



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

TIME INSURANCE COMPANY

AS OF

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EXECUTIVE SUMMARY

A target market conduct examination of the Time Insurance Company was performed on the Company's activities related to Out-of-State Group Short-term Major Medical Health Plans. A review of the Company's claim settlement practices was conducted to determine compliance with Section 626.9541, Florida Statutes. The Company's claim settlement procedures and policy forms were reviewed for compliance with Section 627.6515, Florida Statutes. The Company's rescission practices were examined to determine if contracts were rescinded according to policy provisions. A review of the Company's complaint handling procedures was conducted to determine compliance with Section 626.9541, Florida Statutes. The Company's fraud plan was reviewed to determine compliance with Sections 626.9891, Florida Statutes.

The following violations were found during this examination:

<u>TABLE OF VIOLATIONS</u>				
Statute or Rule Cite	Description	Total Universe of Files	Files Reviewed	Number of Violations
Section 626.9541(1)(i)3.c, Florida Statutes	Failure to timely acknowledge or act promptly upon communication with respect to claims	44,162	250	43
Section 624.318, Florida Statutes	Failure to Provide Documentation or Maintain Adequate Records	44,162	250	110
Section 626.9541(1)(j), Florida Statutes	Failure to Follow Complaint Handling Procedures	89	89	6
Rule 69D-2.003(1)(d), Florida Administrative Code	Anti-Fraud Plan failed to acknowledge that the insurer or Special Investigation Unit shall report all suspected fraudulent insurance acts directly to the Division of Insurance Fraud electronically using a digital reporting interface.	N/A	N/A	1
Section 626.9891(3)(c), Florida Statutes	Anti-Fraud Plan failed to include a description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel	N/A	N/A	1

This examination was conducted by INS Regulatory Insurance Services, Inc.

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of Time Insurance Company (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by INS Regulatory Insurance Services, Inc. The scope period of this examination was January 1, 2005 through June 30, 2008. The examination began October 10, 2008 and ended February 5, 2009.

The purpose of this examination was to review the Company's activities related to its Out-of-State Group Short-term Major Medical Health Plans. The examination included the following procedures:

- The Company's claim settlement procedures were reviewed to determine if all claims were investigated appropriately and then paid or denied in compliance with Section 626.9541(1)(i), Florida Statutes.
- An examination of the Company's claim settlement procedures and policy forms was conducted to determine if mandated benefits were covered for Out-of-State Group Short-term Major Medical Healthcare policies in compliance with Section 627.6515, Florida Statutes.
- The Company's rescission practices were examined to determine if contracts were rescinded according to policy provisions.
- A review of the Company's complaint handling procedures was conducted to determine compliance with Section 626.9541(1)(j), Florida Statutes.
- The Company's fraud plan was reviewed to determine compliance with Sections 626.9891(1) and (3), Florida Statutes.

The Company records were examined at its Wisconsin office located at 501 W. Michigan Street, Milwaukee, WI 53203. This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

Time Insurance Company is a foreign life and health insurer licensed to conduct business in the State of Florida on June 26, 1956. The Company provides Life, Accident and Health and Individual and Group Annuities in the State of Florida.

Total Direct Premiums Written in Florida for Out-of-State Group Short-term Major Medical Health Plans were as follows:

Year	Total Written Premium In Florida (Per information provided by Company)
2005	\$4,701,484
2006	\$3,705,280
2007	\$3,280,272
2008	\$3,656,091

EXAMINATION FINDINGS

I. INVESTIGATION AND CLAIMS SETTLEMENT

The Company identified 44,162 Out-of-State Group Short-Term Major Medical health claims that were paid, denied, closed without payment or compromised during the scope period. Samples from each category were reviewed to determine if all claims were investigated and either paid or denied in compliance with Florida Statutes.

Payment Status	Total Number Of Claims	Number Reviewed
Paid (Paid as billed)	1,937	50
Denied & Closed W/O Payment	31,115	100
Compromised (Paid other than as billed)	11,110	100

A. PAID CLAIMS

The examiners reviewed a random sample of 50 of the 1,937 claims the Company paid as billed during the scope period with the following violations found:

1. **In 19 of the 50 files reviewed, the Company failed to timely acknowledge or act promptly upon a communication with respect to a claim as required by Section 626.9541(1)(i)3.c., Florida Statutes.**

Corrective Action: The Company should revise its claim processing procedures to timely acknowledge and act promptly with respect to claims.

Company Response: The Company respectfully maintains substantial compliance with Florida Statutes, Section 626.9541(1)(i)3.c. It reports its systems structures have been updated which will generate acknowledgement letters to the provider within one calendar day of receipt of an electronic claim and within 15 calendar days of receipt of a non-electronic claim.

2. **During the review of paid claims the examiners found 4 files with missing, incomplete or inaccurate data in violation of Section 624.318, Florida Statutes.** The examiners noted missing documentation necessary to complete the file in 3 of the 50 samples reviewed. The Company agreed that the information was missing and stated it was unable to provide it. In another file, the examiners found that the claim receipt date did not match the data listing. The Company agreed with the examiners' finding.

Corrective Action: The Company should ensure accurate information is provided to examiners as required by Section 624.318, Florida Statutes.

Company Response: The Company reports it has instituted a company-wide records management and document retention program covering both paper and electronic records to be implemented in phases over multiple years.

B. DENIED and CLOSED WITHOUT PAYMENT CLAIMS

The examiners reviewed a random sample of 100 of the 31,115 claims the Company denied or closed without payment during the scope period. During this review, the examiners found no instances where claims for mandated benefits were inappropriately denied. In review of the Company's claim settlement practices, the following violations were found:

1. **In 9 of the 100 files reviewed, the Company failed to timely acknowledge or act promptly upon a communication with respect to a claim as required by Section 626.9541(1)(i)3.c., Florida Statutes.**

Corrective Action: The Company should timely acknowledge and act promptly with respect to claims.

Company Response: The Company respectfully maintains substantial compliance with Florida Statutes, Section 626.9541(1)(i)3.c. It reports its systems structures have been updated which will generate acknowledgement letters to the provider within one calendar day of receipt of an electronic claim and within 15 calendar days of receipt of a non-electronic claim.

2. **During the review of denied and closed without payment claims the examiners found 54 files with a total of 55 instances of missing, incomplete or inaccurate data in violation of Section 624.318, Florida Statutes.** The examiners noted missing Explanation of Benefit forms in two files. In 53 of the sample files, the claim close date on the data listing was different than the claim close date noted within the file. One file had both a missing EOB form and a discrepancy in the claim closed date. The Company stated that the date discrepancies were due to batch processing operations and that these processing systems were modified to correct this discrepancy in May of 2007. The examiners did not find any data discrepancies in samples with claims filed after this date.

Corrective action: The Company should ensure accurate information is provided to examiners as required by Section 624.318, Florida Statutes.

Company Response: The Company reports it has instituted a company-wide records management and document retention program covering both paper

and electronic records to be implemented in phases over multiple years. A system enhancement implemented in May 2007 corrected the difference in claim closed date.

C. COMPROMISED CLAIMS

The examiners reviewed a random sample of 100 of the 11,110 claims the Company paid other than as billed during the scope period. The following violations were found during this review:

1. **In 15 of the 100 files reviewed, the Company failed to timely acknowledge or act promptly upon communication with respect to claims as required by Section 626.9541(1)(i)3.c., Florida Statutes.**

Corrective Action: The Company should timely acknowledge and act promptly with respect to claims.

Company Response: The Company respectfully maintains substantial compliance with Florida Statutes, Section 626.9541(1)(i)3.c. It reports its systems structures have been updated which will generate acknowledgement letters to the provider within one calendar day of receipt of an electronic claim and within 15 calendar days of receipt of a non-electronic claim.

2. **During the review of the compromised claims the examiners found 51 files with inaccurate data in violation of Section 624.318, Florida Statutes.**

The examiners found that in 51 of the sample files, the claim close date on the data listing was different than the claim close date noted within the file. The Company stated that the date discrepancies were due to batch processing operations and that these processing systems were modified to correct this discrepancy in May of 2007. The examiners did not find any data discrepancies in samples with claims filed after this date.

Corrective Action: The Company should ensure accurate information is provided to examiners in accordance with Section 624.318, Florida Statutes.

Company response: A system enhancement implemented in May 2007 corrected the difference in claim closed date.

II. RESCISSIONS

The Company identified a total population of 36 certificates that were rescinded during the scope period. The examiners reviewed all 36 rescission files and all claims associated with those certificates.

The examiners found that 32 of the 36 certificates were rescinded due to pre-existing conditions not disclosed or material misrepresentations on the application. Coverage with another carrier was cited as the reason for the rescission in the remaining four files.

No violations were found.

III. COMPLAINTS

The Company provided a complaint register with a total of 89 complaints. The complaints were segregated by the Company into Consumer Direct Complaints, Appeals and Department of Insurance Complaints.

Complaint Type	Total Number Of Complaints	Number Reviewed
Consumer Direct Complaints	60	60
Appeals – Level 2 Grievance	1	1
Department of Financial Services Complaints	28	28

The examiners reviewed all 89 complaints for the scope period and noted the following violations:

1. **In 6 of the 89 files reviewed, the Company failed to follow complaint handling procedures in violation of Section 626.9541(1)(j) Florida Statutes.** The examiners found that 2 files did not include documentation relative to the complaint. The Company agreed with this finding. In one complaint, the Company took 83 days to respond, failing to meet its written standard of 60 days. The Company agreed with this finding. In 2 files, the examiners noted discrepancies between the disposition codes on the data listing and those found in the file. Upon presentation of this information, the Company agreed with the findings. The examiners also noted the Company failed to adequately respond to all issues in 1 complaint. In addition to the request to appeal a claim denial, the complainant referenced another claim where the benefit should have been applied to the deductible. The Company admitted that it did not address this issue in the response to the complainant. This violation is within the permissible error ratio of 10% under Rule 69O-142.011(4)(g)(2), Florida Administrative Code.

Corrective Action: The Company should revise its complaint handling procedures to ensure compliance with Section 626.9541(1)(j), Florida Statutes.

Company Response: The Company reports it has sent a reminder to its Correspondence Department to reinforce the requirements of Section 626.9541(1)(j), Florida Statutes, to ensure compliance.

IV. ANTI-FRAUD PLAN AND INVESTIGATIVE UNIT

The examiners requested a copy of the Company's anti-fraud investigative unit description and anti-fraud investigative unit procedure manual used during the scope period. The Company responded by providing screen shots of a web-based document entitled, *SIU Manual*. It was noted that this document was last updated on July 7, 2008.

After review of the above materials, the examiners subsequently requested a copy of the Company's anti-fraud plan and any updates filed with the Division of Insurance Fraud and in effect during the scope period. The Company responded by providing copies of the 2006, 2007, and 2008 reports it filed along with the acknowledgements of receipt from the Division of Insurance Fraud (Division). The response indicated that the Company was unable to locate a copy of its 2005 report. As the Company provided more than one report for the scope period, the examiners reviewed the 2008 filing for compliance.

The following violations were found during the review of the Company's anti-fraud plan and procedures:

1. **The Company's anti-fraud plan failed to include written acknowledgement that the insurer or Special Investigation Unit shall report all suspected fraudulent insurance acts directly to the Division electronically using a digital reporting interface as required by Rule 69D-2.003(1)(d), Florida Administrative Code.** The anti-fraud plan included an acknowledgement that the Company will report all suspected fraudulent insurance acts directly to the Division using the appropriate formats, however it did not specifically reference the Division's website: www.fldfs.com/fraud.

Corrective Action: The Company should re-file its anti-fraud plan to include an acknowledgement that it shall report all suspected fraudulent insurance acts directly to the Division's website at www.fldfs.com/fraud.

Company Response: The Company respectfully maintains substantial compliance with Rule 69D-2.003, Florida Administrative Code. It reports it will implement a change to its anti-fraud plan to include an acknowledgement that will report all suspected fraudulent acts directly to the Division's website at www.fldfs.com/fraud.

2. **The Company's anti-fraud plan failed to include a description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel as required by Section 626.9891(3)(c), Florida Statutes.** The Company was asked to provide a listing of all training relative to the detection and investigation of fraudulent insurance acts for all personnel involved in anti-fraud efforts during the scope

period. The listing was to include the date and a brief summary of the training activity. A list of 18 seminars held during the scope period was provided. The information on each training session was limited to the name of the seminar and the date held. No information summarizing the nature and scope of the training activity was provided or the employees attending. This violation is subject to the penalty provisions of Section 626.9891(7), Florida Statutes.

Corrective Action: The Company should be able to document the nature and scope of all anti-fraud training sessions held as well as a list of all trainees.

Company Response: The Company believes it is in compliance with Section 626.9891(3)(c), Florida Statutes, however, in order to reach an amicable agreement with the Department, it will modify its anti-fraud plan to include this information.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issued this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.