction and proceed with this historical case with the parties on equal footing. This is what due process and fairness require.

MEMORANDUM OF LAW

I. The Defendants Are Not a "Common Enterprise"

The FTC erroneously seeks to have all of the Defendants held jointly and severally liable for their conduct because the FTC alleges that they are a "common enterprise." TRO Memorandum, 31-32. To establish that the Defendants constitute a common enterprise the FTC bears the burden of establishing that the Defendants: (i) have common control; (ii) share office space and officers; (iii) transact business through a maze of interrelated companies; (iv) commingle corporate funds and fail to maintain separation of companies; (v) have unified advertising; and (vi) are not distinguishable. *FTC v. Wolf*, 1996 WL 81240, at *7 (S.D.Fla. Jan. 31, 2016) (collecting cases). In support of its contention that the Defendants form a "common enterprise" the FTC nakedly asserts that the Defendants "engage in the same health insurance scam; share ownership, management, office locations, employees, fictitious business names, insurance licenses, leads and lead generation websites; and commingle funds." TRO Memorandum, p. 32. The FTC failed to provide ***any*** substantiating evidence for these allegations. In reality, apart from the corporate Defendants sharing common ownership by HCM, for which they undertook efforts to maintain corporate formalities, the corporate Defendants do not share any of the other hallmarks of a common enterprise: (i) apart from a couple of members of senior management and HBO's account department, they do not maintain common employees; (ii) they have distinct and separate office space; (iii) they have independent operations; (iv) they maintain separate accounts and books and records; and (v) they have independent marketing and advertising efforts and strategies. *See* Dorfman Decl., ¶¶ 42-46. Furthermore, ***HBO is the only Defendant against whom the FTC made any specific allegations against.*** Accordingly, the FTC failed to meet its burden of establishing that the Defendants are engaged in a common enterprise and that they should held jointly and severally liable.

Seemingly, the FTC's overzealous efforts to characterize the Defendants as a "common enterprise" stem from its fundamental misapprehension of the different business activities of each Defendant described above and in the Dorfman Declaration. As highlighted below, properly attributing the alleged misrepresentations at issue to the appropriate Defendant, as opposed to clumsily attempting to collapse all of the Defendants into a single entity, provides a more contextual analysis of why the Defendants did not make any actionable representations to consumers. Accordingly, the Court should deny the FTC's request that the Defendants be treated as a "common enterprise" and be held jointly and severally liable for their individual conduct.

II. The Proposed Preliminary Injunction is Improper.

A. Legal Standard.

For the FTC to obtain injunctive relief it bears the burden of showing that (1) it is likely to ultimately succeed on the merits of the case and (2) that a balancing of the equities supports the injunctive relief sought. *FTC v. IAB Mktg. Assocs., LP*, 746 F.3d 1228, 1232 (11th Cir. 2014); *see also* 15 U.S.C. § 53(b). "In light of the severe adverse consequences of a preliminary injunction, the FTC has a substantial burden under Section 13(b)." *See FTC v. Great Lakes Chem. Corp*., 528 F. Supp. 84, 86 (N.D. Ill. 1981). Where, as here, the FTC seeks extraordinary injunctive remedies beyond merely enjoining allegedly violative conduct, it is required to satisfy an even higher burden of proof. *See SEC v. Compania Internacional Financiera S.A.*, 2011 WL 3251813, at *7 (S.D.N.Y. July 29, 2011) ("Like any litigant, the Commission [is] obliged to make a more persuasive showing of its entitlement to a preliminary injunction the more onerous are the burdens of the injunction it seeks.").

B. The FTC Did Not Meet its Burden of Establishing that it Will Succeed on the Merits.

The FTC alleges that the Defendants engaged in deceptive acts or practices in violation of Section 5(a) of the FTC Act, 15 U.S.C. § 45(a), and deceptive telemarketing acts or practices that

violate the Telemarketing Sales Rule, 16 C.F.R. §§ 310.3(a)(2)(iii), (a)(2)(vii), & (a)(4). *See* Complaint at 23-26. Specifically, the FTC claims HBO engaged in deceptive conduct by misleadingly claiming to customers that: (i) HBO's limited benefits plans and medical discount memberships are comprehensive health insurance or the equivalent; (ii) that these products are qualified health insurance plans under the Affordable Care Act; (iii) that HBO is an experts on, or provider of, government-sponsored health-insurance policies; and (iv) HBO is affiliated with AARP or the Blue Cross Blue Shield Association. *See* TRO Memorandum, 35-36. The FTC is wrong. HBO did not engage in intentionally deceptive conduct.

To establish deceptive acts or practices, the FTC bears the burden of showing that (1) the defendant made a representation; (2) the representation was likely to mislead customers acting reasonably under the circumstances; and (3) the representation was material. *See FTC v. Tashman*, 318 F.3d 1273, 1277 (11th Cir. 2003). As shown below, the FTC will not prevail on the merits of its claims against the Defendants for alleged deceptive practices for a number of independent reasons: (i) third parties, not the Defendants, made the alleged misrepresentations; (ii) the representations at issue were true and not actually misrepresentations; and (iii) even if the representations were misleading, they were immaterial because the Defendants adequately disclosed the terms and conditions of the health insurance products that consumers purchased.

1. The FTC Failed to Meet its Burden to Establish that the Defendants Made Any Misrepresentations.

a. HBO Did Not Represent that Consumers Were Purchasing Comprehensive Health Insurance.

The FTC alleges that HBO represented to consumers that it sold comprehensive health insurance by citing to:

- Declarations from a handpicked sample of customers who claim that HBO's representatives told them that the health insurance policy they were purchasing was a

preferred provider organization (i.e., a "PPO") health insurance policy. TRO Memorandum, 12-13.

- Declarations from FTC investigators and former customers indicating that they claim that HBO's representatives told them that the plan they purchased covered: (i) doctor office visits, (ii) hospital visits, (iii) diagnostic testing, (iii) medications, and (iv) surgical procedures. *Id.*, 14-16.

In other words, the FTC claims the fact that HBO's representatives told customers that the plans they purchased were PPOs and provided the covered benefits is equivalent to the Defendants' representation that the subject plans were comprehensive health insurance. However, neither of these representations, even if proved, supports the allegation that HBO mislead consumers into believing they were purchasing comprehensive health insurance plans.

First, the fact that a health insurance plan or product gives customers access to a Preferred Provider Organization or "PPO" does not mean that the plan or product is comprehensive health insurance. A PPO is merely a network of healthcare providers, such as doctors, urgent cares, hospitals, or labs. Dorfman Decl., ¶¶ 21-24. The fact that a health insurance plan is a "limited benefit plan" does not mean that it cannot simultaneously include a PPO network. Dorfman Decl., ¶ 22. Critically, none of the customer-witnesses' declarations reflect that that HBO representatives told the consumers that they were purchasing comprehensive health insurance.[2] Indeed, the audio recordings of the HBO's representatives' conversations with the FTC's consumer-witnesses, which will be played during the Preliminary Injunction Hearing, confirm as much and even go

[2] *See* TRO Memorandum Footnote 33 *citing* PX 6, Banksi Dec. ¶ 5 (no allegation that HBO's representative told her she was purchasing "comprehensive health insurance" or an ACA-compliant plan); PX9, Hackethal Dec. ¶ 6 (same); PX 10, Hall Dec. ¶ 5 (same); PX 13, Macary Dec. ¶ 5 (same); PX 14, Mandarich Dec. ¶ 4 (same); PX 15, Prescher Dec. ¶ 5 (same); PX 17, Skordilis Dec. ¶¶ 3-6 (same); PX 20, Thompson Dec. ¶ 3 (same); PX 21, Touchet Dec. ¶ 3 (same); PX 22, Van Deusen Dec. ¶¶ 3-4 (same).

further to show that many of these witnesses (i) specifically said they did not want comprehensive health insurance (because they could not afford it) and (ii) were affirmatively told that they were not purchasing comprehensive health insurance. Accordingly, the FTC's allegation that HBO misrepresented to consumers that they were purchasing comprehensive health insurance is wrong. Additionally, transcripts of HBO's representatives calls with the FTC's undercover investigators also highlight that HBO informed the FTC's undercover agents that the plans they were "purchasing" were not comprehensive health insurance. *See, e.g.* PX 3, Al-Najjar Dec., page 23 (Where HBO representative advises Mr. Al Najjar that the plan he is purchasing is not comprehensive health insurance, major medical health insurance, or ACA-Complaint).

Second, healthcare benefits such as doctor visits, hospital visits, diagnostic testing, prescriptions, and surgical procedures are not exclusively afforded by comprehensive health insurance, but also provided by other plans such as limited benefit insurance plans. Dorfman Decl., ¶ 8. Further, the health insurance plans that the witnesses purchased in fact provided benefits for doctor visits, hospital visits, diagnostic testing, medications, and surgical procedures.[3]

In sum, the FTC failed to meet its burden of establishing that HBO's representations misrepresented the type of benefits their plans afforded consumers.

[3] *See* PX 1, Menjivar Dec., p. 451-452 (providing coverage for physician are, prescriptions, and lab testing), 459 (providing schedule of benefits for hospitals, doctors visits, and emergency room visits), 482 (prescription coverage), 485 (imaging and laboratory testing coverage), 486 (medical supplies and equipment coverage); PX 2, Hawkins Dec., p. 62 (providing schedule of benefits for hospitals, doctors visits, and emergency room visits), 79, 86, 105 (prescription coverage), 89 (imaging and laboratory testing coverage), 90 (medical supplies and equipment coverage); PX 8, Declaration of Jules Fernandez (failing to attach any documents evidencing that he did not receive any of the benefits he alleged that the Defendants promised he would receive); PX 9, Hackethal Dec. (failing to attach any documents evidencing that he did not receive any of the benefits he alleged that the Defendants promised he would receive); PX 16, Scott Dec., (failing to attach any documents evidencing that he did not receive any of the benefits he alleged that the Defendants promised he would receive); PX 18, Slawson Dec., ¶ 4 (Defendant's representative advised customer that she was purchasing a "limited plan.") (failing to attach any documents evidencing that he did not receive any of the benefits he alleged that the Defendants promised he would receive); PX 19, Stanley Dec. (failing to attach any documents evidencing that he did not receive any of the benefits he alleged that the Defendants promised he would receive)

b. **HBO Did Not Represent to Consumers that they Were Purchasing Affordable Care Act-Compliant Plans.**

The second category of alleged misrepresentations that the FTC claims HBO made and are actionable is that HBO told consumers that the plans they purchased qualified under the Affordable Care Act. TRO Memorandum, 7-11. Again, the facts do not support the FTC's claim. Tellingly, none of the consumer-witnesses claimed that HBO representatives told them that HBO's plans are qualified Affordable Care Act plans or government-sponsored health insurance.[4] *See also,* PX 3, Al-Najjar Dec., page 23 (Where HBO representative advises Mr. Al Najjar that the plan he is purchasing is not comprehensive health insurance, major medical health insurance, or ACA-Complaint). To the contrary, as will be highlighted during playback of the consumer-witnesses recorded calls during the Preliminary Injunction Hearing, HBO explicitly advised the consumer-witnesses that the plans they were purchasing from HBO ***were not*** Affordable Care Act plans. Accordingly, the FTC failed to meet its burden of establishing that HBO misrepresented to the consumer-witnesses that they were purchasing ACA-compliant plans.

To the extent that any of the lead generation companies that HBO purchased leads from represented that they were affiliated with other insurance agencies that sold ACA-compliant plans, HBO is not liable for those representations because those representations (i) were made by a third party and/or (ii) are true. Dorfman Decl. ¶¶ 30-36; 58. Indeed, the FTC failed to submit any evidence (through declarations or otherwise) that the lead generation companies that represented that they were affiliated with agencies that sold ACA-compliant or comprehensive health insurance plans did not in fact send leads to agencies that sold those types of health insurance

[4] *See* TRO Memorandum footnote 39; PX 9, Hackenthal Dec. ¶ 6 (reflecting that HBO's representative did not state that she was purchasing an ACA-complaint plan); PX 10, Hall Dec. ¶¶ 3 & 5 (same); PX 13, Macaray Dec. ¶¶ 4-5 (same); PX 14, Mandarich Dec. ¶ 3 (same); PX 21, Touchet Dec. ¶¶ 3-4 (same); and PX 22, Van Deusen Dec. ¶ 3 (same).

plans. To the contrary, the lead generation companies that HBO purchased leads from did in fact sell leads to other insurance agencies that sold ACA-complaint and comprehensive health insurance plans. *See* Dorfman Decl. ¶¶ 58, 98. Accordingly, the FTC failed to meet ***its burden*** of establishing that the Defendants actionably represented that they sold ACA-complaint or comprehensive health insurance plans.

c. **HBO Did Not Represent to Consumers that they Were Purchasing Plans Issued by the Blue Cross Blue Shield Association or AARP.**

The FTC also seeks to hold HBO liable for SIL's and other lead generation's representations on their websites that they were affiliated with the Blue Cross Blue Shield Association ("**BCBS**") or AARP. TRO Memorandum, 6-7. As a preliminary matter, there are no allegations or substantiating evidence that HBO represented to consumers that they were purchasing BCBS or AARP Plans. Accordingly, the Court should disregard any insinuation that HBO made such a representation. Additionally, similar to its failure to meet its burden of establishing that the lead generation companies sold leads to insurance agencies that sold ACA-compliant or comprehensive health insurance plans, the FTC failed to present any evidence that the lead agencies that HBO purchased leads from did not sell leads to agencies that sold plans issued by BCBS or AARP.[5] In truth, those lead agencies did in fact sell leads to agencies that sold health insurance plans issued by BCBS or AARP. *See* Dorfman Decl., ¶¶ 58, 98. In sum, the FTC failed to meet its burden of showing that (i) ***HBO*** made any representation that it sold AARP or BCBS health insurance plans and (ii) that those lead generation companies did not in fact send

[5] Tellingly, while HBO does not claim to sell policies issued by AARP and Blue Cross Blue Shield Association, neither the declaration issued by AARP's representative (PX 27) nor the declaration issued by Blue Cross Blue Shield Association's representative (PX 29) reflect that their health insurance policies are not sold by any of HBO's competitor insurance agencies that also procure leads from the same lead generation companies as HBO.

leads to insurance brokerages that sold plans issued by BCBS or AARP. Accordingly, these representations are not actionable.

d. **HBO Was Qualified to Advise Consumers on the Affordable Care Act.**

The FTC also claims that HBO misrepresented to consumers that it was an expert on the Affordable Care Act. However, to the extent that HBO "boast[ed] about their superior ability to advise consumers about options under the ACA," that statement is not a misrepresentation since, as the FTC explicitly acknowledges, HBO sold numerous ACA-qualified policies – giving them adequate experience to "advise consumers about options under the ACA." *See* TRO Memorandum, 11.

2. Even if the Representations were False, they were Immaterial and it was Unreasonable for Consumers to Rely on Them.

Even if (i) HBO's sales representatives misrepresented to consumers that the plans they purchased were (a) ACA-complaint or (b) comprehensive health insurance or (ii) the lead generation companies that HBO purchased leads from misrepresented that they had business relationships with insurance brokerages that sold plans issued by BCBS or AARP, the FTC failed to meet its burden of establishing that those statements were material and that it was reasonable for consumers to rely on them when purchasing their policies from HBO. This is so because, even as the FTC's witnesses acknowledged in their declarations, HBO's representatives disclosed the plans' benefits, terms, and conditions with consumers when they purchased the plans and the consumers received documentation setting forth those details as well. Dorfman Decl., ¶¶ 60-62, 72-76, 91-93; *see also*¸ Footnote 3 above.

"When assessing whether a representation is misleading, courts look to the representation's overall, net impression rather than the literal truth or falsity." *See FTC v. Consumer Collection Advocates Corp.*, 2015 WL 12533013, at *4 (S.D. Fla. Sept. 9, 2015). A representation or

omission is material if it is of the kind usually relied on by a reasonably prudent person. *See FTC v. SlimAmerica, Inc.*, 77 F. Supp. 2d 1263, 1272 (S.D. Fla. 1999). Mere puffery is not considered deceptive. "Where a claim is merely exaggerated advertising, blustering, and boasting upon which no reasonable buyer would rely, it may be un-actionable puffery." *FTC v. Direct Mktg. Concepts, Inc.*, 624 F.3d 1, 11 (1st Cir. 2010) (citations and quotes omitted); *see also FTC v. NPB Advert., Inc.*, No. 8:14-CV-1155-T-23TGW, 2016 WL 6493923, at *7 (M.D. Fla. Nov. 2, 2016) ("An advertiser may lawfully engage in puffery,' i.e., state an opinion about a product") (citation omitted).

Disclaimers and disclosure to consumers may shield defendants in FTC cases from liability if they are communicated to consumers. In a frequently cited case regarding the avoidance of liability through disclaimers, the First Circuit stated:

> Disclaimers or qualifications are not adequate to avoid liability **unless they are sufficiently prominent and unambiguous to change the apparent meaning of the claims and to leave an accurate impression**. Anything less is only likely to cause confusion by creating contradictory double meanings.

FTC v. Direct Mktg. Concepts, Inc., 624 F.3d 1, 12 (emphasis added); *see also, FTC v. Capital Choice Consumer Credit*, 2003 WL 25429612, at *5 (S.D.Fla. 2003) (citing above passage from *Direct Mktg.*); *FTC v. Alcoholism Cure Corp.*, 2011 WL 13137951, at *44 (M.D. Fla. 2011) (same).

Here, the FTC's own exhibits evidence that the consumer-witnesses purchased limited benefit and discount membership plans from HBO and were never told that they were purchasing anything other than those products. All of HBO's customers were required to review and consider the terms and conditions of the health insurance plans they were purchasing prior to consummating their purchase. Dorfman Decl., ¶¶ 60-63; *see also*, Footnote 3. As evidenced by the plan documents submitted by the FTC and attached to the FTC's consumer-witnesses declarations, this disclosure

set forth with painstaking detail the benefits, coverage, limits, terms, and other conditions of the plans that consumers were purchasing from HBO. Further, as will be evidenced by playbacks of recordings of the conversations that the consumer-witnesses had with HBO's representatives, HBO's representatives also disclosed the nature of the benefits, terms, and conditions of the plans that consumers purchased. In sum, the terms of the health insurance plans that the customers were purchasing were "prominent and unambiguous" and certainly left customers with an accurate depiction of the product they were purchasing. *See Direct Mktg*., 624 F.3d at 12.

Therefore, even if any of the representations identified by the FTC were (i) misleading and (ii) attributable to HBO, the FTC failed to meet ***its burden*** of establishing that those misrepresentations were material or that it was reasonable for consumers to rely on them in the face of prominent, clear disclosures that the plans they were purchasing were not comprehensive health insurance or ACA-complaint.

C. The FTC's Case is Based on the Complaints of a Select Few Disgruntled Customers Out of Tens of Thousands Customers.

Finally, taking the above into consideration, it is also important to note the inadequate sample size of customer complaints offered by the FTC and the obvious selection bias at hand. HBO sold over five hundred thousand (500,000) insurance plans and other products and supplements to customers since 2013. Dorfman Decl., ¶ 52. Meanwhile, the FTC brings its allegations of widespread deceptive practices by the Corporate Defendants based on *only* 16 customer complaints, which represents less than 0.0035% of the Corporate Defendants' customers. *See* PX Decl. 6-22, in support of Motion for TRO. The few declarations of disgruntled customers are not representative of a fair sample of Corporate Defendants' customers.

D. Steven Dorfman Is Not Individually Liable for any of the Corporate Defendants' Conduct.

As the FTC highlights, for an individual to be held liable for corporate misdeeds, the FTC has the burden of showing that the individual has knowledge of the misrepresentations made by his company or should be aware of those misrepresentations. *See, generally,* TRO Memorandum, 37. The FTC claims that Mr. Dorfman is liable for any of the corporate Defendants' misdeeds because he is their sole officer, controls their practices, and is aware that customers have cancelled health insurance plans that they purchased from the corporate Defendants because they were unhappy with the coverage that it provided them. TRO Memorandum, 38. However, this alone does not impute liability for any wrongful conduct to Mr. Dorfman. In *Coro, Inc. v. FTC,* 338 F.2d 149 (1st Cir. 1964), the court found that FTC could not meet its burden of establishing that an individual should be personally liable for his company's bad acts just because he was the company's largest shareholder, president, and chairman and was responsible for the company's acts and practices. *Coro,* 338 F.2d at 154.

The FTC's effort to impute individual liability on Mr. Dorfman fails for the same reason as it did in *Coro*. Simply put, although Mr. Dorfman was ultimately in charge of the corporate Defendants' operations, he did not have and could not reasonably have been expected to have knowledge that one or a few of his thousands of employees may have been making material misrepresentations to customers. Indeed it would be an impossible task for any executive of any large organization to know exactly what his employees were doing. For this reason, Mr. Dorfman built-in safeguards at his companies, requiring all of his employees to follow a script (the "**Script**") when marketing and selling health plans to customers and to comply with the Policies. Dorfman Decl. at ¶¶ 64-76. The Script explicitly required the Defendants' employees to advise customers that the health plans they were purchasing provided discounts and included an indemnity

component that did not cover the entire cost of services, that the "plan does not meet the definition of minimal essential coverage, therefore, you could be subject to a tax penalty," and that the Defendants' agent would confirm the details of the insurance portion and discount part of the health plan. *See* PX 30, Baker Decl., ¶ 9 ("All agents were required to follow a sales script."), 13 ("The script explain[ed] the differences between limited benefit plans and major medical insurance. It also noted that limited plans did not meet the ACA's minimum essential coverage requirements."), p. 8-10. Despite requiring employees to follow the Script, apparently a few of them may have allegedly "skipped these disclosures." *Id.*, ¶ 13. Mr. Dorfman also created a quality assurance team to monitor the HBO's sales representatives sales pitches to consumers to make sure that they completely explained and disclosed the terms and conditions of the plans and policies that consumers purchased. *See,* PX 31, Seraphin Decl., ¶ 29. Employees that failed to adequately explain the terms and conditions of policies that they were selling to consumers were reprimanded. *Id.*; *see also,* PX 30, Baker Decl., ¶ 15. The FTC's own witness testified that the Defendants never told their employees to lie to consumers. PX 31, Seraphin Decl., ¶ 26.

Additional grounds for not imputing the corporate Defendants' conduct to Mr. Dorfman exist because the corporate Defendants were audited by HII, the third party administrator that compiled the health insurance policies and products that HBO sold, regularly audited HBO's employee training and sales and verification processes. A copy of documents produced by HII is annexed hereto as **Exhibit "B."** In each instance, HII after onsite visits and interviews with HBO employees, confirmed that HBO's business practices complied with all statutory and regulatory requirements. HII most recently audited HBO on September 13, 2018. *See* HII_000130-142. The purpose of the audit, as all that preceded it, was to:

- Assess the extent of HBO's compliance with regulatory and insurance requirements, as well as HII's own policies;
- To assess whether HBO's procedures are effective and ensure integrity; and
- To verify that HBO and HII have sufficient controls over HBO's processes and employees.

See HII_000133. To that end, HII reviewed HBO's sales process, verification processes, and consumer complaints and interviewed HBO employees. *See* HII_000134-35. HII's audit confirmed that two HBO employees, Kirschner Alteme (with 15 years of experience) and David Caldes (with 10 years of experience) conducted sales and verification training for HBO employees. *See* HII_000136. HBO invested a week of sales training in its employees with both a classroom and floor monitoring component and two weeks of sales verification training. *Id*. Additionally, HII's audit verified that HBO trains its employees using materials provided by HII and insurers. HII_000137. After conducting its extensive audit, HII concluded that apart from updating a few questionnaire responses, HBO did not have any deficiencies in its sales and verification processes. *See* HII_000142 (2017-2018 audit). HII reached the same conclusion, that HBO's processes were sufficient, in its other recent audits as well. *See* HII_000109 – 121 (June 11, 2018 audit); HII_000147-150 (February 24, 2016 audit); HII_000151-158 (March 26, 2015 audit). In sum, based on HII's own review of HBO's policies and practices it "found Simple Health's practices to be in adherence with HII Compliance guidelines." *See* HII_000111.

III. The Proposed Blanket Asset Freeze is Improper.

An asset freeze is an extremely severe remedy, justifiable only in extraordinary circumstances and which must be very carefully circumscribed. The FTC claims that an asset freeze is necessary because Mr. Dorfman is wrongly siphoning assets to offshore bank accounts. TRO Memorandum, 39-40. However, the FTC has not submitted any evidence of risk of dissipation of the Defendants'

assets. Instead, the FTC relied on half-truths and speculation cloaked as facts when representing that Mr. Dorfman was funneling the Defendants' assets to offshore accounts. Accordingly, the FTC failed to meet ***its burden*** of establishing that the blanket asset freeze is warranted. In reality, the identified transfers were periodic payments to companies that provided customer and call center support for HBO. Dorfman Decl., ¶¶ 108-13.

Even if the Court determines that the FTC has the common law-created remedies of disgorgement and restitution at its disposal, the FTC is not entitled to an asset freeze because it failed to meet its burden of showing that there is a substantial risk that the Defendants will dissipate, conceal, or transfer away assets before a final judgment is rendered. *See CFTC v. Sterling Trading Group, Inc.*, 605 F.Supp.2d 1245, 1304 (S.D. Fla. 2009) (denying asset freeze in part because the CFTC did not make "showing of dissipation or hiding of assets"); *see also, SEC v. ABS Manager, LLC*, No. 13cv319-GPC (JMA), 2013 WL 1164413, at *6 (S.D. Cal. Mar. 20, 2013) (denying asset freeze because, "[i]n support of its motion to freeze assets, the SEC . . . offered no evidence that [the] Defendant . . . will likely dissipate his own personal assets or the corporate assets."); *SEC v. Schooler*, 902 F. Supp. 2d 1341, 1360 (S.D. Cal. 2012) (modifying asset freeze in part because "SEC . . . offered no evidence that Defendants are sheltering or hiding money, or shuffling it around nefariously"); *FTC v. Millennium Telecard, Inc.*, 2011 WL 2745963, at *12-13 (D.N.J. Jul. 12, 2011) (refusing to continue asset freeze because incidents of financial impropriety – including the principal's history of writing checks to cash on corporate accounts, of writing bad checks and of co-mingling personal and corporate funds – failed to demonstrate a likelihood that the defendants would dissipate any assets); *FTC v. John Beck Amazing Profits, LLC*, No. 2:09-cv-4719-FMC-FFMx, 2009 WL 7844076, at *15 (C.D. Cal. Nov. 17, 2009) (denying asset freeze of defendants' personal assets: "[T]here is no evidence that Defendants have ever previously attempted to intentionally dissipate, hide or otherwise

shelter corporate or personal assets from an effort to collect a debt or judgment against Defendants."). This is the principal inquiry on this issue because the purpose of an asset freeze is to ensure that defendants will not dissipate, conceal, or divert assets before a final judgment, "thereby defeating the possibility of effective final relief in the form of equitable monetary relief." *See CFTC v. Mad Fin., Inc.*, 2002 WL 1972063, at *7 (S.D. Fla. 2002). Thus, without a substantial showing of a likelihood of dissipation, there is no need for an asset freeze through the duration of this proceeding. Further, to establish the possibility of dissipation, the FTC "cannot rely on conjecture, instead, [it] must offer evidence specific to the Defendant that reveals a possibility that the Defendant will dissipate assets." *FTC v. Debt Solutions, Inc.*, No. C06-298JLR, 2006 WL 1041996, at *7 (W.D. Wash. Apr. 3, 2006). In *Debt Solutions, Inc.*, the Court froze the corporate defendants' assets upon proof that the corporate assets had been secreted to Canada, but declined to freeze the assets of the individual defendants. *Id.* The court recognized that the individuals were "accused of violations that could subject them to substantial liability," but concluded that, if "this were sufficient to stablish a 'possibility' of dissipation, then every defendant subject to an injunction under the FTCA would automatically be subject to an asset freeze." *Id.*

The FTC has failed to make any showing whatsoever that the Defendants and Mr. Dorfman are likely to dissipate or conceal assets. The FTC's efforts to demonstrate a likelihood of dissipation are premised on innuendo, speculation, and falsehoods. To create the false appearance of questionable offshore transfers, the FTC **blatantly misrepresented** to the Court that Mr. Dorfman was "funneling large sums of cash overseas." *See* TRO Memorandum, 48. This is a total falsehood. Simply put: none of the Defendants have or have ever had offshore bank or financial accounts. Dorfman Decl., ¶ 113. Rather, the international wire transfers identified by the FTC's forensic accountant relate to payments from the Defendants to offshore call centers used by the Defendants

to conduct their business. Dorfman Decl., ¶¶ 108-12, PX 5, ¶ 37. Furthermore, Mr. Dorfman's actions in this case have evidenced that he is not attempting to conceal assets and has gone above and beyond to identify and voluntarily turnover assets to the receiver. Indeed, the FTC and Receiver can attest to, Mr. Dorfman voluntarily walked-over assets worth in excess of $1 million to the Receiver on the same day that he was served with the TRO.

In sum, the FTC has not submitted any competent evidence that Mr. Dorfman or the corporate Defendants present any risk of dissipation of assets. Clearly the FTC failed to meet the extraordinary burden imposed when seeking such a severe remedy. *See SEC v. Compania Internacional*, 2011 WL 3251813, at *7 ("Like any litigant, the Commission [is] obliged to make a more persuasive showing of its entitlement to a preliminary injunction the more onerous are the burdens of the injunction it seeks.").

IV. The Court Should Remove the Temporary Receivership or, at Most, Convert it to a Corporate Monitorship.

Section 13(b) of the FTC Act grants courts broad equitable powers, including the power to appoint a receiver incident to a preliminary injunction. But the appointment of a receiver "is, like an injunction, an extraordinary remedy and ought never to be made except in cases of necessity upon a clear showing that . . . emergency exists, in order to protect the interests of the plaintiff in the property." *CFTC v. Combest Trading Corp.*, 481 F. Supp. 438, 441 (D. Mass. 1979). *See also FTC v. Direct Marketing Concepts, Inc.*, 2006 WL 149039, at *4 (D. Mass. Jan. 19, 2006) (describing the appointment of a receiver as an extreme, "draconian" remedy); *FTC. v. The Crescent Publishing Group, Inc.*, 129 F. Supp. 311, 326 (S.D.N.Y. 2001) (declining to appoint receiver, which, the Court noted, is "an extraordinary remedy to be employed cautiously and usually when no lesser relief would be effective.").

There are a number of factors a court should consider in determining whether to appoint a receiver, among them: (i) the nature of the alleged fraud; (ii) the extent to which the property at issue is in imminent danger of being lost, concealed, squandered or otherwise diminished in value; (iii) the adequacy of available legal remedies; (iv) whether any harm to the plaintiff would be greater that any injury to the parties opposing the receiver; and (v) the plaintiff's likelihood of success in the action and the possibility of irreparable injury to his or her interests in the property. *Combest Trading Corp.*, 481 F. Supp. at 441. Additionally, courts should evaluate whether the interests sought to be protected would be well served by the receiver, that is, whether the assets subject to the proposed receivership would be of sufficient value to outweigh the added costs that likely would result from the receivership. *Id.* Finally, courts also determine whether a defendant is compliant with discovery or other requests or "willfully opposing discovery or refusing to answer questions relating to relevant business operations." *CFTC v. Lake Shore Asset Management Ltd.*, 2007 WL 2915647, at *17 (N.D.Ill. 2007).

The Court should deny the FTC's request to extend the receivership over the corporate Defendants through the preliminary injunction for the same reasons it should deny the FTC's request for an asset freeze. *First*, as shown above, the Defendants did not engage in any type of consumer fraud or deceptive marketing practices, and the FTC is unlikely to prevail on the merits.

Second, as shown above, there is no risk of dissipation of the corporate Defendants' or Mr. Dorfman's assets. The FTC has failed to offer a scintilla of evidence showing that there is a likelihood that the corporate Defendants' or Mr. Dorfman's assets being marshalled and controlled by the Receiver will be concealed, diverted or dissipated before a final judgment in this case.

Third, the balance of the equities favors removal of the Receiver (as well as denying the other injunctive relief sought). Given the record evidence here, it is evident that appointment of the

receiver has imposed a much greater harm on the corporate Defendants and Mr. Dorfman than any alleged potential harm that might occur if the Receiver is removed. Mr. Dorfman's companies have been stripped from him—without notice—and their assets and operations marshalled by the receiver. Through no fault of the Receiver himself, who is simply following the orders the FTC requested that the Court impose on the receiver, the receivership has fundamentally disrupted and likely destroyed the corporate Defendants' businesses; only served to exacerbate any alleged customer complaints, which constitute a fraction of the corporate Defendants' customer base; left the corporate Defendants' employees without pay due to them; and interrupted the provision of tens of thousands of health insurance policies as individuals head into the open enrollment period for obtaining necessary health insurance. Conversely, the FTC has not shown any overriding reason why the receivership is necessary given that it has not shown any dissipation of assets.

Fourth, Mr. Dorfman has been forthcoming and open in sharing information with the FTC and the receiver about the corporate Defendants. Within a few days of receiving the TRO, he provided the FTC with a financial disclosure requiring significant information about his assets and financial history, and he also met with the Receiver and his counsel and has responded to their various inquiries requesting information.

Given consideration of these factors, the Court should refuse to continue the temporary receivership through a permanent injunction and it should allow Mr. Dorfman to take possession of the corporate Defendants and provide for their respective defense in this action. It is clear that a receiver is not only unnecessary, but that the takeover of the corporate Defendants and cessation of their business has hurt the Defendants and their diverse stakeholders. Alternatively, if the Court would prefer some level of supervision of over the corporate Defendants' operations, then Mr. Dorfman requests that the Court convert the receivership into a corporate monitorship whereby Mr.

Dorfman and the monitor agree to a revised business plan for the corporate Defendants and the monitor supervises the corporate Defendants' operations and receives periodic reports regarding corporate Defendants' services and its finances.

CONCLUSION

For the foregoing reasons, Mr. Dorfman respectfully requests that the Court deny the entry of a preliminary injunction, dissolve the asset freeze and receivership, and for all further relief the Court deems just and proper.

Dated: March 25, 2019

DLA Piper LLP (US)

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CERTIFICATE OF SERVICE

The undersigned certifies that he filed this pleading through the court's electronic filing system and that all parties requesting electronic notice of pleadings have been served with the pleading.

/s/ Ryan D. O'Quinn
Ryan D. O'Quinn

EXHIBIT A

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

FEDERAL TRADE COMMISSION, Plaintiff, v. **SIMPLE HEALTH PLANS LLC, et al.,** Defendants.	**Case No.: 18-cv-62593-DPG**

DECLARATION OF STEVEN DORFMAN

Pursuant to 28 U.S.C. § 1746, I, Steven Dorfman, declare as follows:

My name is Steven Dorfman, and I am over eighteen years of age. I make this declaration based upon my personal knowledge and in support of Defendants' Memorandum in Opposition to the Preliminary Injunction.

1. HEALTH INSURANCE PLANS

A. Major Medical Health Insurance

1. A major medical health insurance plan (otherwise known as the Affordable Care Act or comprehensive health insurance) is a private health insurance plan that complies with the requirements of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*. ("**ACA**" or "**Act**").

2. Major medical health insurance plans offer ten essential health benefits: (1) ambulatory patient services; (2) emergency services; (3) hospital care; (4) pregnancy, maternity, and newborn care; (5) mental health and substance use disorder services; (6) prescription drug coverage; (7) rehabilitative services and devices; (8) laboratory services; (9) preventive and

wellness services; and (10) pediatric services, including oral and vision care (collectively, the "**Essential Benefits**").

3. Consumers are often required to enroll in major medical health insurance plans during the open enrollment period, which runs from November 1st to December 15th of each year ("**Open Enrollment Period**").

4. Some exceptions that allow a consumer to enroll in major medical health insurance plans outside of the Open Enrollment Period include: certain "qualifying life events" such as marriage, childbirth, or losing other health insurance coverage.

B. Limited Benefit Health Insurance Plans

5. Limited benefit health insurance plans are health insurance plans that do not offer all of the Essential Benefits provided by major medical health insurance plans and are not regulated by the ACA.

6. These plans are less expensive for consumers and, therefore, offer fewer benefits than a major medical health insurance plan.

7. Consumers may elect to purchase limited benefit medical plans because: (i) they are generally cheaper than major medical insurance; (ii) the individual desires to secure a health insurance option outside of the Open Enrollment Period and did not otherwise qualify to obtain a major medial plan outside of the Open Enrollment Period; (iii) the individual seeks an option with more flexibility to choose their doctor, healthcare professional, hospital, or service provider; and (iv) the individual seeks a supplement to a high-deductible major medical insurance plan.

8. Limited medical indemnity insurance plans usually cover a limited portion of the insured's total costs for doctors' visits, hospital stays, prescriptions, diagnostic testing, surgical procedures, and other procedures up to a certain amount. Once this pre-determined cap is met, the

insured is responsible for the remaining medical expenses. Unlike major medical health insurance, the insured is responsible for paying his medical costs at the time they are incurred and then seeking indemnity from the insurer by filing a claim.

C. Medical Discount Plans

9. Limited medical indemnity insurance plans are often coupled with medical discount plans. Medical discount plans offer members discounted pricing at participating healthcare providers including doctor's office visits, hospital visits, lab testing, pharmacies, dental services, vision services, and/or other medical services.

10. A discount medical plan is not insurance. Issuers of the medical discount plans do not pay or reimburse the consumer's healthcare costs. The plan member is billed by the provider at the time of service at the pre-negotiated discounted rate.

D. Short-Term Health Insurance Plans

11. Short-term health insurance plans are insurance policies with shorter terms, usually less than one year.

12. Consumers may elect to purchase short-term plans because they are often less expensive (providing fewer benefits) than other health insurance plans.

13. Consumers may elect to purchase short-term plans because they desire to secure a health insurance option outside of the Open Enrollment Period and do not qualify for an exception to registering outside of the Open Enrollment Period.

E. Wellness Plans

14. Wellness plans are programs intended to improve and promote health and fitness.

15. Through these programs insurers offer consumers discounts for certain health and fitness services such as dental programs, vision programs, alternative medicine, physical therapy,

imaging, laboratory testing, and, certain prescriptions, vitamins and supplements, and medical supplies and equipment.

F. Other Terms

16. Accident Insurance covers medical and out-of-pocket costs incurred after an accidental injury, including but not limited to emergency treatment, hospital stays, and medical exams.

17. Critical Illness Insurance provides coverage in the event of a medical emergency, including but not limited to a heart attack, stroke, or coronary bypass.

2. COMMON TERMS

A. Premium

18. An insurance premium is the insured-consumer's up-front cost of purchasing health insurance payable to insurers.

B. Co-payment

19. A co-payment is a payment-sharing arrangement between the insurance company and the insured. This concept generally involves a structure where the insured pays a fixed out-of-pocket amount for covered services, such as doctor visits or prescription drugs after the insured's deductible has been met.

C. Deductible

20. A deductible is the minimum threshold payment an insured must make before the insurer is obligated to provide any coverage under a health insurance plan.

D. Preferred Provider Organization

21. A preferred provider organization ("**PPO**") is a network of healthcare providers, such as doctors, urgent cares, hospitals, or labs. Customers who purchase plans serviced by PPO

networks can visit any provider in the network. As a condition of being part of the network, providers in PPO networks charge these customers less than individuals who do not have plans serviced by the PPO network. In some instances, the provider can also bill the administrator directly using this network.

22. A PPO health plan contracts with medical providers, such as hospitals and doctors, in order to create a network of participating providers that will render subscribed participants services at an agreed upon reduced rate. The fact that a health insurance plan is a "limited benefit plan" does not mean that it cannot simultaneously include a PPO network.

23. PPO participants are free to utilize the services of any contracted medical or healthcare provider within the PPO. PPO participants are also able to utilize the services from out-of-network care, but such services may result in higher costs to the insured.

24. First Health Group Corp. ("**First Health**") is wholly owned subsidiary of Aetna Inc. First Health is an independently operated enterprise that describes itself as "one of the largest national PPO networks." According to its website, First Health's clients include third party administrators, carriers, employers, Taft-Hartly trusts, and government entities. First Health provides access to its national PPO network and other programs to help its clients manage costs for their employee benefit plans.

3. The Health Insurance Industry: Creating, Marketing, and Selling Health Insurance

A. Health Insurance Carriers

25. Health insurance carriers (otherwise known as insurers) control the underwriting process, claims process, pricing, and overall management of health insurance plans.

26. Health insurers are obligated to provide their policy holders and other covered persons with the benefits set forth in each member's respective health insurance plan and for

paying the qualified providers for qualified services provided to the insurer's policy holders and covered persons.

B. Third Party Administrators

27. Third party administrators are independent companies that work with insurers to create and administer health insurance plans and process medical insurance claims to insurers.

C. Health Insurance Agencies

28. Insurers and third party administrators contract with health insurance brokerage agencies for the agencies to market and sell health insurance plans to consumers.

29. Insurance agencies are not responsible for underwriting insurance plans and are not directly employed by any particular insurance carrier. Insurance agencies generally can choose which insurance carrier(s) or third party administrator(s) they would like to represent and which products they would like to market and sell.

D. Lead Generation Companies

30. Lead generation describes a marketing process for stimulating, directing, and capturing interest among (potential) consumers regarding a particular service or product for the purpose of developing sales.

31. In the health insurance industry, lead generation companies often operate websites that generate "leads" by identifying consumers that are searching for health insurance or other healthcare plans.

32. Lead vendors are independent businesses and agents that often work with multiple insurance agencies and third party administrators to sell different insurance plans or healthcare products.

33. Lead vendors often maintain relationships and contract with multiple insurance agencies and insurance carriers in order to sell the "leads" they generate to the insurance agencies. These relationships are often advertised or marketed through the lead generation website to educate consumers about the wide array of insurance plans and other healthcare products that are available through the multiple agencies contracting with the lead generation companies.

34. Lead generation websites frequently assert that their client agencies offer health insurance plans from commonly-known brands and insurers such as the Blue Cross Blue Shield Association or AARP. Because the lead generation sites often work with numerous agencies, it is likely that some of the agencies that receive consumer traffic driven by these lead generation companies do not sell health insurance plans from the touted insurers identified on the lead generation company's website.

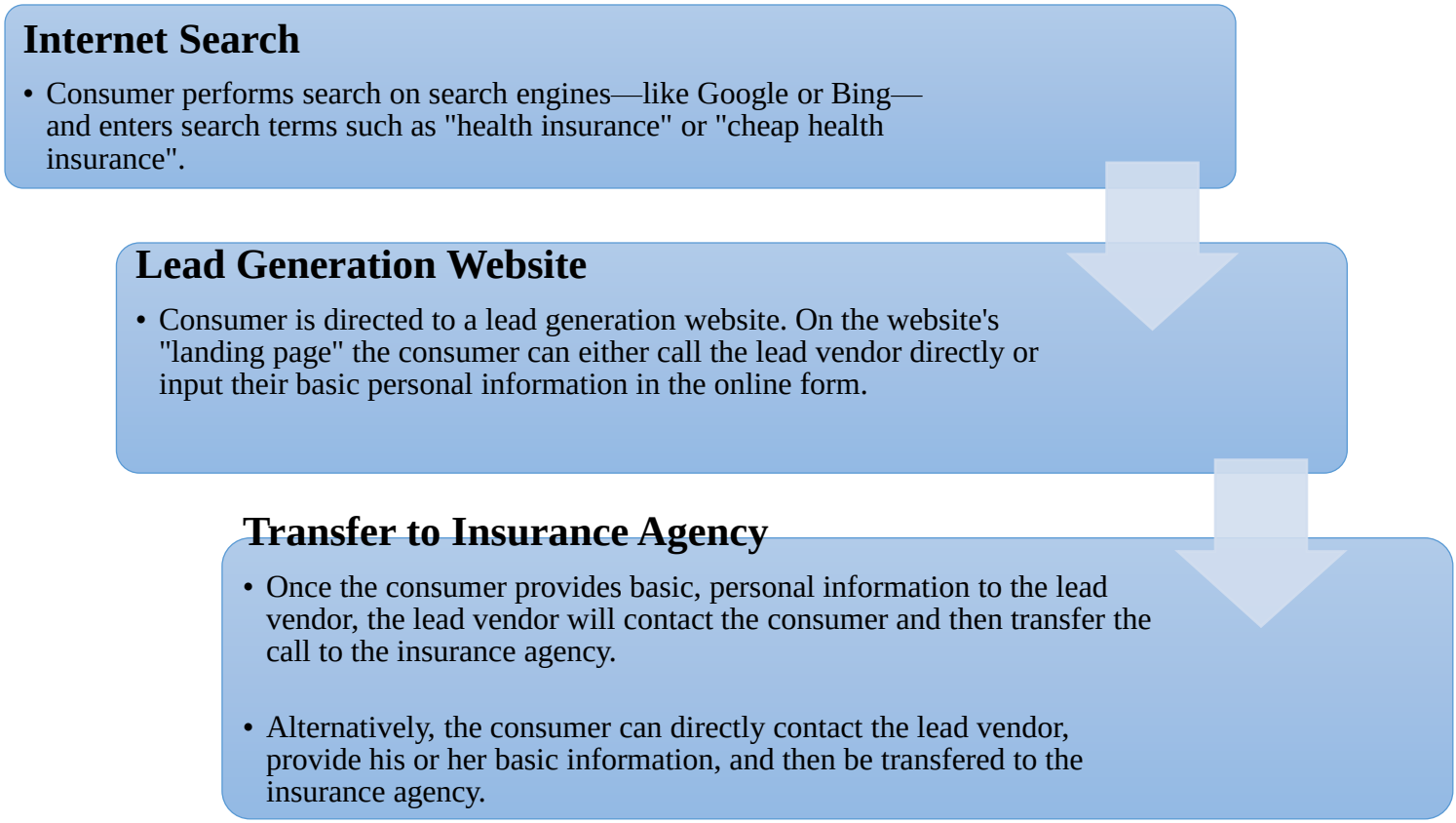
35. Lead generation companies are independent businesses, and are not the same as the insurance agencies with whom they contract.

36. Individual agencies are not responsible for the advertising practices of the independently operated lead generation websites.

E. How Lead Generation Websites Send "Leads" to Agencies or Buyers

37. Consumers who are interested in purchasing health insurance often start their search by entering the term "health insurance" into an internet search engine. Generally, this leads an individual to multiple lead generation companies' websites. At these websites, the consumer is prompted to complete a short form with basic, personal information. The lead vendor gathers this information (known as a "lead") and immediately sells the "lead" to numerous independent insurance agencies.

38. As soon as the insurance agencies obtain the "lead" the various competing agencies rush to contact the lead by phone or email to attempt to sell the consumer an insurance policy or healthcare product sold by that agency. The below chart further illustrates this process.



3. DEFENDANT ENTITIES

39. I have worked in the health insurance industry since approximately 2008.

40. Until the receiver was appointed in this case, I was the chief executive officer of Simple Health Plans LLC, Health Benefits One LLC, Innovative Customer Care LLC, Simple Insurance Leads LLC, and Senior Benefits One LLC.

41. Health Center Management LLC is a holding company that holds 100% of the interests in all of the other corporate Defendants. I own 99% of the membership interests in Health

Center Management LLC and Matthew Spiewak owns 1% of the membership interests in Health Center Management LLC.

42. Apart from myself, a couple of employees in senior management, and HBO's accounting department, the corporate Defendants did not share any common employees.

43. The corporate Defendants had separate and distinct office space.

44. The corporate Defendants were independently operated business entities that sold a variety of products and services.

45. The corporate Defendants had separate books and records and did not commingle funds.

46. The corporate Defendants each had their own advertising and marketing budgets and strategies.

47. None of the corporate Defendants ever maintained a bank or financial account outside of the United States of America.

A. Health Benefits One, LLC

48. Health Benefits One, LLC ("**HBO**") (dba Simple Health) is a limited liability company formed in 2012.

49. Before, the temporary restraining order entered in this case, I was HBO's chief executive officer.

50. HBO sold limited medical indemnity policies, short-term health insurance policies, wellness plans, and, until in or around 2014, major medical health insurance policies that were ACA complaint.

51. Prior to the institution of the receivership, HBO had approximately 150-200 employees.

52. Since it was founded, HBO sold more than five hundred thousand (500,000) health insurance policies and products.

53. Since approximately 2013, HBO sold health insurance plans and products primarily created by Health Insurance Innovations ("**HII**"), a third party administrator.

i. Process of Purchasing Health Insurance from HBO

54. HBO contracted with at least forty-five (45) lead generation companies to obtain leads for consumers interested in purchasing health insurance (collectively, the "**HBO Lead Generators**").

55. The HBO Lead Generators used websites (collectively, the "**HBO Lead Generators' Websites**") to obtain and send leads to HBO.

56. The HBO Lead Generators worked with multiple health insurance agencies, which sold different types of health insurance plans than HBO and from different issuers than those that created the plans sold by HBO.

57. HBO has never had any control over the marketing or advertising on the HBO Lead Generators' Websites or otherwise.

58. At least some of the other agencies that had relationships with the HBO Lead Generators sold health insurance plans affiliated with the Blue Cross Blue Shield Association or AARP or that were ACA-compliant.

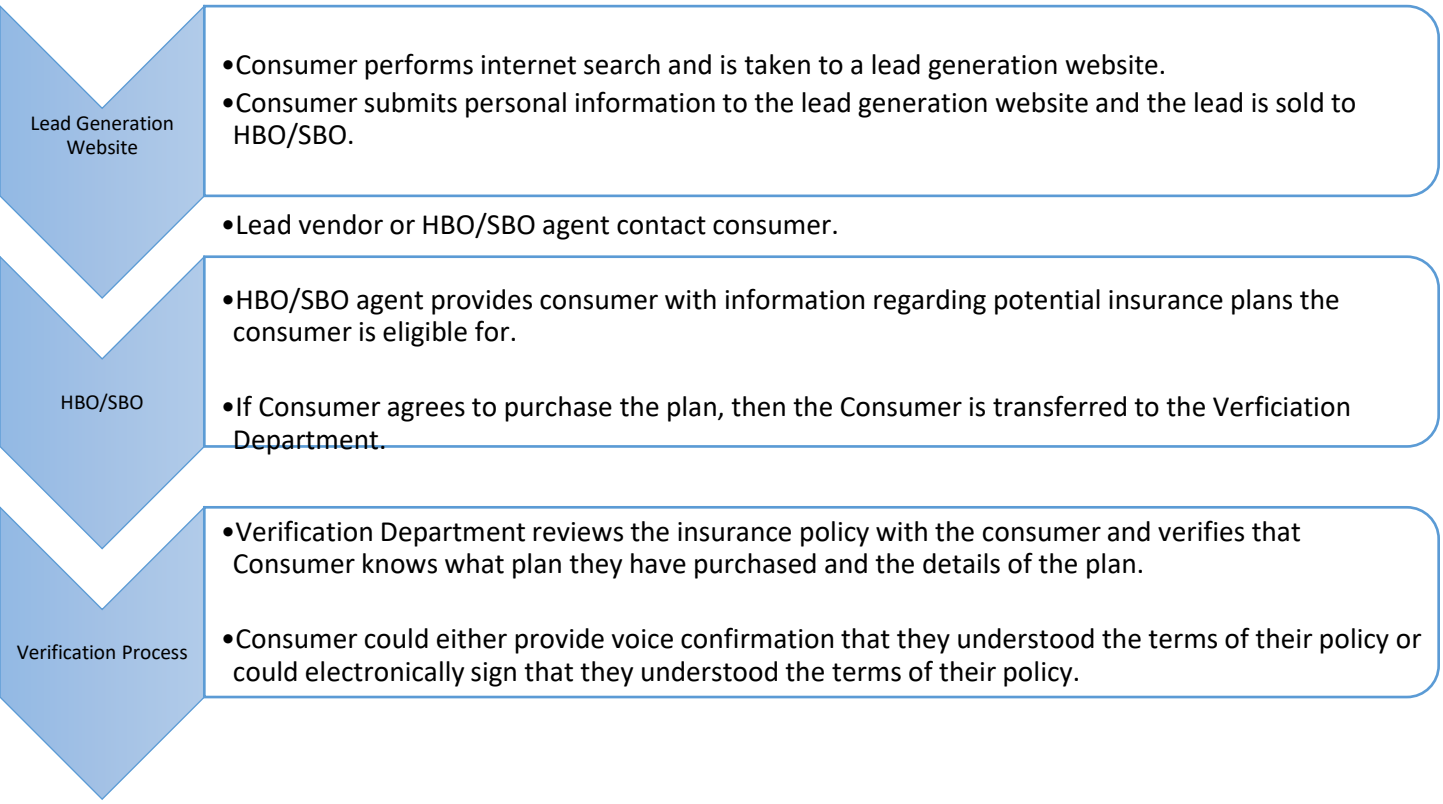
59. After receiving a lead from an HBO Lead Generator, an HBO agent would contact the lead and attempt to sell him or her one of the short-term health plans, limited benefit plans, and/or supplemental insurance and non-insurance products offered by HBO.

60. Generally, after a consumer chose a plan, the HBO agent would give the consumer the option of reviewing the terms, conditions, and benefits of the plan either electronically (e.g., on their smart phone or email) or with a live agent in HBO's verification department.

61. If the consumer chose to review the benefits of the plan electronically, the HBO agent would send an e-mail or text message to the consumer with the product application. The consumer would then verify his understanding of the plan's terms, conditions, and benefits, and his desire to purchase the plan, by electronically signing the verification.

62. If the consumer instead chose to review the plan with a live agent, the HBO sales agent would transfer the consumer to the HBO verification department. There, an HBO verification agent would identify the type of plan the consumer was purchasing and read aloud the terms and benefits of the plan to the consumer. The consumer would verify his understanding of the plan's terms, conditions, and benefits, and his desire to purchase the plan, by orally indicating his assent on the phone. The third party administrators that HBO worked with required this verification process to be recorded and conducted without any interruption by the consumer. If the consumer asked the agent verifying the terms and conditions of the policy he purchased to answer any questions, the verification agent was required to transfer the consumer back to the sales representative so that the sales representative could discuss those terms with the consumer.

63. The below chart further illustrates the process of purchasing health insurance with HBO.



ii. Script

64. All HBO employees were required to follow a script (the "**Script**") while speaking with potential consumers.

65. The Script was periodically reviewed by HII.

66. HII never objected to HBO's use of the Script.

67. This Script has been modified over the years as insurance products changed, or new regulations and restrictions regarding insurance plans and products were implemented.

68. This Script was provided to HBO employees in large part to ensure that the employees would not misstate or make misrepresentations when selling the insurance plans to the potential consumers.

69. Each agent was required to have this Script on his or her computer screen the entire time that they spoke with the consumer.

70. Until the receivership was initiated, HBO agents sold limited medical indemnity insurance plans, short term medical plans, medical discount plans, critical illness plans, wellness plans, and accident insurance to consumers.

71. Pursuant to the Script, the HBO agent was to advise the consumer that the "plan did not meet the definition of minimal essential coverage."

72. Additionally, according to the Script, the HBO agent was required to disclose that the consumer purchased a "Limited Medical INDEMNITY Insurance Plan, not a major [medical]" insurance plan.

73. The Script also shows that the HBO agent would inform the consumer that he or she was going to go through a verification process in which he or she would review the terms and conditions of the plan or product the consumer was purchasing. The consumer could elect to do this electronically or instead be transferred to the verification department, where another agent would verbally disclose and explain the details of the insurance portion of the plan and the details of the discount portion of the plan.

74. Employees from the verification department also followed a script in order to disclose additional information regarding the insurance products that the consumer purchased.

75. I did not create the verification script; rather, HII provided the details of each of its insurance products and the mandatory disclosures for each product.

76. The purpose of the verification script was to ensure that the consumer understood the terms and conditions of the products that they purchased.

iii. Employee Policies

77. The majority of the agents selling policies and products on behalf of HBO were independent contractors who were required to comply with all applicable laws and regulations, including not making any material misrepresentations in the course of their business activities.

78. HBO's employees and independent contractors, including the sales and verification representatives, were required to sign employment or independent contractor agreements that prohibited them from violating the law or making any misrepresentations in the course of their business with HBO.

B. Senior Benefits One LLC

79. In June 2013, I created Senior Benefits One, LLC ("**SBO**").

80. Until the time that the receiver was appointed in the above-captioned proceeding, I was SBO's chief executive officer.

81. SBO sold Medicare products to consumers, such as Medicare Advantage Programs, Medicare Supplements, and Prescription Drug Plans.

82. These products were primarily sold during the Medicare annual election period beginning October 15th to December 7th.

83. SBO sold Medicare products in 2016 and 2017 only.

84. SBO sold its Medicare products to consumers using the same marketing, lead generation, sales, and verification process as described above for HBO.

i. Process of Purchasing Medicare Insurance Plans from SBO

85. SBO contracted with many of the same lead generation companies as the HBO Lead Generators to obtain leads for consumers interested in purchasing Medicare insurance (collectively, the "**SBO Lead Generators**").

86. The SBO Lead Generators used multiple websites (collectively, the "**SBO Lead Generators' Websites**") to obtain and send leads to SBO.

87. The SBO Lead Generators worked with multiple insurance agencies, which sold different types of insurance plans than SBO and from different insurers than those that created the plans sold by SBO.

88. SBO has never had any control over the marketing or advertising on the SBO Lead Generators' Websites or otherwise.

89. Notably, at least some of the other agencies that had relationships with the SBO Lead Generators sold Medicare insurance plans affiliated with the Blue Cross Blue Shield Association or AARP.

90. After receiving a lead from an SBO Lead Generator, an SBO agent would contact the lead and attempt to sell him or her one of the Medicare Advantage, MedSupp, and Prescription Drug plans offered by SBO.

91. Generally, after a consumer chose a plan, the SBO agent would give the consumer the option of reviewing the terms, conditions, and benefits of the plan either electronically (e.g., on their smart phone or email) or with a live agent in SBO's verification department.

92. If the consumer chose to review the benefits of the plan electronically, the SBO agent would send an e-mail or text message to the consumer with the product application. The consumer would then verify his understanding of the plan's terms, conditions, and benefits, and his desire to purchase the plan, by electronically signing the verification.

93. If the consumer instead chose to review the plan with a live agent, the SBO sales agent would transfer the consumer to the SBO verification department. There, an SBO verification agent would identify the type of plan the consumer was purchasing and read aloud the terms and

benefits of the plan to the consumer. The consumer would verify his understanding of the plan's terms, conditions, and benefits, and his desire to purchase the plan, by orally indicating his assent on the phone. The third party administrators that SBO worked with required this verification process to be recorded and conducted without any interruption by the consumer. If the consumer asked the agent verifying the terms and conditions of the policy he purchased to answer any questions, the verification agent was required to transfer the consumer back to the sales representative so that the sales representative could discuss those terms with the consumer.

C. Simple Insurance Leads, LLC

94. In or around July 2013, I formed Simple Insurance Leads LLC ("**SIL**").

95. Until the time that the receiver was appointed in the above-captioned proceeding, I was SIL's chief executive officer.

96. Prior to the institution of the receivership, SIL had approximately 10 employees.

97. SIL was a lead generation company in the health insurance industry that sold leads to HBO, SBO, and more than sixty (60) other insurance agencies and more than forty-five (45) other lead generators/affiliates.

98. Some but not all of the health insurance agencies that SIL sold leads to sold health insurance plans affiliated with the Blue Cross Blue Shield Association or AARP or that were ACA-compliant.

99. The following lead generation websites are associated with SIL:

- usahealthinsure.net
- usamedsupp.org
- premiumhealthquotes.com
- medigapquote.org
- freedomcarequotes.com
- healthinsurancedeadline2018.com
- simpleinsuranceleads.com
- hbcquotes.com

- trumpcarequotes.com
- hbcquotes.direct
- myobamacareapplication.com
- americashealthadvisors.com
- healthinsurance4me.com

D. Innovative Customer Care, LLC

100. In November 2016, I formed Innovative Customer Care, LLC ("**ICC**").

101. Until the time that the receiver was appointed in the above-captioned proceeding, I was ICC's chief executive officer.

102. ICC is an entity that provides customer service to customers of non-affiliated health insurance agencies.

E. Simple Health Plans, LLC

103. In or around November 2015, I formed Simple Health Plans, Inc. ("**SHP**").

104. SH never operated. I created SH so that competitors could not squat on the "Simple Health" name and create confusion in the marketplace by causing customers to believe that they were doing business with HBO a/k/a Simple Health, when they were in fact doing business with a competitor.

F. Health Center Management, LLC

105. In or around May 2013, I formed Health Center Management Corp ("**HCM**").

106. Until the time that the receiver was appointed in the above-captioned proceeding, I was HCM's managing member.

107. HCM is a holding company for all of the above-named Defendants. I own 99% of the membership interests in HCM and Matthew Spiewak owns 1% of the membership interests in HCM.

G. Off-Shore Entities in Panama and the Dominican Republic

108. Since approximately 2014, HBO and SBO have out-sourced much of its administrative and verification process to Health Benefits Center Corp., a company based in Panama which is not a party to the lawsuit, and Solutions Umpfre, a company based in the Dominican Republic (the "**Service Companies**").

109. The Service Companies are responsible for handling SIL screenings, billing, and the verification process for HBO, SIL, and SBO.

110. HBO, SBO, and SIL were contractually obligated to pay the Service Companies for the services they provided to them.

111. Kelley A. Slaughter identified that the following payments were made to the off-shore entities: $10,721,883.93 to the Dominican Republic and $9,752,468.92 to Panama.

112. These payments were made to these off-shore entities to pay for the services that they provided to HBO and SBO.

113. None of the Defendants in this action have or have ever had off-shore bank accounts.

I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED ON: March 25, 2019

Steven Dorfman

EXHIBIT B

CERTIFICATION OF AUTHENTICITY
OF HEALTH INSURANCE INNOVATIONS INC.'S
RECORDS OF REGULARLY CONDUCTED ACTIVITY

Rule 902(11), Federal Rules of Evidence and Section 90.902 (11), Florida Evidence Code

The undersigned declarant hereby declares, certifies, verifies or states under penalty of perjury the following:

1. The declarant is a records custodian or other qualified person who can provide a written declaration regarding the records of regularly conducted business activity which are the subject of this certification;
2. The records of regularly conducted business activity (hereinafter "records") which are the subject of this certification are numbered/Bates stamped as HII_000001 through HII_000162.
3. The records are originals or duplicate copies of domestic (United States) business records; which are true and correct copies of the original record(s) prepared and/or maintained by Health Insurance Innovations, Inc.
4. The records were made at or near the time of the time of the occurrence of the matters set forth by, or from information transmitted by, a person with knowledge of those matters;
5. The records were kept in the course of a regularly conducted business activity; and
6. The records were made as a regular practice in the course of regularly conducted business activity.

I declare, under penalty of perjury, pursuant to the provisions of 28 U.S.C. §1746, that the foregoing is true and correct. Executed on this 11th day of December 2018.

Christine L. Gillis
Signature of Declarant

Christine L. Gillis
Printed Name

Senior Compliance Manager
Title

Health Insurance Innovations, Inc.
Business Name

15438 N. Florida Ave., Ste. 201 Tampa, FL 33613
Address

877-376-5831
Telephone

SIMPLE HEALTH - SITE VISIT

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EXECUTIVE SUMMARY

This report represents the results of our site visit to Simple Health to get a better understanding of the organizations current sales practices and understanding of how compliance responsibilities are carried out. Our audit covered a review of the management control framework in place to ensure compliance with Department of Insurance, Insurance Carriers, and HII's own policies as applicable. We further reviewed to ensure that current procedures are effective, efficient, and safeguard integrity in accordance with our agreements to the carriers.

During our site visit C. Girouard and staff provided answer to the HII Due Diligence Agenda (Questionnaire). On July 22, 2018, C. Girouard emailed the questionnaire response in a pdf and the agency employee roster in an excel format. Based on their responses, we found Simple Health's practices to be in adherence with HII Compliance guidelines.

OBJECTIVE

The main purpose of this audit is to provide senior management of HII with an independent assessment of the following three objectives:

- To assess the extent of agency compliance with Regulatory and Insurance Carrier requirements, as well as Health Insurance Innovation's own policies when applicable.
- To assess whether agency procedures are effective, efficient, provide value and ensure integrity.
- To determine if appropriate agency management controls exist that:
  - Establishes, monitors and communicates contractual processes and procedures
  - Identifies and reinforces values and ethics to be followed by managers with delegated authority
  - Ensures reliable information is available for decision-making and reporting
  - Establishes and communicates roles and responsibilities for all parties involved in the servicing and solicitation of products administrated by HII
  - Provides managers with appropriate training and management tools.

SCOPE

Audit coverage included the examination of sales verifications, sales productions, consumer complaints and consumer escalations, for the period January 1, 2017 to May 31, 2018. An agency file review and interview with the agent of record (AOR) and other management was conducted.

The audit preparation analyzed the following parameters:

- Sales production
- BBB Consumer complaints
- DOI inquiries
- Sales verification percentages (Echo Signed, VVAP, Enrollee signed)

APPROACH

The approach for this audit included the following steps:

- Obtaining a listing of contracted agents to HII
- Examination of the organization and their everyday practices/procedures
- Performing a preliminary review of the organizations sales production, Verifications, Complaints and Escalations data
- Reviewing the Audit preparedness, Compliance Audit Agenda, and Employee Roster (Appendix B)
- Specific examination of procedures and processes including: requirements set by regulators and employee rosters
- Meeting with Candida “Cameron” Girouard and staff

DETAILED OBSERVATION

Information Gathering and Reporting

Below is a synopsis of what was reviewed and provided both to the agency and by the agency. These areas are summarized below and detailed in the attached body of the report:

- Regulatory Departments
  - Regulatory Inquiries –
    - Are processed by the organizations internal Compliance Department
- Office Locations
  - Currently has two locations
    - 2 Oakwood Blvd., Suite 100, Hollywood, FL 33020
    - 300 S. Park Road, Suite 465, Hollywood, FL 33021
- Hiring practices
  - Recruiting is done with local publications, internet job sites and career fairs
  - Their staff are combined with W-2 and 1099 employees
  - Background Checks are done with Hireright.com
  - Candidates with felonies are offered a position. Should a misdemeanor come from the background check, it will depend on the type of charge, the resolution and date of charge
  - HBC pays for all its employees licensing at no cost to the individual
- Training Practices
  - Training is conducted by Kirschner Alteme who has 15 years of related experience
  - David CaIdes is charged with the verification training and he has 10 years of related experience
    - Training takes place onsite in their training room, using Litmos Training Program
    - Sales training is total of 1 week with classroom and floor monitoring
    - Customer service training is 2 weeks and verification is 1 week
      - Training materials used are ones provided by our carriers and MGA's. All HII marketing material can be accessed from within

- HII products are introduced and power points provided by the carriers are viewed by the staff
- Retraining is provided with product information given by HII. Should an employee need to be reprimanded, HBC follows the procedures as follows:
  - 1'' offense verbal warning
  - 2nd offense retraining and
  - 3rd is possible termination

- Phone System
  - Elastix PBX and Vici Dial are the phone systems being used
  - Simple Health has the capability to record calls; but they do not record sale calls at this time
    - All agents are able to record verifications
  - The phone system is capable of auto dialing, but the organization is not currently using the feature
  - Simple Health follows all FCC, FTC and TCPA guidelines required by law including but not limited to the National Do Not Call List. All current vendors are certifying they are scrubbing for the NDNC List
- Sales Process
  - When an inbound lead is connected to an agent:
    - Caller's information is confirmed for identity protection
    - A need and cost analysis are completed on the consumers behalf
    - Once paired with a product by the agent, the member is then transferred to verification
    - Verification confirms the caller's information for identity purpose
      - Verifier reads script provided by HII
      - Once completed successfully, caller's payment information is processed for enrollment
  - All leads are inbound. Outbound calls are only made if call is disconnected
  - Members are given the information received by the carriers provided by HII
  - Each agent is submitting under their own writing number and quoting links

- Agents sell, according to the states in which the agency and their licenses are registered
  - Calls are routed by a state specific queue routed to a specific extension.
- HBO does not provide members with any product information by means of email or text, in addition, HBO does not conduct welcome calls. Sales presentation to the member is conducted verbally during the sales call

❖ Agent Monitoring

- HBO is able to listen in on live calls and do so on a daily basis. A report is conducted and provided to the CCO
- Verifications are saved and stored to our server. Then, uploaded to HII's FTP site
  - Calls are reviewed daily by our quality assurance department for accuracy
- HBO conducts secret shopping of their own agents and keep a log
  - Average call volume is about 1,200 calls per day
  - Average length of call is 30-40 minutes for sale and 5-10 minutes for non-sale
  - Convers ion Ratio is 20%

❖ Advertising and Lead Generation

- HBO's website is http://www.simplehealthplans.com/
  - HBO does not utilize its website to generate leads
- Leads are obtained through lead generation web pages with their sister company, Simple Insurance Leads and other lead generating companies. The leads are distributed to agents based upon states they are licensed in and who is available for a call
  - Leads are scrubbed for the DNC as required by the FCC, FTC as well as all TCPA guidelines are executed
  - All leads are from lead generation companies online
  - Less than 1% of their leads are from referrals
  - All leads are inbound
- HBO does not do any television, newspaper radio or direct mail advertising

❖ Customer Service Process

- Customer Service, retention and the reapply department head is Candida Girouard, with Kirschner Alteme leading as the active manager

- Each representative takes on a daily basis an average of approximately 40-60 calls per day and all calls are logged in their CRM system as well as HII's Back Office (ARIES)
- Once a call is received, the customer service representative addresses any questions or concerns, notates in HBO's CRM system and if applicable, in HII's Retention Queue

Agency Performance Evaluation

The agency currently has sufficient internal, documented policies and procedures and controls in place to monitor agent performance and protect business. While on site the agency provided a document that outlines the agencies control framework for Quality Control, Consumer Complaints, Marketing & Advertising, Record Keeping, Regulatory & Compliance Requests, Employee Training, Agent Licensing, Hiring/Recruiting, Leads, and Protection of Client PHI.

As the organization evolves the agency should provide evidence of changes to the documented policies and procedures and establishment of controls.

Deficiencies

- N/A

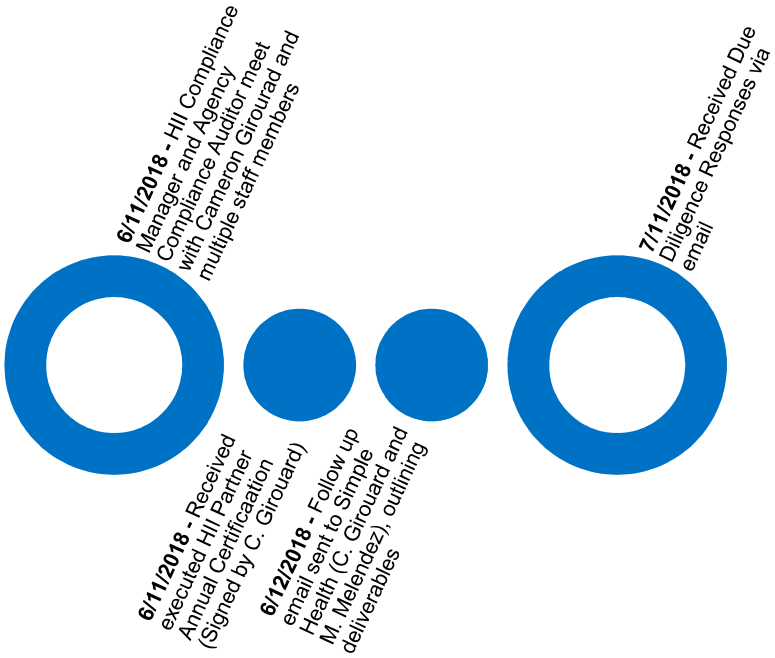
Agency Deliverables

- Providing updated employee rosters to worozo@hiiquote.com, rgardner@hiiquote.com and gvernon@hiiquote.com, no later than the 5th of the month

Follow-up Items from HII

- N/A

APPENDIX A – AUDIT TIMELINE



APPENDIX B –


6.11.18_Simple Health_Signed_PAC.


HII Audit Response 6.2018.pdf


SH Employee and sales list.xlsx


Simple Health_Health Bene

APPENDIX C – AUDIT RECOMMENDATIONS

As discussed during the audit visit June 11th, with Christine Gillis, Compliance Manager and Ruben Gardner, Agency Compliance Auditor, we are recommending to Simple Health to make the following changes:

- Provide updated answers to the HII Compliance Due Diligence Questionnaire

In addition, the agency should continue:

- Providing updated employee rosters to worozo@hiiquote.com, rgardner@hiiquote.com and gvernon@hiiquote.com, no later than the 5th of the month

Health Benefits One

Response

Candida Girouard
Chief Compliance Officer
Health Benefits One LLC
2 Oakwood Blvd Suite 100
Hollywood, FL 33020
1-800-492-1834 Ext. 11136
cgirouard@simplehealthplans.com

Compliance Department
C/o Compliance Auditor
Health Insurance Innovations
Tamps, FL 33613
1-877-376-5831 Ext. 290
DGaravuso@hiiquote.com

Dear Compliance Auditor:

Please allow this letter to serve as a formal response to the Compliance Audit Agenda set for June 12, 2018.

Please see the overview and responses listed below:

I. **Overview of Compliance**

The purpose of the detail s below is to satisfy the inquisition regarding Health Benefits One's process and procedures as well as compliance issues made by Health Insurance Innovations. It is our hope the listed responses will satisfy all questions.

II. **Introductions**

1. Cameron Girouard -Chief Compliance Officer
2. Melissa Melendez- Senior Compliance Analyst

III. **Regulatory Departments**

1. When a Department of Insurance complaint is received via telephone, email or facsimile, it is processed by the Compliance Department
2. Each complaint is responded to in a timelymanner
3. Should additional assistance be needed, a request for assistance is emailed to the Compliance Department at Hii and phone call is given to advise of the issue
4. When a compliance email is sent over from Hii, the verification is uploaded to the FTP (if not on file already), then a response letter is prepared and sent over to Hii' s Compliance Department for review andsubmission

IV. **Office Location**

1. HBl has 18 "rooms" at its Oakwood Plaza location in Hollywood, which serves as the corporate location. This includes sales, marketing, verification support, quality assurance, human resource, recruiting, compliance, administration, management andexecutives.
2. John Sand is the Vice President of Sales and has 19 years of management and sales experience and been with HBC since opening
3. Candida Girouard has 17 years of management, sales and compliance experience and been with HBl since opening
4. David Caldes has 10 years of management experience and has been with HBl for 4years
5. HBC rent is all the space we are current utilizing
6. Current location length of time (as of July 2014) with a 5 year lease
7. Squarefootageisapproximately 7,500
8. This location was chosen for it' s easy access to the main freeway, local transportation and extended public transportation
9. HBl has a 6 "room" training facility.
10. 300 S. Park Rd. STE 465 Hollywood, FL 33021
11. HBl hasa sales and customer service location at 8400 Doral Blvd. Suite 140 Doral, FL 33166
12. HBl currently has an office in Panama for the purpose of processing and verifications
13. HBl currently has an office in the Dominican Republic for the purpose of lead generation.

V. **Hiring Practices**

1. Health Benefits One mission is to provide affordable care solutions to those who cannot afford or qualify for traditionall options. We strive to provide superior customer satisfaction to create long lasting relationships with our customers
2. Recruiting is done with local publications, internet job sites and career fairs
3. Our staff are combined with W-2 and 1099 employees
4. Background Checks are done with Hireright .com
5. No candidates with felonies are offered a position. Should a misdemeanor come from the background check, it will depend on the type of charge, the resolution and date of charge
6. HBC pays for all its employees licensing at no cost to the individual

7. Employment packets are omitted for core competency purposes. (Previous packet has been provided and nothinghas changed)
8. Sign off sheet copies are omitted for core competency purposes
9. Total employment and contractors list was sent prior to today's visit.
10. The HBC employment retention rate succeeds national averages

VI. Training Practices

1. The Corporate Trainer is Kirschner Alteme who has 15 years of related experience. David Caldes handles the verification training with 10 years of related experience.
2. Training takes place in our training room with our Litmos Training Program
3. Sales training is total of 1 week withclassroom and floor monitoring, customer service Training is 2 weeks and verification is 1 week. Training materials used are ones provided by our carriers and MGA's. All Hii marketing material can be accessed from within
4. Hii products are introduced and power point provided by carrier areviewed
5. Retraining is provided with product information given by Hii. Should an employee need to be reprimanded, HBC follows the procedures as follows: 1'' offense verbal warning, 2nd offense retraining and 3rd is possible termination

VII. Phone System

1. Elastix PBX and Vici Dial are our phone system. A brochure cannot be provided
2. We are capable of recording calls; but we do not record sale calls at this time
3. All agents are able to record verifications
4. The phone system is capable of auto dialing, but we are not currently using this program
5. HBC follows all FCC, FTC and TCPA guidelines required by law including but not limited to the National Do Not Call List. All current vendors are certifying they are scrubbing for the NDNC List

VIII. Sales Process

1. When an inbound lead is connected to an agent:
    - Caller's information is confirmed for identity protection
    - A need and cost analysis isdone
    - Once paired with a product by agent, member is then transferred to verification
    - Verifier confirm s caller's information for identity purpose
    - Verifier reads script provided by Hii
    - Once completed successfully, caller's payment information is processed for enrollment
2. All leads are inbound. Outbound calls are only made if call is disconnected
3. Members are given the information received by the carriers provided by Hii
4. Each agent is submitting under their own writing number
5. Agents sell according to states in which the agency and their licenses are in. Calls are routed by a state specific queue routed to a specific extension.
6. Sales scripts haveyy been provided prior to today.

7. HBl does not provide members with any product information by means of email or text. We also do not conduct welcome calls. Presentation to the member is conducted verbally during the sales call.
8. Requested sale calls have been provided to Hii in conjunction with Secret Shopping Audits

IX. Agent Monitoring

1. HBl is able to listen in on live calls and do so on a daily basis. A report is conducted and provided to the CCO
2. Verifications are saved and stored to our server. Then, uploaded to Hii's FTP site
3. Calls are reviewed daily by our quality assurance department for accuracy
4. We do secret shop our own agents and keep a log
5. Average call volume is about 1,200 calls per day
6. Average length of call is 30-40 minutes for sale and 5-10 minutes for non-sale
7. Convers ion Ratio is 20%

X. Advertising and Lead Generation

1. HBl website is http:/ /www.simplehealthplans.com/
2. HBl does not utilize its website to generate leads
3. Leads are obtained through lead generation web pages w it h our sister company Simple Insurance Leads and other lead generating companies. The leads are distributed to agents based upon states they are licensed in and who is available for a call. Leads are scrubbed for the DNC as required by the FCC, FTC as well as all TCPA guidelines are executed
4. All leads are from lead generation companies online
5. Less than 1% of our leads arereferrals
6. All leads are inbound
7. HBl does not do any television, newspaper radio or direct mail advertising

XI. Customer Service Process

1. Customer Service, retention and reapply department head is Candida Girouard, with Kirschner Alteme managingg
2. Each represent ative takes on a daily average of approximately 40-60 calls per day. All calls are logged in our CRM system as well as Hii' s Retention Back Office
3. Once the calls received, the customer service representative addresses any questions or concerns, notates in HBl CRM system and if applicable, in Hii's Retention Queue

XII. "Hot points" State, carriers, Hii

4. HBl Compliance is always in constant contact with Hii's compliance department. A list of all "Non-Negotiables" are posted on the sale scripting page
5. Not every caller we are in contact are able to be paired with a Hii product. Callers are referred to other options when necessary
6. HBl is aware of all necessary licensing obligations and take every effort to follow it to the best of our capabilities. Hii is need of assistance to keep up without contracting needs as we are growing faster than what can be kept up with

7. HBI takes all compliance issues like twisting, but not limited to, seriously. Our goal is to only maintain not only licensed, but moral and ethical agents
8. HBI has always maintained transparency with Hii in regards to any actions or inquiry taken by regulatory agencies
9. Licensing has always been informed when a subagent is to be released from Hii and reasons why

Attached are the requested supporting documentation. Should you have any additional request or concerns, please feel free and contact me at 1-800-492-1834. Monday through Friday from 9am-5pm EST.

Sincerely,

C. Girouard

C. Girouard
Chief Compliance Office


Simple
Health

HEALTH INSURANCE INNOVATIONS

Partner Annual Certification

HII strives to foster strong professional and compliance standards to enhance its business relationships with its agents. This will result in a solid business partnership as we jointly strive to meet our clients' needs and serve their best interests. This Certification verifies Agent's commitment to these standards.

I, C. Girouard, as the owner/principal/officer, of Health Benefits One, LLC (Agency), do hereby certify and attest on behalf of myself and Agency as follows:

1. I am familiar with and understand the laws and regulations regarding agent licensing and appointment of every state in which I or agents for whom I am responsible do business.
2. I agree to abide by these laws and regulations.
3. I have reviewed the list of agents who HII's records show are contracted and/or appointed within my hierarchy.
4. The list is complete and accurate as is or as I amended. It represents all personnel for whom I am either directly or indirectly responsible and who are selling, soliciting or negotiating insurance for HII.
5. As new agents become contracted with Agency, or existing agents are no longer contracted by Agency, I agree to promptly inform HII.
6. All of the agents for whom I am responsible will submit and have submitted (if applicable) all business under their own broker of record links.
7. To the extent I become aware of any issues involving sales, solicitation or negotiation of insurance by individuals who are not properly licensed and appointed by HII, I agree to promptly notify HII following such discovery.
8. I certify that I will only use carrier-approved verification scripts when completing voice verifications.
9. I am familiar with and agree to comply with all federal, state and/or local laws related to

HEALTH INSURANCE INNOVATIONS

the use of telephones, email, fax, texts, and automated telephonic equipment to make informational and/or telemarketing phone calls or to relay messages to phone numbers.

10. I have reviewed the Audit Preparedness Guide and understand my responsibility to comply with the guidelines set forth.
11. I attest as owner/principal/officer that I can and will provide upon request certification that consumer leads used by the agency I represent are "Opt-In" and are fully TCPA compliant.
12. I will immediately send to HII a copy of any correspondence from a regulatory or non-regulatory entity regarding a product sold via HII.

Signature and Date C. Girouard 6/11/18

Printed Name C. Girouard

SIMPLE HEALTH - SITE VISIT

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EXECUTIVE SUMMARY

This report represents the results of our site visit to Simple Health to get a better understanding of the organizations current sales practices and understanding of how compliance responsibilities are carried out. Our audit covered a review of the management control framework in place to ensure compliance with Department of Insurance, Insurance Carriers, and HII's own policies as applicable. We further reviewed to ensure that current procedures are effective, efficient, and safeguard integrity in accordance with our agreements to the carriers.

During our site visit, M. Melendez provided updates to the HII Due Diligence Agenda (Questionnaire) since the last visit in June. The most notable changes were made to the agency's hiring practices. Previously the organization had a combination of W-2 and 1099 contractors, going forward all staff will be W-2 employees. Simple Health adopted the new policy sometime in August 2018. In addition, while doing research HII Compliance found out that the organization has a third location in Texas (5720 Lyndon B Johnson FWY. Dallas, TX, 75240) which was not disclosed in any of the documents we received nor in person during the site visits.

OBJECTIVE

The main purpose of this audit is to provide senior management of HII with an independent assessment of the following three objectives:

- To assess the extent of agency compliance with Regulatory and Insurance Carrier requirements, as well as Health Insurance Innovation's own policies when applicable.
- To assess whether agency procedures are effective, efficient, provide value and ensure integrity.
- To determine if appropriate agency management controls exist that:
  - Establishes, monitors and communicates contractual processes and procedures
  - Identifies and reinforces values and ethics to be followed by managers with delegated authority
  - Ensures reliable information is available for decision-making and reporting
  - Establishes and communicates roles and responsibilities for all parties involved in the servicing and solicitation of products administrated by HII
  - Provides managers with appropriate training and management tools.

SCOPE

Audit coverage included the examination of sales verifications, sales productions, consumer complaints and consumer escalations, for the period January 1, 2017 to August 31, 2018. An agency file review and interview with the agent of record (AOR) and other management was conducted.

The audit preparation analyzed the following parameters:

- Sales production
- BBB Consumer complaints
- DOI inquiries
- Sales verification percentages (Echo Signed, VVAP, Enrollee signed)

APPROACH

The approach for this audit included the following steps:

- Obtaining a listing of contracted agents to HII
- Examination of the organization and their everyday practices/procedures
- Performing a preliminary review of the organizations sales production, Verifications, Complaints and Escalations data
- Reviewing the Audit preparedness, Compliance Audit Agenda, and Employee Roster (Appendix B)
- Specific examination of procedures and processes including: requirements set by regulators and employee rosters
- Meeting with Melissa Melendez

DETAILED OBSERVATION

Information Gathering and Reporting

Below is a synopsis of what was reviewed and provided both to the agency and by the agency. These areas are summarized below and detailed in the attached body of the report:

- Regulatory Departments
  - Regulatory Inquiries –
    - Are processed by the organizations internal Compliance Department
- Office Locations
  - Currently has three locations
    - 2 Oakwood Blvd., Suite 100, Hollywood, FL 33020
    - 300 S. Park Road, Suite 465, Hollywood, FL 33021
    - 5720 Lyndon B Johnson FWY. Dallas, TX, 75240 (location was not disclosed by the organization)
- Hiring practices
  - Recruiting is done with local publications, internet job sites and career fairs
  - All staff members are W-2 employees
  - Background Checks are done with Hireright.com
  - Candidates with felonies are offered a position. Should a misdemeanor come from the background check, it will depend on the type of charge, the resolution and date of charge
  - HBC pays for all its employees licensing at no cost to the individual
- Training Practices
  - Training is conducted by Kirschner Alteme who has 15 years of related experience
  - David CaIdes is charged with the verification training and he has 10 years of related experience
    - Training takes place onsite in their training room, using Litmos Training Program
    - Sales training is total of 1 week with classroom and floor monitoring
    - Customer service training is 2 weeks and verification is 1 week

- Training materials used are ones provided by our carriers and MGA's. All HII marketing material can be accessed from within
- HII products are introduced and power points provided by the carriers are viewed by the staff
- Retraining is provided with product information given by HII. Should an employee need to be reprimanded, HBC follows the procedures as follows:
  - 1'' offense verbal warning
  - 2nd offense retraining and
  - 3rd is possible termination

❖ Phone System

- Elastix PBX and Vici Dial are the phone systems being used
- Simple Health has the capability to record calls; but they do not record sale calls at this time
  - All agents are able to record verifications
- The phone system is capable of auto dialing, but the organization is not currently using the feature
- Simple Health follows all FCC, FTC and TCPA guidelines required by law including but not limited to the National Do Not Call List. All current vendors are certifying they are scrubbing for the NDNC List

❖ Sales Process

- When an inbound lead is connected to an agent:
  - Caller's information is confirmed for identity protection
  - A need and cost analysis are completed on the consumers behalf
  - Once paired with a product by the agent, the member is then transferred to verification
  - Verification confirms the caller's information for identity purpose
    - Verifier reads script provided by HII
    - Once completed successfully, caller's payment information is processed for enrollment
- All leads are inbound. Outbound calls are only made if call is disconnected

- Members are given the information received by the carriers provided by HII
- Each agent is submitting under their own writing number and quoting links
- Agents sell, according to the states in which the agency and their licenses are registered
  - Calls are routed by a state specific queue routed to a specific extension.
- HBO does not provide members with any product information by means of email or text, in addition, HBO does not conduct welcome calls. Sales presentation to the member is conducted verbally during the sales call

❖ Agent Monitoring

- HBO is able to listen in on live calls and do so on a daily basis. A report is conducted and provided to the CCO
- 2. Verifications are saved and stored to our server. Then, uploaded to Hii's FTP site
- 3. Calls are reviewed daily by our quality assurance department for accuracy
- 4. We do secret shop our own agents and keep a log
- 5. Average call volume is about 1,200 calls per day
- 6. Average length of call is 30-40 minutes for sale and 5-10 minutes for non-sale
- 7. Convers ion Ratio is 20%

❖ Advertising and Lead Generation

- HBO's website is http://www.simplehealthplans.com/
  - HBO does not utilize its website to generate leads
- Leads are obtained through lead generation web pages with their sister company, Simple Insurance Leads and other lead generating companies. The leads are distributed to agents based upon states they are licensed in and who is available for a call
  - Leads are scrubbed for the DNC as required by the FCC, FTC as well as all TCPA guidelines are executed
  - All leads are from lead generation companies online
  - Less than 1% of their leads are from referrals
  - All leads are inbound
- HBO does not do any television, newspaper radio or direct mail advertising

- ❖ Customer Service Process
  - ➢ Customer Service, retention and the reapply department head is Candida Girouard, with Kirschner Alteme leading as the active manager
  - ➢ Each representative takes on a daily basis an average of approximately 40-60 calls per day and all calls are logged in their CRM system as well as HII's Back Office (ARIES)
  - ➢ Once a call is received, the customer service representative addresses any questions or concerns, notates in HBO's CRM system and if applicable, in HII's Retention Queue

Agency Performance Evaluation

The agency currently has sufficient internal, documented policies and procedures and controls in place to monitor agent performance and protect business. While on site the agency provided a document that outlines the agencies control framework for Quality Control, Consumer Complaints, Marketing & Advertising, Record Keeping, Regulatory & Compliance Requests, Employee Training, Agent Licensing, Hiring/Recruiting, Leads, and Protection of Client PHI.

As the organization evolves the agency should provide evidence of changes to the documented policies and procedures and establishment of controls.

Deficiencies

- N/A

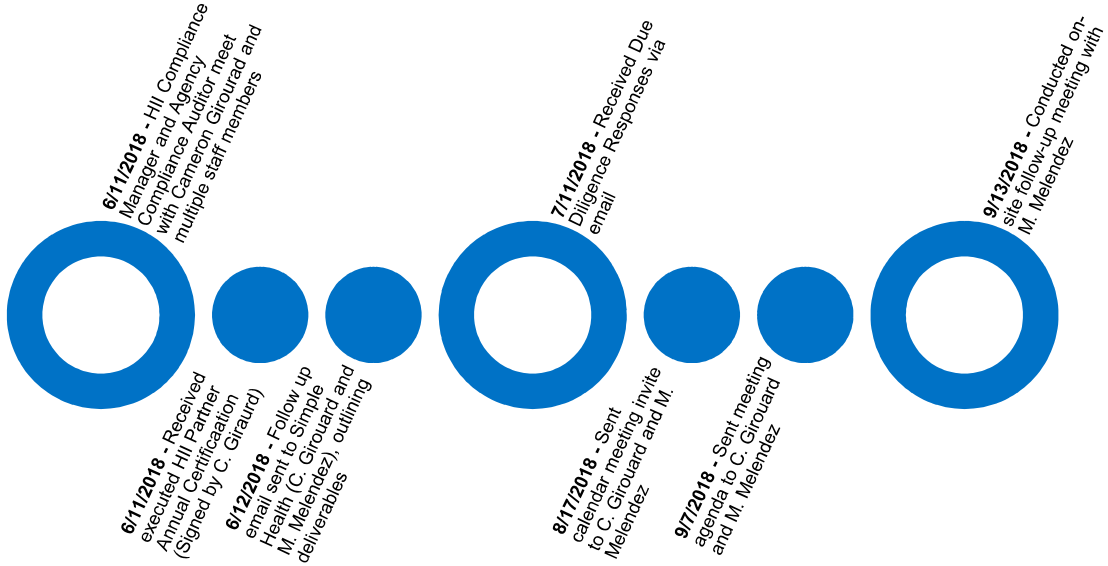
Agency Deliverables

- Providing updated employee rosters to worozo@hiiquote.com, rgardner@hiiquote.com and gvernon@hiiquote.com, no later than the 5th of the month

Follow-up Items from HII

- N/A

APPENDIX A – AUDIT TIMELINE



APPENDIX B – ATTACHMENTS


6.11.18_Simple Health_Signed_PAC.


HII Audit Response 6.2018.pdf


SH Employee and sales list.xlsx


Simple Health_Health Bene

APPENDIX C – AUDIT RECOMMENDATIONS

As discussed during the audit visit September 13th, with Ruben Gardner, Agency Compliance Auditor, we are recommending to Simple Health to make the following changes:

- Provide updated answers to the HII Compliance Due Diligence Questionnaire

In addition, the agency should continue:

- Providing updated employee rosters to worozo@hiiquote.com, rgardner@hiiquote.com and abrady@hiiquote.com, no later than the 5th of the month

HEALTH™ INSURANCE INNOVATIONS

Compliance Due Diligence Agenda

I. Overview of Objectives

a. Ensure compliance with HII and Carrier standards
b. Identify potential opportunities for improvement
c. Identify potential liabilities and risks
d. Develop remediation plan, if applicable

II. Regulatory Departments

a. Department of Insurance Complaints
b. Who is the Compliance Manager and please provide background and contact information?

III. Office Location

a. How many offices does (Agency Name) have? Inside or outside the United States of America?
b. What made you choose this specific location?
c. Do you own or rent the space?
d. How long have you been in this space? Short-term or long term? Square footage?
e. Please offer addresses of locations.
f. Who are the managers for each office and please offer background of their experiences and how long they have worked at the company.

IV. Hiring practices

a. What is your company hiring philosophy?
b. Recruiting – how do you obtain employees, agents, etc. (local adds, internet)?
    i. Are they licensed or non-licensed?
c. Are your staff actual employees of the company or are they leased, temporary, or commissioned?
d. Do you hire any remote employees?
e. Background Checks – what service do you use? What level did you purchase? First level typically is not enough to get "hits". Recommended to purchase 2nd level. How and where are the individuals that receive a "hit" stored or saved?
f. Do you hire individuals with misdemeanors or felonies? Why?
g. Licensing – does your organization pay for licensing or does the individual? Do you try to recoup?
h. Employee packets – need copy
i. Sign off sheets understanding company policies – ***Please provide copy***
j. Provide list of all Agents, Verifiers and Frontiers – ***Please provide copy*** (specify location)
k. Disciplinary Actions
l. Average employee retention?
m. Name the person who will contact HII upon agent termination (with or without cause).

V. Training practices

a. Who is the Trainer and please offer background of their experience and how long they have worked at the company?

b. Where does training take place?
c. How long is an agent in training? How many hours in training?
d. Is there a written syllabus or agenda for training program?
e. What is the training process? Need a copy of materials distributed including training manual.
f. Retraining practices – do you test? Need a copy of tests that are administered.
g. What records are maintained regarding training and re-training? How long are they kept?
h. If any employees are remote, how does training process differ?

VI. Phone System

a. Please provide a copy of the phone system brochure.
b. Does your phone system record sales calls?
c. How long are recorded sales calls kept?
d. Review of phone system capabilities – Does your phone system have the capabilities of auto-dialing?
e. Do you have access and use the "Do Not Call List"? Are you certifying that leads are scrubbed on the DNC list by lead vendors? How do you know?
f. Do you maintain an internal "Do Not Call" list? What criteria do you use to add numbers to this list?
g. (CHUBB only) How often do you scrub against carrier "Do Not Call" list?

VII. Sales Process

a. Meet and Greet with Sales Manager
b. Sales call process
c. How are calls routed or dispositioned to ensure agents are only selling in states licensed?
d. Presentation of insurance products to members
e. Enrollment process
f. What do you do when a consumer says they want Obamacare?
g. Please provide copy of Sales Script
h. What other products do you sell? Any discount products?
i. Does your office send communication to consumers once they have enrolled?
j. Does your office conduct welcome calls?
k. Please provide three sales calls prior to my visit.

VIII. Agent Monitoring

a. Who is responsible for uploading voice verifications? Please provide contact information.
b. Who is responsible for conducting Quality Assurance?
c. Review of Sales Calls? – are you reviewing for quality assurance?
    i. How often?
    ii. Who is handling?
    iii. Do you have a log and scoring system?
d. Review of Verifications – are you reviewing these calls for quality assurance?
    i. How often?
    ii. Who is handling?
    iii. Do you have a log and scoring system?

e. How verifications are saved, stored and accessed
f. Call recordings system – do you review and log for quality assurance?
g. Do you secret shop your own agents to ensure quality assurance? Do you keep a log?
h. Average call volume
i. Average length of call
j. Conversion ratio

IX. Advertising and Lead Generation

a. Do you have a website (provide website address)?
b. Do you use your website to generate leads?
c. How do you obtain your leads?
    i. Do you have lead-gen web pages?
    ii. How do you know how many to purchase?
    iii. How do you ensure that the leads have been properly scrubbed against the DNC list and consumer provided consent to call? Please provide evidence from lead vendor.
    iv. What is your closing ratio?
d. Are all leads produced online? Do you obtain some through "fronting" companies?
e. What percentage are leads from referrals?
f. Do you do inbound or outbound calls for solicitations – which do you find more effective & why?
g. Do you advertise on TV, radio, newspaper or via direct mailings? (Provide samples of each, if used. Remind that all advertising resulting in the sale of an HII product, whether we or the carrier are mentioned, needs to be approved by Compliance).
    i. If you advertise, how do you ensure your advertising falls within state, HII, and carrier guidelines?

X. Customer Service Process

a. Who handles customer service, retention and reapplies?
b. What is your call volume?
c. What are your process and procedures for Retention, CS, and Re-Applies?
d. Do you log these?
e. Please submit your process and procedure in writing.
f. Who handles customer complaints?
g. How is retraining handled for agents who have complaints

XI. "Overview of "Hot Points" of HII and carriers

a. Non-Negotiables in solicitation
b. Suitability: selling the right plan for the person's needs – example: If somebody needs to be on an exchange plan and can afford it, that's what they need.
c. Licensed/Appointed/Contracted: Licensed in the state you sell in, appointed by the carrier, contracted with HII. Potential Clients record calls themselves – they know who they spoke to – and the Insurance Department asks about everyone that spoke to the complainant. If you are not licensed in Colorado, for example, the agent cannot discuss plan benefits in that state –

pass the caller on to whomever is. If your agents are not contracted with HII, they cannot talk about plan benefits to clients, period.

d. Reporting Actions – Regulatory Actions taken by states against you since you were contracted, background updates if you've had a felony charge – we're hooked up to NIPR and are reviewing reports before each audit – tell us in advance so we can discuss it before the carrier catches it and turns off your links.
e. Reporting Terminations/ Separation of employment – especially if you term someone for cause, there's a very good chance we don't want to work with that person either – we also need to turn off the links, email Wilma Orozco, worozco@hiiquote.com.

XII. Overview of Current Business Produced

a. Production – run through current production and future expectations
b. Lapse Ratio / Persistency
c. Charge Back review
d. Verification review scores
e. Any DOI complaints that need to be addressed

XIII. Wrap Up / Deliverables

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

HEALTH™ INSURANCE INNOVATIONS

From: JC Moreno
To: Lori Kosloske & Dan Garavuso
Subject: Due Diligence Audit
Date of Visit: Wednesday, February 24, 2016
Attendees: Cameron Girouard, Melissa Melendez, & JC Moreno

I. Overview of Objectives

We started the audit by explaining why we are there; to ensure that (Agency Name) is in compliance with federal regulations, carrier expectations, and HII processes and procedures. I thanked them for taking the time to see me, since I told them that HII is there to partner with them and gather information regarding their organization related to business practices, compliance procedures – especially the implementation and enforcement of (Agency Name) compliance process & procedures.

II. Regulatory Departments

During our visit, we discussed our process and procedures on submitting regulatory and non-regulatory complaints to HII to ensure prompt investigation and response to these departments.

We communicated the various ways that complaints come into HII and how to proceed. (Input DOI, BBB and Non-Regulatory Complaints)

No DOI's - While (Agency Name) & its agents have not received any DOI's, we have detailed our process and procedure below for their review and so they are aware of our expectations should we require the agency to respond to any future concerns. (Provide contact for any regulatory complaint that comes through)

Policy:

It is the policy of Health Insurance Innovations to respond to complaints from each state's governing department of insurance oversight and from consumer advocacy groups in a timely, efficient, effective, and holistic manner. To coordinate our response to complaints, expectations of both our Compliance Department and of insurance agencies have been thusly established. This policy &

procedure addresses HII's Compliance Department's role in resolving complaints

Procedure:

Upon HII's ***direct** receipt of a complaint from a state regulatory agency or consumer advocacy group, either the Regulatory Compliance Manager or Compliance Specialist notify the carrier, the agent, and the claims administrator and begin an investigation, following the approved stages below:

1. Send copy of complaint to the carrier
2. Send copy of complaint to the agent of record
3. Send a copy to the claims administrator (for claims-based complaints)
4. Log complaint into our secure, Compliance Back Office system
5. Request Agent Verification Call
6. Request Agent Statement regarding the details of the complaint
7. Review notes in our system to assist in verifying details and timelines
8. Review Customer Service Call(s)
9. Review echosigned application, when applicable
10. Outline/Write the response letter, ensuring all concerns have been addressed
11. Review/Edit the letter and submit for final approval (to the Director of Compliance)
12. Send letter and supporting documentation/files to the carrier for approval
13. Once approved, send overnight or via email, whichever is the preferred method of the regulatory agency or advocacy group

III. Office Location

IV. Hiring Practices

V. Training Practices

VI. Phone System

HEALTH™ INSURANCE INNOVATIONS

VII. Agent Monitoring

VIII. Advertising and Lead Generation

IX. Sales Process

X. Customer Service Process

XI. Overview of "Hot Points" of HII and carriers

1. Reach out to Compliance – DOI, BBB, Market Inquiry, Attorney Letter, Litigation – If it involves a plan we administer, we need to be involved – contact Tricia Heaney at x239 directly.

2. Suitability: selling the right plan for the person's needs – example: If somebody needs to be on an exchange plan and can afford it, that's what they need.

3. Licensed/Appointed/Contracted: Licensed in the state you sell in, appointed by the carrier, contracted with HII. Potential Clients record calls themselves – they know who they spoke to – and the Insurance Department asks about everyone that spoke to the complainant. If you are not licensed in Colorado, for example, the agent cannot discuss plan benefits in that state – pass the caller on to whomever is. If your agents are not contracted with HII, they cannot talk about plan benefits to clients, period.

4. Twisting: In the past year, we have termed two agencies for twisting. We find out – persistency numbers drop off, people complain to us about their agent, or they call the DOI.

5. Reporting Actions – Regulatory Actions taken by states against you since you were contracted, background updates if you've had a felony charge – we're hooked up to NIPR and are reviewing reports before each audit – tell us in advance so we can discuss it before the carrier catches it and turns off your links.

HEALTH™ INSURANCE INNOVATIONS

6. Reporting Terminations/ Separation of employment – especially if you term someone for cause, there's a very good chance we don't want to work with that person either – we also need to turn off the links, so let Dan know directly.

Analysis

Deliverables:

15438 N Florida Ave Ste 201 Tampa, FL 33613
OFFICE 877.376.5831 FAX 877.376.5832
www.hiiquote.com

HEALTH™ INSURANCE INNOVATIONS

From: JC Moreno
To: Lori Kosloske & Dan Garavuso
Subject: Due Diligence Audit
Date of Visit: Thursday, March 26, 2015
Attendees: Cameron Girourd; Matthew Spiewak, JC Moreno

I. Overview of Objectives

Health Benefits Center is familiar with the HII annual due diligence audit since this is our third visit; they understand that we are there to ensure that Health Benefits Center is in compliance with federal regulations, carrier expectations, and HII processes and procedures. I thanked them for taking the time to see me, since I told them that HII is there to partner with them and gather information regarding their organization related to business practices, compliance procedures – especially the implementation and enforcement of Health Benefits Center compliance process & procedures.

II. Regulatory Departments

During our visit, we discussed our process and procedures on submitting regulatory and non-regulatory complaints to HII to ensure prompt investigation and response to these departments.

We communicated the various ways that complaints come into HII and how to proceed. We have 20 Department of Insurance complaints for Health Benefits Center, 10 Better Business Bureau complaints since July of 2014 and they were all handled according to HII guidelines. 10 of the 20 DOI complaints are showing for Steven Grant since a lot of their business is written under his business link. We also have 47 non-regulatory complaints that were submitted to compliance within the last year. Health Benefits Center wrote 13,664 applications from January 2014 – February 2015 and the percentage of regulatory and non-regulatory complaints versus applications written is .006%. Cameron Girouard feels that their customer service department is the key to preventing complaints and making sure the business stays on the books. Any responses to the DOI come from Cameron Girouard.

Cameron Girouard has been responsive and keeps consistent communication with HII's Regulatory Compliance Manager on any regulatory complaints that come in.

Some trends and feedback were addressed at the audit such as:

- Complaints that Carol can come across rude and will disconnect calls when things heat up.
- Retention reps can come across aggressive when attempting to save a client.
- Clients do not have to submit a written cancelation request.
- Two of our carriers advised of clients who were getting the runaround to cancel the policies.

Process and Procedure:

i. Receive & Review complaint, list entities to be contacted
ii. Create folder for the new complaint in the Compliance section of the network drive;
iii. Log complaint on the current year's regulatory complaint spreadsheet & save;
iv. E-mail complaint to agency, carrier, and/or claims administrator (agency & claims administrator are notified if the complaint require either entities' response);
v. Request agent response, if required
vi. Acquire & Review-all relevant policy documents, notes and recordings. Store all items in the complaints network folder;
vii. Prepare 1st draft response after review of number iv as follows:
  - Outline allegations;
  - Research each allegation(s);
  - Respond to each allegation;

viii. Forward 1st draft letter to carrier
ix. Address any concerns the carrier raises
x. Sign and deliver final letter via verifiable delivery method (fax, e-mail, etc.)

III. Office Location

Health Benefits Center
200 South Park Road Suite 465
Hollywood, FL 33021

Health Benefits Center moved into the 7,500 square foot location in July of 2014 and signed a 5 year lease. The new location is across the street from the previous location they had; they stayed near in that area because it's easy access to the main freeway, local transportation, and extended public transportation. They are also opening a new office which will be an extension of their office that is located at 2 Oakwood Boulevard Hollywood, FL 33020. In the future, Health Benefits

Center has plans of opening 3 other locations in Boca Raton, Fl; Miami, Fl; and Tampa, Fl.

John Sand is a sales floor manager with Health Benefits Center and he has 17 years of management and sales experience. The sales floor manager at the new Hollywood location has not been determined yet.

IV. Hiring Practices

Health Benefits One's mission is to provide affordable care solutions to those who cannot afford or qualify for traditional options. We strive to provide superior customer satisfaction to create long lasting relationships with our customers. When recruiting, Health Benefits Center posts ads on local publications, internet job sites and also attends career fairs when available. Health Benefits Center has all admin, customer service and management W-2 but all sales agents are 1099 employees. Health Benefits Center feels that they set high standards when hiring so they perform background checks on all new employees that come onboard to make sure there are not any potential issues that could affect their business. Once the results are received, candidates with felonies are not offered a position. Should misdemeanor come up in the results, they will review the charge, the resolution and the date of the charge.

When agents are hired Health Benefits Center will pay for any licenses they need. Agents are appointed in each state they conduct business in. When initially hired, Health Benefits Center will only license them in their top selling states and more state licenses are purchased as the agent gains tenure with the company.

Employment packets and sign-off sheets were not provided for core competency purposes. However, a list of agents, verifiers and fronter's were provided.

V. Training Practices

Health Benefits Center has three different trainers that focus on training in three different areas. Victor De Aza is the Sales Trainer and he is also the Human Resource Manager for Health Benefits Center; he has six years of Human Resource experience, was in the Air Force for 10 years, and has been with Health Benefits Center since March of 2013. David Caldes is the Operations Manager and Verification Manager for Health Benefits Center since December of 2012; he handles training for anyone hired to do verifications. David worked for several professional sports team in media operations and was also an instructor at the University of Massachusetts Amherst for almost 2 years. Cameron Girouard is the customer service trainer and has been with the Health Benefits Center since May of 2012; she has 5 years of related experience including the time she's been with Health Benefits Center. Cameron also worked for Northstar Health Corp for 2 years.

Health Benefits Center has a designated conference room for training. Sales training is two to three days, customer service training is two weeks and verification training is one week. Sales training material is based on HII's brochures and PowerPoint presentations that were issued. Health Benefits Center has a customer service training manual that Cameron presented while at the office but did not provide a copy for core competency purposes.

Retraining is done if there is a minor offense committed on a sales call such as: product knowledge, complaints that come through, etc… The Sales Trainer will have a one on one with the agent and discuss product info and place the agent on a 90 day probation based on the offense. Also, if a complaint is received from a client, Cameron will have a customer service representative monitor calls for that agent for an entire day.

Disciplinary Actions is as follows:

1st Offense: Verbal Warning
2nd Offense: Retraining
3rd Offense: Termination

VI. Phone System

Health Benefits Center currently uses Elastix PBX is their phone system but within the next 30 days they will be launching a new phone system called Matrix. A phone system manual was provided on the new system they will be transitioning to. The current system they are utilizing has the capabilities of recording calls and all agents are able to record verifications. The phone system has the capabilities of auto dialing, but they are not currently using this feature since all calls are inbound. Health Benefits Center makes sure to stay up to date with FCC, FTC and TCPA guidelines by making sure to make sure they are knowledgeable in the laws and also attending annual compliance conferences that DOI commissioners attend.

VII. Agent Monitoring

Health Benefits Center records and monitors all voice verification calls. Once recorded all voice verifications are stored to their server and uploaded to HII via FTP on a weekly basis. They also use a third party agency by the name of CallMiner which is a speech analytics results assurance program. Cameron Girouard sends CallMiner random recorded calls to monitor and it captures the agent's empathy, tone, and alerts trigger words provided by Cameron. HII will pull a pre-selected amount of voice verifications on a monthly basis. Once reviewed, HII's Compliance Specialist will send an email with results on a

monthly basis. Several concerns were addressed to Cameron Girouard regarding the voice verification reviews such as:

- Verifiers read through the script too quickly
- Pronunciation on the medical conditions needs improvement
- Make sure all ancillaries are being read

Cameron Girouard stated that the verifiers are not in training as long as customer service or the agents when they are hired. Cameron states they don't spend as much time with the verifiers because they are just provided with a script they have to read. The verifiers training is focused primarily on the system they use. Cameron stated that she will provide feedback to David Caldes who trains the verifiers.

VIII. Advertising and Lead Generation

Health Benefits Center's website is www.hbcinsure.com and is used for consumer education and to help generate leads. Leads are obtained through lead generation web pages with their sister company Simple Insurance Leads and other lead generating companies. The leads are distributed to agents based upon states they are licensed in and who is available for a call and 100% of leads are inbound calls. Health Benefits Center does not advertise on television, newspaper, radio or direct mail advertisement and 1% of their leads are based on referrals.

IX. Sales Process

Health Benefits Center primarily sells Companions Principle Advantage plan which is 80% of their business with HII and they present the product as a group plan. They advise the client that they will be joining a group association PPO plan that is reserved for a limited amount of people in their area. Once the agent obtains all of the consumer's personal data such as name, address, date of birth, income, insurance budget, etc… They advise the consumer they are able to approve the client for this plan. Cameron says this helps add value to the plan. Once the agent advises the client they qualify for the plan, they begin providing all the benefits of the plan using the carrier approved brochure and complete the application in HII's backoffice. Health Benefits Center is currently writing business under six licensed agents contracted with HII: Alane Kravatz, Aldo D. Hreczny, Brenda Swain, Gina Zohar, Matthew Spiewak, and Steven Grant. Health Benefits Center has 13 agents that are currently contracted with HII but only the six mentioned are being used to write business. I advised Cameron that we must have all agents contracted with us using their own specific links. According to the employee list provided, Health Benefits Center has 60 licensed agents included within management but we only have a total of 13 who are contracted with HII.

Cameron Girouard stated that they are going to launch a new CRM that is more advanced to help assist with having all agents using their own links.

Listening to Call Notes:

- **Lead company warm transferred the call to Brenda Swain (selling agent):** Consumer mentioned that she was transferred all over the place. Agent stated that they represent most insurance carriers. The consumer mentioned that he wants dental, vision,
  The agent said that she is going to run a search through the state to provide all of the consumer's options. "Based on the search she was able to approve the client for a Nationwide PPO and a group plan" The plan is reserved for 1,000 people in his area 90% of Doctors will take the plan. The agent does go over all of the major benefits they have in the package. They tell the consumer about the group they have been accepted in to help build value. The client is purchasing the association; According to Cameron, this is the reason why they bring up the group plan language in their pitch.

- **Lead company warm transferred the call to Adam (selling agent):** The lead company even provides the clients budget. They represent all the "A" rated carriers in the state of LA. What do you value in a health insurance plan? (this helps determine what the customers' needs are) They still need to find out what is available in the state still. The call was transferred to another department since the consumer only had a $90 budget. An unlicensed agent will handle to offer the discount plan.

- **Lead company warm transferred the call to Steven Grant (selling agent):** Consumer is in Idaho and she is looking for a plan for a family of 5. The client has a health plan and she pays about $200 a month but is needing dental and vision. The client had United Metro Insurance for a family of 4. The agent advised that their plan is the best option but the agent did offer a prescription plan for $24 a month. The agent also advised that the plan she has a discount plan and he offered a $500 + plan (STM).

X. Customer Service Process

Cameron Girouard is the customer service director, Carol Watson is the customer service manager and MacArthur Walker is the customer service team lead. Carol Watson has been with the organization for 2 years. Health Benefits Center has a team of 11 customer service representative that handle customer service, retention and rewrites. All customer service agents with Health Benefits Center are licensed agents. Currently, all of Health Benefit's Centers clients that call into HII's customer service department are transferred to them for assistance. If the client calls into HII and has a complaint or escalation then it is handled in-house. Each representative takes on a daily average of approximately 40 calls per day. Once

the call is received, the customer service representative addresses any questions or concerns, notates in the Health Benefits Center CRM system and if applicable, in HII's Retention Queue. Health Benefits Center is assigned a queue in HII's backoffice where HII's customer service representatives will add clients that are requesting to cancel so that Health Benefits Centers customer service representative can call and attempt to save. If the customer service rep is not able to save they will refer client back to HII for cancellation and make the appropriate documentation on clients account in the HII backoffice.

XI. Overview of "Hot Points" of HII and carriers

1. Reach out to Compliance – DOI, BBB, Market Inquiry, Attorney Letter, Litigation – If it involves a plan we administer, we need to be involved – contact Dan Garavuso directly.

2. Suitability: selling the right plan for the person's needs – example: If somebody needs to be on an exchange plan and can afford it, that's what they need.

3. Licensed/Appointed/Contracted: Licensed in the state you sell in, appointed by the carrier, contracted with HII. Potential Clients record calls themselves – they know who they spoke to – and the Insurance Department asks about everyone that spoke to the complainant. If you are not licensed in Colorado, for example, the agent cannot discuss plan benefits in that state – pass the caller on to whomever is. If your agents are not contracted with HII, they cannot talk about plan benefits to clients, period.

4. Twisting: In the past year, we have termed two agencies for twisting. We find out – persistency numbers drop off, people complain to us about their agent, or they call the DOI.

5. Reporting Actions – Regulatory Actions taken by states against you since you were contracted, background updates if you've had a felony charge – we're hooked up to NIPR and are reviewing reports before each audit – tell us in advance so we can discuss it before the carrier catches it and turns off your links.

6. Reporting Terminations/ Separation of employment – especially if you term someone for cause, there's a very good chance we don't want to work with that person either – we also need to turn off the links, so let Dan know directly.

Agency Analysis:

Health Benefits Center has doubled in size since the last site visit in April of 2014 and according to Cameron Girouard they have plans to open 3 other locations in Boca Raton, FL; Miami, FL; and Tampa, FL. Cameron Girouard also stated that Health Benefits Center is looking into obtaining their third party license in order to handle customer service calls for other companies seeking these services.

Health Benefits Center is writing over 4,000 applications a month and the business is being dispersed between 6 agents; this creates a high risk situation since they have licensed agents writing business under someone else's link. HII has 13 licensed agents contracted with HII but according to the updated employee list provided by Cameron they have 60 licensed agents in the office. Health Benefits Center is working on launching a new system but we will begin having all other agents in the office contracted with HII to make sure that links are available once the new system is launched.

They have a unique sales pitch when selling Principle Advantage Plan (underwritten by companion) by advising the client that there is limited availability in their area and advising the client that they are approved and can be accepted for a PPO group plan. The client is also advised that the premium is significantly lower because they will be part of a group association which makes the rate lower. The benefits are provided for the plan so the client is aware of the coverage but the acceptance to the group seems to come across as misleading since it is a guarantee issue plan. There aren't specific standards set for a client to sign for the policy. Cameron states that this is just the way the plan is marketed and how they present that the client is part of the MSGA association.

Deliverables:

- Start process to have all licensed agents complete sub-agent paperwork.
- Follow-up on launch date of new phone system

Simple Health Visit – meeting notes May 23rd

AXIS attendees
Brian O'Connell
Dominick Zenzola

HII attendee
Bryan Krul

Simple Health attendees
Cam Girouard – Chief Compliance Officer
Robert Kneeter – Chief Marketing Officer

Simple Health's Chief Compliance officer (Cam) gave us a tour of their office and call center. Overall their facility is very professional and appeared well organized and managed. Their call center is a large room that could fit well over 100 agents and customer service reps. They have a floor/quality control manager who listens in on agent calls and provides immediate feedback to the agents if they notice any issues. In some situations they can also jump in and put the consumer on hold to correct the agent if something was communicated incorrectly. Simple Health has four of these floor managers roam the floor throughout the day.

After the tour we spent time with Cam and Robert in a meeting room. We spent the first 30 minutes focusing mainly on marketing since Robert could only join us for that amount of time.

Lead Generation / Sales targets:

Robert talked about the lead generation and indicated there are essentially two types:

- Internal traffic which is email/website leads. They spend about $75k a week to Google for key word searches which generate leads. They have over 400,000 key words. Majority of their leads come from this type of generation (90% of sales are inbound).
- 3rd party Aggregators – Simple Health must have contract with aggregators

They track marketing from the point of leads and have the ability to track 100% back from the complaint. However, they do require at least 48 hours.

The account management team has 230 vendors that manage the google accounts, setup email marketing campaigns as well as all levels of tracking. The expenses are significant and they take this responsibility very seriously all the way through to metrics.

Simple Health has a website but they indicated that no leads are generated from their own site, consumers do not access their site. Website does not drive any business.

Qualifiers do not know of or speak to any product with a potential customer. If questions are asked of them they redirect by emphasizing they will be done shortly and are quickly determining who they should speak with after a few simple questions.

When a lead comes in the qualifiers gather information from the consumer and decide whether there is a plan that could meet their needs. If so the qualifiers will pass that lead on to an agent. The lead is passed on to the next available agent but they also look at the state and make sure the consumer is forwarded to a licensed agent in that state.

To decide which plan to sell the agent looks at three criteria of the consumer; the state, the family size and the cost/amount they are looking to spend.

Simple Health expects agents to close on 25% of the leads that are qualified and sent to them. If the agents don't hit their financial metrics Simple Health will not hesitate to terminate them.

Training:

In terms of training Simple provides agents with two weeks of classroom training. Besides product training, they also learn about the nature of call centers, industry language and other nuances of the business. The agents must then take a 50 question test and get a 100% score. They must retake the test until all questions are answered correctly.

The agents then have one week of monitoring and on the job training. The 4th week they start selling but get assistance from a manager.

They do retraining if they notice any issues with specific agents or general training needs. Cam indicated this is done typically monthly. They also have department wide training for both agents and customer service.

Simple is currently creating a new video training program which agents can use. Simple recently met with HII to discuss updating the sales scripts. This is feedback from AXIS, we asked for more clear disclaimers to be mentioned during the sales process.

Simple and HII meet regularly (monthly) to discuss the business, concerns and changes that need to be implemented.

Complaints/Compliance:

Simple explained that they can't always get back to us quickly on information because they need to ask their sub agents for the data. The request goes to HII first who then ask Cam at Simple who then has to reach out to the agent.

Cam emphasized that "asking for an extension of time" to respond to states is key. The first step in receiving a question or complaint from a state should be to call DOI and ask for more time to research and respond. Usually one week or more is given. Then explain to the DOI the chain or layers involved in thoroughly researching any issues. If pushed, they also indicate that state rule is normally 15 days and that we need more than a few days.

Cam mentions she also talks directly to Patricia and Karen. Cam was also open to visiting the Princeton office to meet and spend time with our compliance/legal team. We also talked about scheduling weekly or bi-weekly meetings which include Cam so we can go through the specific questions/issues we have with Simple directly with them on the phone.

Simple does track metrics for each agent and customer service rep. In 2017 Simple has fired one customer service rep and approximately 20 agents as a result of poor customer service/phone skills and/or not correctly following the right script.

With respect to the licensing of agents Simple does a cross check with HII on a regular basis.

Each quarter Simple performs audits and does a full compliance review.

Simple follows the 80/20 rule – focusing in on the top 20%'ers to make sure script adherence is being followed. Trying to determine why they are selling so much and making sure procedures are followed.

Cam indicated that they utilize "BOX" to share/ send message recordings. They would very much encourage our team to share any call being evaluated for issues so that she could join in earlier and assist in research.

Verification process recorded 100% of the time and saved into system, 100% is uploaded to HII. Call-miner is being tested and implemented by Simple Health. Target date is June for implementation at which time 100% of verifications will be checked by Call-Miner as HII has in place.

Cancellations:

We discussed how we want Simple to handle cancellations. If a customer calls in to cancel we ask that the customer service rep process their cancellation in lieu of trying to convince them otherwise. This was in response to a recent complaint where a manager for Simple took the

call and asked the customer why they were canceling. This lead to confusion around the benefits offered and the re-pricing on certain medical expense. This seemed to frustrate the customer when this could have been avoided by just cancelling their plan as they requested.