

**FLORIDA DEPARTMENT
OF
INSURANCE**

TARGET MARKET CONDUCT EXAMINATION REPORT

OF

PROVIDENT INDEMNITY LIFE INSURANCE COMPANY

AS OF

DECEMBER 31, 2000

**DIVISION OF INSURER SERVICES
BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT
MARKET CONDUCT SECTION**

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May 16, 2005

Honorable Tom Gallagher
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32390-0300

Commissioner Gallagher:

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated January 10, 2000, a Target Market Conduct Examination has been performed on:

Provident Indemnity Life Insurance Company
2500 DeKalb Pike
Norristown, PA 19401

NAIC COMPANY CODE 68187

The examination was conducted at the offices of the Company's third party administrator, Health Plan Services, located at 3501 E. Frontage Road, Tampa, Florida. The report of such examination is herein respectfully submitted.

Sincerely,

Boyd A. Higgins, CIE, FLMI, CLU, ALHC
Independent Contract Analyst

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SCOPE OF EXAMINATION

The Florida Department of Insurance (Department) conducted a limited scope target market conduct examination of Provident Indemnity Life Insurance Company, hereinafter referred to as PILIC or the Company. Independent contract analyst, Boyd A. Higgins, CIE, FLMI, CLU, ALHC conducted the examination pursuant to §624.3161, Florida Statutes.

This examination covers the period from January 1, 1998 through December 31, 2000 and was conducted at the offices of PILIC's contracted third party administrator, Health Plan Services, at 3501 East Frontage Road, Tampa, FL 33607. The examination commenced on January 10, 2001 and was completed April 4, 2001.

The purpose of this Target Market Conduct Examination was to determine if the PILIC's practices and procedures conform to the Florida Statutes and the Florida Administrative Code.

Procedures and conduct of the examination were in accordance with the Department's Field Examination Guidelines and the Market Conduct Examiner's Handbook produced by the National Association of Insurance Commissioners (NAIC).

The examination was limited to assessing compliance and overall procedures used by PILIC to administer Association Group Preferred Provider Organization (PPO) health plans sold to Florida residents who were, or became, members of out of state associations. The primary areas reviewed were as follows:

1. Producer Licensing
2. Billing and Posting
3. Claims Denials
4. Claims Handling
5. Consumer Complaint Handling
6. Form Filings

PILIC has not assumed policies from other companies in the lines of business subject to this examination.

Files were examined on the basis of file content at the time of examination. Comments and recommendations were made in those areas in need of correction and improvement.

COMPANY PROFILE

History

The Company was incorporated as the Keystone Indemnity Company on April 7, 1904, and commenced business on April 11, 1904.

The Company's corporate name was changed to Provident Industrial Life, Health and Accident Insurance Company in 1921. In 1940, PILIC adopted its present name.

As of December 31, 1998, PILIC sold Provident American Life Insurance Company to Ceres Group, Inc., of Strongsville, Ohio. Early in 1999, PILIC sold its pre-need and final expense life insurance business to Lincoln Heritage Life Insurance Company and its military market and governmental employees life insurance business to Life & Health Insurance Company of America.

Provident Indemnity Life Insurance Company was sold to AHC Acquisition, Inc., with the transaction being completed sometime between the November 19, 1999 board of directors meeting and January 1, 2000.

The current organization chart shows that Provident Indemnity Life Insurance Company is a subsidiary of AHC Acquisition, Inc., which is in turn owned by Alvin H. Clemens as sole shareholder. Effective December 31, 1998, PILIC entered into an agreement with The Reinsurance Company of Hanover (Hanover) and Central Reserve Life Insurance Company (Central Reserve) whereby Hanover reinsures one hundred percent (100%) of losses incurred and Central Reserve assumes responsibility for administration of the policies. Central Reserve, a Ceres Group, Inc. subsidiary, contracts with third party administrator Health Plan Services for administration of the policies.

PILIC is licensed in the District of Columbia, the U.S. Virgin Islands, Florida and twenty-four (24) other states.

Certificate of Authority

PILIC's Certificate of Authority was suspended in Florida through a consent order dated August 18, 1999 under case no. 29151-99-co. The suspension is still in effect. However, the following four (4) cases show effective dates after the suspension became effective.

Case Number	Name	Issue Date
61831C	Lisa Severance	10/01/99
65914C	Sarah Militano	10/01/99
99481C	Sarah Rahaim	6/01/00
03164D	Mark Karr	10/01/00

As of March 30, 2001, the internet web site www.digitalinsurance.com was showing PILIC as one of the insurance companies whose products are being offered to Florida residents as a membership benefit by the Consumer Benefits of America Association, with HealthAxis.com as the licensed independent agent. Based on information in PILIC and PAMCO's combined board of directors' minutes dated March 29, 1999, Health Axis was a PAMCO subsidiary. The possible "upstream merger" of Health Axis into a PAMCO subsidiary was discussed at the most recent board of directors meeting, which was held on November 19, 1999.

This ongoing solicitation and placement of coverage is in direct conflict with the consent order and a violation of §624.401(4), Florida Statutes.

PRODUCER LICENSING

Agent appointment records produced by the Company included one hundred eight (108) agents who did not appear on the records produced by the Department, and the records from the Department showed eighty five (85) agents with active Company appointments who were not shown on the Company's records. An additional one hundred eighty-four (184) agents shown as terminated on the Department's records were listed as active in the Company's records. One hundred eighty-six (186) agents were on both sets of records. In total, the Company's listing showed four hundred seventy-eight (478) active agents, although the Company's certificate of authority had been suspended since August

18, 1999. The Department's records show one hundred fifty seven (157) agents currently appointed to represent the Company.

First year commissions were paid to two thousand six hundred eighty-nine (2,689) agents during the period under examination. The Company informed the examiner that they had relied on the provisions of §626.837, Florida Statutes, in accepting up to twenty-four (24) applications per year from the agents not directly appointed. They produced records in support of this for only forty-eight (48) of the eighty-five (85) agent sampling, a forty-four percent (44%) violation rate. This leaves thirty-seven (37) agents from whom the Company accepted business in violation of §626.837(6)(b), Florida Statutes, and to whom the Company paid commissions in violation of §626.838(1), Florida Statutes.

Based on the fact that PILIC's certificate of authority is under suspension, the Department is concerned that the agents who remain appointed to represent PILIC could use that authority to produce up to twenty four (24) applications each year from Florida residents with any number of insurers. Their purported authority would be the appointment with PILIC, notwithstanding the fact that the authority to write business in Florida has been suspended. This could leave the insurance buying public vulnerable in the absence of a principal-agent relationship, especially in a market that relies heavily on out of state association groups.

BILLING AND POSTING

The examination of billing and posting was performed to determine if the Company was accurately and timely posting policyholder premiums. The examiner reviewed fifty (50) of the two thousand one

hundred sixty-eight (2,168) cases on the active cases run and fifty (50) of the eight thousand five hundred seventy-seven (8,577) terminated cases. The examiner conducted tests to determine if:

- the premium included on the group proposal agreed with the premium charged on the initial premium billing statement; and
- the Company was posting premium payments on a timely basis.

The examination revealed no exceptions for the one hundred (100) files reviewed.

CLAIMS PROCESSING

The examiner performed a claims review to determine if company procedures complied with Florida laws as well as with provisions of the members' contracts. The examiner conducted tests on random samples of denied, paid, and pended claims. The tests included:

- time studies to determine if claims were processed in a timely fashion. Although §627.613, Florida Statutes, does not apply to out-of-state groups, the 45 day {§627.613(2)} and 120 day {§627.613(4)} deadlines were used as standards for analysis.
- verification that reasons given for denied claims were appropriate and communicated to claimant in accordance with provisions outlined in §626.9541(1)(i)(3)(f), Florida Statutes; and
- verification that claims payments were made to the correct provider, at the correct amount, and on the date indicated by the claim history.

Paid Claims

The initial response to the Department's request provided records for one hundred twenty-nine thousand nine hundred twenty-one (129,921) paid claims for the period under examination. The examiner selected a sampling of one hundred (100) files and reviewed them for compliance. There

were an unusually large number of very small claims in the sample, but the systematically selected files would have produced a statistically valid review of a legitimate population. However, replies to the examiner's non-compliance comments (received with less than two (2) weeks left to complete the examination) revealed that the paid claims listing included a substantial number of "dummy" claims records created as bookkeeping corrections. An additional electronic sort showed at least seventeen thousand seven hundred twenty-six (17,726) such corrections; thirty-one (31) of the sampled files were "dummy" records. This left only sixty-nine (69) files as a sampling of one hundred twelve thousand one hundred ninety five (112,195) paid claims, which does not constitute a statistically valid sampling. In order to have a valid sampling, it would have been necessary to select a totally new sampling of at least one hundred (100) files. There was not sufficient examination time remaining to perform such a review.

The disarray in the claims records constitutes multiple violations of §624.318(2), Florida Statutes.

The review of denied claims revealed similar "dummy" records. The examiner routinely checked the diagnosis and treatment codes listed on the claims forms against the icda and cpt-3 manuals to verify that payments/denials correctly identify covered services. Initially, there seemed to be significant non-compliance due to denials of mandated benefits and other covered medical diagnoses and procedures. However, a follow up on the payment/denial codes showed fourteen thousand two hundred twenty-two (14,222) denials due to duplicate claims submissions, not due to medical or contractual reasons.

Analysis of the paid claims and denied claims files remaining in the samplings after these extraneous entries had been removed showed a potential of delays. The raw claims data suggests a potential of more than forty eight thousand (48,000) violations of §626.9541(1)(i)(3), Florida Statutes, for failing

to act promptly with regard to payment of claims. This claim data does not consider allowable pending delays resulting from requests for additional information from the insured, investigations for pre-existing conditions, or contestable period investigations.

However, the examiner reviewed a sufficient number of files to validate that a significant number of delays were taking place. In many instances, the company and examiner were unable to agree on the need for requesting additional information. Given the number of files in question, the Department is citing this as a violation of §626.9541(1)(i)(3, Florida Statutes. The delays built into the claims processing system, especially for large claims, indicate either a business practice of willful violations for cash flow management or poor customer service.

Since the claims samplings were rendered invalid by the extraneous records, the report on the delays is based on electronic calculations of time between dates received and dates paid. The calculations were performed directly from the records provided by the Company for the one hundred twelve thousand one hundred ninety-five (112,195) remaining paid claims files, with the following results:

DAYS IN PROCESS	NUMBER OF CLAIMS	PERCENTAGE
Less than 46 days	73,187	65.2%
More than 45 days	39,008	34.8%
More than 120 days	16,118	14.4%
More than 365 days	1,884	1.7%

PILIC business is written in the State of Florida as an out-of-state association group, and is therefore not subject to §627.613, Florida Statutes, relating to the timeliness of claims payment. If §627.613, Florida Statutes, were applicable to PILIC, this would have resulted in interest payments in the amount of four hundred thirty-one thousand seventy-two dollars and ninety-nine cents (\$431,073) on delayed

claims. Using the method of increasing the received date by fifteen (15) days to reflect the time spent at the Company's re-pricer and pre-processing vendor, as occurred in determining time frames for paying interest in connection with findings of market conduct examinations conducted by Colorado and Oklahoma, the interest on the Florida delayed claims would have been four hundred seventy-two thousand one hundred ninety-five dollars (\$472,195).

If these were not out-of-state group policies, these calculations would show thirty-nine thousand eight (39,008) potential violations of §627.613(2), Florida Statutes, a thirty-four and eight tenths percent (34.8%) non-compliance rate, and sixteen thousand one hundred eighteen (16,118) potential violations of §627.613(4), a fourteen and four tenths percent (14.4%) non-compliance rate.

Although the provisions of §627.613, Florida Statutes, do not apply to PILIC, the forty-five (45) day threshold in this law is a good standard to evaluate whether communication of paid or denied claims is "prompt" under §626.9541(1)(i)(3), Florida Statutes. Using this standard, these delayed payments would constitute thirty-nine thousand eight (39,008) potential violations of §626.9541(1)(i)(3), Florida Statutes, using the received dates in the records. Consistent with the treatment of the date of receipt in the Colorado and Oklahoma examinations, adding fifteen (15) days resulted in the number of violations increasing to fifty thousand seven hundred forty six (50,746).

Since claims in excess of two thousand five hundred dollars (\$2,500) are referred from the TPA to the Company's representative for review before payment is made, the examiner was interested in evaluating the delay in processing payments on the one thousand five hundred seventy-five (1,575) claims above this threshold, as shown by the following table:

DAYS IN PROCESS	NUMBER OF CLAIMS	PERCENT OF TOTAL
Less than 46 days	428	27.2%
More than 45 days	1147	72.8%
More than 120 days	518	32.9%
More than 365 days	60	3.8%

The total amount billed on this block of claims in excess of two thousand five hundred dollars (\$2,500) was sixteen million eight hundred eighty-nine thousand nine hundred forty-four dollars (\$16,889,944) and the amount paid was eleven million eight hundred thirty-three thousand eight hundred fifty dollars (\$11,833,850). This reflects an aggressive re-pricing program that is evident throughout the claims payment process. Total billings for claims paid during the period under examination were forty-eight million five hundred fifty-three thousand seven hundred forty-one dollars (\$48,553,741) and the amount paid was twenty-four million three hundred fifty thousand six hundred fifty-two dollars (\$24,350,652).

The rationale for adding the fifteen (15) days to the processing time is based on acknowledgement by the Company and Health Plan Services, in response to findings by the examiner and by earlier examinations for Colorado and Oklahoma, that time for the following procedures was not recorded.

The health care provider sends the claim to a network or re-pricer by mail. Re-pricing takes from four (4) to fifteen (15) days, and then the claim is sent to Health Plan Services via mail. Health Plan Services then forwards the claims via overnight delivery to ACS, a vendor in Middleton, New York for sorting, imaging and data entry. The received date in the records is entered only after the claim has been received by ACS, and the claim is electronically downloaded from ACS to Health Plan Services within four (4) working days after ACS has entered the received date into the record.

A memorandum dated April 5, 2001 from the Company examination coordinator, outlines the steps the Company has taken to have records more accurately reflect the received date.

The typical claim has already been in the hands of the Company's contracted representative for one (1) week to three (3) weeks before the TPA even looks at the claim. After the TPA has reviewed the claim, there remain multiple criteria, including the two thousand five hundred dollar (\$2,500) threshold, requiring the TPA to forward the claim to the Company's representative for final review and approval. Each of these different functions is completed before a claim is passed on to the next area. Time service could be improved dramatically if some of these functions could be handled concurrently rather than being compartmentalized and handled consecutively.

It was determined that procedures used to register and process claims indicated a general business practice that failed to acknowledge and act promptly upon communications with respect to claims, violating §626.9541(1)(i)(3)(c), Florida Statutes.

Denied Claims

The initial response to the Department's request provided records for thirty-seven thousand eight hundred and sixty-five (37,865) denied claims. After filtering out claims identified as denials for reasons not pertaining to policy provisions, there remained twenty-three thousand six hundred forty-three (23,643) records. The following table shows the number of days between the received date and the denied date in the records:

DAYS IN PROCESS	NUMBER OF CLAIMS	PERCENT OF TOTAL
Less than 46 days	15,502	64.3%
More than 45 days	8,441	35.7%
More than 120 days	4,162	17.6%
More than 365 days	853	3.6%

As stated previously, PILIC business is written in the State of Florida as an out-of-state association group and is therefore not subject to §627.613, Florida Statutes, relating to timeliness of claims payment. Applying a forty-five (45) day standard results in eight thousand four hundred forty-one (8,441) potential violations of §626.9541(1)(i)(3)(f), Florida Statutes. As noted previously, the fifteen (15) day adjustment would increase the number of violations to ten thousand seven hundred twelve (10,712).

COMPLAINT HANDLING

The Examination of complaint handling was reviewed to determine if the Company had maintained complaint-handling procedures in accordance with §626.9541(1)(j), Florida Statutes.

The examination of complaint handling was limited to reviewing the written correspondence received through the Department in 2000. In order to assess the actual procedures used by PILIC to process complaints, sixty-five (65) complaint files processed in 2000 were reviewed.

The examination procedures included calculating the processing time between the date the correspondence was received and the date the file was closed; a review of the file was conducted to determine the nature of the correspondence and to determine if the Company responded appropriately.

The data file submitted to the Examiner included three hundred ten (310) complaints received between January 1, 1998 and December 31, 2000. The sixty-five (65) complaint files received in 2000 were selected to review overall procedures and processing time required to resolve the complaints. The processing times for the Department files reviewed are depicted below:

Time in Process	Department Records	Company Log
0-30 Days	29	61
31-60 Days	35	3
More than 60 Days	1	1

The differences between the Company log and Department records reflect the fact that the Company consistently waited nearly thirty (30) days before responding. This, combined with mailing time, made the complaints exceed the thirty (30) day standard in Department records although the Company records indicate the standard was met.

One hundred eighty seven (187) of the three hundred ten (310) complaints were caused by delays in claim processing. The numbers developed in the claims time studies support the complaints.

Another issue seen in eighteen (18) of the complaints was the allegation by policyholders and providers that claims were lost or misplaced and had to be submitted multiple times. The following time studies of paid claims is based on a calculation of the number of days elapsing between the date of service and the date the claim form is entered into the Health Plan Services' records as received.

Time in Transit	Number of Claims	Percent of Total
Less than 120 days	79,973	81%
More than 120 days	18,928	19%
More than 180 days	11,228	11%
More than 365 days	2,066	2%

There were one hundred sixty-five (165) complaints sent to the Department in 1998, eighty-five (85) complaints in 1999, and sixty-five (65) in 2000.

The examiner did not review complaints sent directly to the company or Health Plan Services because these complaints had all been classified as appeals and co-mingled with regular appeals.

FORMS FILINGS

The Company provided copies of all policy forms used during the period under examination and listings indicating which plans were issued on which forms. Every form presented had official stamps affixed by the Florida Insurance Department marked "Filed" with the date shown. An attached listing showed which cases had been filed for approval and which had been filed for informational purposes only.

CONCLUSION

The target conduct examination report on Provident Indemnity Life Insurance Company is respectfully submitted to the Honorable Tom Gallagher, Insurance Commissioner of the State of Florida.

The customary practices and procedures promulgated by the National Association of Insurance Commissioners were followed when possible. Some processes that are normally done using sampling techniques were completed instead by performing electronic sorting, filtering and calculating on the total population of claims paid and claims denied.

The examiner wishes to express his appreciation for the courteous cooperation and assistance given by the Company's designees.

Sincerely,

Boyd A. Higgins, CIE, FLMI, CLU, ALHC

Independent Contract Analyst

FINDINGS AND RECOMMENDATIONS

The following findings were made in the preceding pages of this report. The Company should:

- Page 7 Comply with the existing consent order (29151-99-CO) and §624.401(4), Florida Statutes, by having the Company's name removed from the internet marketing solicitation site and taking steps to insure that no more insurance is written while the certificate of authority is under suspension.
- Page 8 Comply with §626.837(6)(b) and §626.838(1), Florida Statutes, by not accepting business from unlicensed agents.
- Page 10 Change record keeping system to assure that record categories allow retrieval in accordance with §624.318(3), Florida Statutes, and prevent inclusion of extraneous materials or information.
- Page 12 Comply with §626.9541(1)(i)(3), Florida Statutes, by processing claims promptly.
- Page 14 Comply with §626.9541(1)(i)(3)(c), Florida Statutes, by acknowledging and acting promptly upon communication with respect to claims.
- Page 15 Comply with §626.9541(1)(i)(3)(f), Florida Statutes, by providing a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim.

Submit to the Department (quarterly) CDs or ZIP computer disks containing records of Claims Paid and Claims Denied, in EXCEL format and containing the same fields as those provided to the examiner during the examination.

The Company should implement policies and procedures that will facilitate effective oversight of those parties (TPAs) to which it contracts out duties.

The Company should develop an audit program that allows the Company to assess the performance of the outside parties (TPA's) and their compliance with the statutory standards to which the Company will be held.