FLORIDA DEPARTMENT
OF
INSURANCE

TARGET MARKET CONDUCT REPORT

OF

AMERICAN PIONEER 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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Ann M. McClain, CIE, FLMI,
AIRC, ACS, AIS
Independent Contract Examiner
911 Rehwinkle Road
Crawfordville, FL 32327

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Executive Summary

Introduction

The Department targeted the American Pioneer Life Insurance Company (henceforth, "American Pioneer" or "Company"), primarily due to complaints, and Department investigation activity. During the scope period of the examination (1999-2000), the Department's Division of Consumer Services recorded 153 complaints against the Company.

The majority of the complaints were with American Pioneer's Medicare Supplement Business (77 complaints), and the Accident & Health Line (66 Complaints). The Department received nine (9) complaints with regards to its Life and Annuities products, but did not make this the primary focus of this examination. The Department also opened an investigation in March of 2001 regarding the conduct of the Company. The examiner reviewed the file and found no wrongdoing on the part of the Company.

The Company is domiciled in Florida where it primarily focuses on the senior market. The Company notified the Department on December 22, 2000 that it would be exiting the Major Medical market and will non-renew policies beginning June 30, 2001. By December 2002, the Company will not have any in-force Major Medical policies.

Claims Handling / Claims Administration

Most lines serviced by the Company showed a number of claims to be paid beyond 60 days: Major Medical (7%), Dental (9%), Long-Term Care/Home Health (19%). This was also true for claim denial decisions which also took more than 60 days: Major Medical (11%), Dental (17%), Long-Term Care/Home Health (28%).

These statistics validate one reason why the Department has received complaints from American Pioneer's customers. While the examiner did not delve into the specific reasons for these delays, the examiner did find instances of the Company being unable to locate records requested by the examiner. During the examination, 24 premium refund records, 38 claims denial records, and 34 claims paid records could not be produced, and were therefore not included in the calculations stated above.

The Company should review its relationship with its TPA, WorldNet Services, Inc. in Pensacola, to ensure that all Company files can be located and processed in a timely manner.

Premium Issues / Interest Payment Issues

The examiner noted some instances of premium refunds not being paid timely. In a survey of 91 canceled policies, the examiner found 13 (14.3%) that were refunded beyond the 60-day timeframe. The examiner also noted that the Company failed to pay interest on overdue premium refunds.

Pre-Existing Conditions / HIPAA

Although this is of less concern now that American Pioneer is exiting the market, the examiner reviewed health applications to ensure that the Company is appropriately treating HIPAA eligible individuals in terms of creditable coverage and the prohibition against pre-existing conditions.

The examiner noted a few instances where HIPAA eligible individuals were required to sign pre-existing condition clauses. The examiner did not find any instances where individuals were denied claims based on these clauses, however, it is possible that a person did not submit a claim believing that the pre-existing condition clause was in effect.

Other Issues

The examiner did verify that all forms and rates being utilized by American Pioneer during the 1999-2000 timeframe were filed and approved. The Company has a conversion policy in force, and no exceptions were noted in this area. Finally, the examiner verified that the cancellation notices resulting from the Company leaving the major medical market were issued in a manner consistent with Florida Statutes.

Conclusion

The primary concern as a result of this examination is with American Pioneer's processing time and records organization. The Company needs to commit more resources, through its TPA, WorldNet Services, Inc., to ensure that claims are processed timely, unearned premiums are returned timely, and records can be quickly and accurately retrieved.

American Pioneer's holding company, Universal American Financial Corporation, owns the WorldNet Services, Inc., that administers American Pioneer's business. Therefore, American Pioneer should encourage its holding company to compel the TPA to commit additional resources to process claims and retain records.

The Company has stated to the Department that, as a result of the recommendations and findings of the examiner, the Company has taken steps to improve file control, security and management. The Company further asserted that it has implemented new premium refund and claims procedures to decrease the processing time and to pay interest when due.

SCOPE OF EXAMINATION

The Florida Department of Insurance, hereinafter referred to as the "Department" conducted a limited scope market conduct examination of American Pioneer Life Insurance Company, hereinafter referred to as the "Company." Independent contract examiner, Ann M. McClain, CIE, FLMI, AIRC, ACS, AIS, conducted the examination pursuant to Section 624.3161, Florida Statutes.

This examination covers the period from January 1, 1999 through December 31, 2000 and was conducted at the offices of WorldNet Services, Inc., a Florida licensed third party administrator for the Company, located at 411 North Baylen Street, Pensacola, FL 32501. The examination commenced on June 6, 2001, and the fieldwork concluded on August 10, 2001.

The purpose of this Target Market Conduct Examination was to determine if the Company's practices and procedures conformed 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 National Association of Insurance Commissioners (NAIC) Market Conduct Examiners Handbook. The NAIC handbook standards of a seven percent (7%) error factor for claim resolution procedures and a ten percent (10%) error factor for other procedures were given consideration and applied where appropriate.

The examination was limited to assessing compliance and overall procedures used by the Company to administer Major Medical, Dental, Long-term Care/Home Health Care, and Medicare Supplement plans sold to Florida residents between January 1, 1999 and December 31, 2000.

The primary areas reviewed were as follows:

- Notices of Cancellation and Premium Refunds;
- Claims Denials;
- Claims Handling;
- Policy Conversions;
- Consumer Complaint Handling; and,
- Other Issues.

INTRODUCTION

History

American Pioneer Life Insurance Company is a Florida domiciled stock life and accident & health insurance company licensed to transact insurance business in the State of Florida on August 8, 1961. The Company is a wholly owned subsidiary of Universal American Financial Corporation with a primary focus on the senior market and is licensed to conduct business in thirty-two (32) states and the District of Columbia.

Certificate of Authority

The Company is authorized to write the following lines of business in the State of Florida, subject to compliance with all applicable laws and regulations of Florida:

Life
Group Life and Annuities
Credit Life and Health
Credit Disability
Accident and Health

The Company, pursuant to Section 627.6425, Florida Statutes, notified the Department on December 22, 2000, that it was exiting the Major Medical market and would non-renew its Major Hospital and Major Medical policy forms in Florida beginning June 30, 2001. All forms and notices to policyholders have been filed and approved by the Department.

NOTICES OF CANCELLATION AND PREMIUM/NO PREMIUM REFUNDS

The examiner reviewed the Company's procedures with regard to notices of cancellation and premium/no premium refunds issued. A review was made of the procedures for entering cancellations, death and reinstatements into the Company's database (CAPSIL). There are no procedures given for calculating interest for refunds not paid within a reasonable period of time as required by Section 627.6043, Florida Statutes.

Premium Refunds

A random sample of one hundred (100) premium refund files, from a population of twelve thousand one hundred seventy-five (12,175), was selected for review. Of those requested, ninety-one (91) were actually reviewed, as nine (9) files could not be located.

The review included refunds paid for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss (death of insured) or Cancellation was received and the payment was made. All declinations for which premium was refunded followed the Company's underwriting guidelines.

Calendar Days	Number of Policies	Percentage
0 – 30	**58**	**64%**
31 – 60	**20**	**22%**
Over 60	**13**	**14%**
TOTALS	**91**	**100%**

Premium Refunds Not Required

A random sample of one hundred (100) "no premium refund" files, from a population of fifty-five hundred sixty-four (5,564), was selected for review. Of those requested, eighty-five (85) were actually reviewed, as fifteen (15) files could not be located.

The review included policy cancellations or lapses for which no refund was due for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between receipt of the dated request for cancellation or lapse and the notification to policyholder. Thirty-two (32) are identified as unknown with regard to processing time, as lapse notices were generated by the computer, but copies were not placed in the files. For the period of time reviewed, the computer database (CAPSIL) recorded only the date of policy lapse not the date the notice was mailed to the policyholder. The CAPSIL database has since been redesigned to record the date the notice of lapse is mailed to the policyholder in order to provide necessary tracking information.

Calendar Days	Number of Policies	Percentage
0 – 30	**24**	**28%**
31 – 60	**24**	**28%**
Over 60	**5**	**6%**
Unknown	**32**	**38%**
TOTALS	**85**	**100%**

There were no exceptions found in the sample reviewed.

Violations:

- **Section 624.318, Florida Statutes** – Failure to maintain records, as the Company has been unable to produce twenty-four (24) requested records. The examiner recommends that the Company review its document maintenance procedures. Based on this recommendation, the Company has taken immediate action to correct the file and claim maintenance process.
- **Section 627.6043(2), Florida Statutes** – Failure to pay premium refund in a timely manner and interest when due. Sixteen (16) refunds were not paid within 45 days. Although not required by statute, it is recommended that the Company

identify all policyholders for whom premium refunds were not made within 45 days, and that the Company pay interest on these late premium refunds.

CLAIMS DENIALS

An examination of claims denied for the Accident and Health lines of business was conducted to determine the Company's compliance with Florida Statutes for mandated coverage. The analysis provided is broken down by line of business.

Stratified Sampling

In addition, the examiner performed a stratified sample, by taking a second sample of claims paid in excess of 45 days. The purpose of this stratified sample is to try to determine any specific reasons for late claim payments.

The data in this stratified sample indicates that if a claim is not paid within 45 days, it is usually more than 60 days from the date the Proof of Loss is received before it is paid. As mentioned in the claims handling section of this report, this could indicate that the Company is engaging in post-claims underwriting.

Major Medical Claims Denied

A random sample of one hundred (100) denied claim files, from a population of fourteen thousand three hundred and twenty (14,320), was selected for review. Of the requested sample, eighty-eight (88) were actually reviewed, as twelve (12) documents could not be located.

The review included claims denied for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
0 – 30	**68**	**77%**
31 – 60	**10**	**11%**
Over 60	**10**	**11%**
TOTALS	**88**	**100%**

Major Medical Claims Denied After 45 Days

A random sample of fifty (50) claim files, from a population of fifteen hundred seventy-eight (1,578), was selected for review. Of the requested sample, forty-eight (48) were counted in the review; two (2) were duplicates. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
45 – 60	**5**	**10%**
Over 60	**43**	**90%**
TOTALS	**48**	**100%**

Dental Claims Denied

A random sample of fifty (50) denied claim files, from a population of two hundred ninety-four (294), was selected for review. Of the requested sample, forty-two (42) were counted in the review, eight (8) were duplicates within the same category as there were different portions of each claim that were denied. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
0 – 30	**25**	**60%**
31 – 60	**10**	**24%**
Over 60	**7**	**16%**
TOTALS	**42**	**100%**

Dental Claims Denied After 45 Days

A random sample of twenty-five (25) claim files, from a population of sixty-eight (68), was selected for review. Of the requested sample, twenty-three (23) claim records and policy files were reviewed, and two (2) other claim EOBs and policy files were reviewed, because the actual claim records were not located.

The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
45 – 60	**9**	**36%**
Over 60	**16**	**64%**
TOTALS	**25**	**100%**

LTC/HHC Claims Denied

A random sample of fifty (50) denied claim files, from a population of ninety-six (96), was selected for review. Of the requested sample, forty (40) were actually reviewed, as four (4) documents could not be located and six (6) records within the sample were duplicates.

The review included claims denied for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
0 – 30	**26**	**65%**
31 – 60	**3**	**8%**
Over 60	**11**	**28%**
TOTALS	**40**	**100%**

LTC/HHC Claims Denied After 45 Days

As there were only twenty-eight (28) claims identified as denied past the 45-day time period, all twenty-eight (28) were requested for review. Of the requested records, nineteen (19) were actually reviewed as one (1) record could not be located and eight (8) records within the sample were duplicates.

The review included claims denied for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
45 – 60	**2**	**11%**
Over 60	**17**	**89%**
TOTALS	**19**	**100%**

Medicare Supplement Claims Denied

A random sample of one hundred (100) denied claim files, from a population of eight hundred forty-five thousand two hundred twenty-nine (845,229), was selected for review. Of the requested sample, ninety-three (93) were actually review, as seven (7) documents could not be located.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. Other than one rescission based on a material misrepresentation, no exceptions were noted. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
0 – 30	**91**	**98%**
31 – 60	**1**	**1%**
Over 60	**1**	**1%**
TOTALS	**93**	**100%**

Medicare Supplement Denied Claims After 45 Days

A random sample of twenty-five (25) denied claim files, from a population of seven hundred thirty-three (733), was selected for review. Of the requested records, thirteen (13) were actually reviewed, as twelve (12) records could not be located.

The review included claims denied for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was denied.

Calendar Days	Number of Claims	Percentage
45 – 60	**4**	**31%**
Over 60	**9**	**69%**
TOTALS	**13**	**100%**

Violations:

- **Section 624.318, Florida Statutes** – Failure to maintain records, as the Company has been unable to produce thirty-eight (38) requested records.
- **Section 627.613(2) and (4), Florida Statutes –** Failure to notify within 45 days if a claim or a portion of a claim is contested or denied.
- **Section 627.6487(1)(b), Florida Statutes –** Imposing any pre-existing condition exclusion with respect to HIPAA coverage. One policy was identified as a HIPAA policy, but with exclusions attached. Another policy was identified as a replacement policy with 18 months continuous coverage and was stamped "No Pre-existing"; however, exclusions based on pre-existing conditions were placed

on the policy. **All HIPAA applicants signed the Company's addendum stating that the policy was subject to pre-existing condition exclusions. The procedures manual also instructs data entry clerks to "check to see if policy is HIPAA issue, issued with policy exclusion, (Relim) and if policy is contestable or past contestable period."**

Claim Number	Policy Number	Reason for Denial	At Issue
D0353021700	**OM0907259R**	**Re-priced and paid at reduced rates. (Note: The reason for denial is not the issue in this case.)**	**Policy should have been issued as a HIPAA policy as Certificates of Coverage were provided. Issued with pre-existing conditions exclusions and rate-up, which were not removed upon receipt of Certificates of Coverage.**
B9333000000	**OM8062262**	**Re-priced and paid at reduced rates. (Note: The reason for denial is not the issue in this case.)**	**Policy was a replacement coverage policy. Company stamped it as "No Pre-Existing". Was issued with exclusions.**

- **Section 627.6741(2)(c), Florida Statutes –** Replacing insurer shall waive any time periods applicable to pre-existing conditions. All replacement policies were stamped **"No Pre-existing Conditions."**
- **Section 627.6741(1)(b), Florida Statutes –** Cannot exclude coverage base on pre-existing conditions for individuals having continuous period of creditable coverage. Of those subjected to post-claim underwriting, three (3) were applicants leaving HMOs.

Exhibit A in the workpapers provides a time-study for claim denial processing.
Exhibit B in the workpapers provides documentation relative to the Company's actual denial of claims and documents post-claim underwriting practices.

CLAIMS HANDLING

The examiner reviewed of all procedures used in the processing of claims for Major Medical, Dental, Long-Term Care/Home Health Care, and Medicare Supplement policies to determine the Company's compliance with Florida Statutes and Florida Administrative Code.

All major medical claims are received in the offices of WorldNet Services, Inc. Claims subject to preferred provider repricing are then mailed or faxed to the appropriate PPO vendors. Procedure guidelines require a follow-up by phone or fax to PPO repricing vendors on any pending repricings outstanding for three (3) days or more. However, review by the examiner indicates that repricing was frequently the cause of delay in the payment of claims. The examiner reviewed procedures used to process major medical claims. There is no formal claims procedures manual. The procedures are described in a document identified as *Accident & Health Work Flow.* It should be noted, in a memorandum dated May 17, 1999 relative to an April 1999 audit, a recommendation was made regarding the necessity for a procedures manual specifically in the major medical claims department. The workflow description for major medical claims procedures does not include any time frames for processing claims or obtaining medical records from providers.

Dental claims are received in the offices of WorldNet Services, Inc., which processes all claims for payment according to policy provisions. Premium payments are collected and administered by Morgan-White Administrators, Inc., a Florida licensed third party administrator. The examiner reviewed the procedures used to process dental claims. There is no formal procedures manual. The procedures are described in a document identified as *Dental Claims Workflow*. While the processes described include a quality assurance time frame of 1 day for individual policy claims and 10 days for group policy

claims, there are no procedures described regarding processing through Morgan White should the premium information not be posted.

The Company experienced difficulties during the time period covered by this examination with the proper and timely recording of premiums received at Morgan White. This caused lengthy delays in the processing of claim payments, as status of policy had to be determined prior to such payments being made. This difficulty has been resolved and claim payments are currently being processed on a more timely basis.

Long-term Care/Home Health Care procedures require claim notifications be received through CHCS (Capitated Health Care Services) Care Advisors who perform case management duties of coordination of care between policyholder and provider. They provide WorldNet Services with the appropriate certification of care enabling payment of claims when received. During the time covered by the examination, WorldNet Services was providing the required letters of certification resulting in lengthy delays in claim payments. CHCS has been providing more timely certifications allowing for a more timely payment of claims.

There are established procedures for the processing of Medicare Supplement claims. During the contestable period, a policy is suspended if a claim is received containing a diagnosis code indicative of any condition related to the health questions on the application. This leads to the practice of post-claim underwriting that may prove harmful to policyholders, especially those who have replaced other coverage. It is acknowledged that the Company is exercising the right to investigate whether a material misrepresentation occurred on the application. However, during the period covered by this examination, no pre-approval underwriting was performed by either requesting an MIB or verifying with the family physician that the applicant has not been diagnosed with any of the conditions identified through the health questions on the application. Post-claim underwriting was the primary cause of claim payment exceeding the statutory time limits. An internal audit dated April 1999 also identified this as an area of concern. The Company currently receives approximately 77% of Medicare Supplement claims via

electronic tape, thereby eliminating paper claims. There is currently a high volume of duplicate claims as a result of providers sending in paper claims directly to the Company.

Medicare Supplement – Duplicates and Claim Denials

At this time, the electronic system does not automatically reject the claim if all covered charges were paid by Medicare resulting in a large number of claims identified as denials.

This occurs because Medicare Supplement payments are usually submitted via an electronic tape, and handled electronically by the Company. However, some providers *also* send paper copies. This creates duplicates.

The electronic system should be designed to "reject" the second claim because it is a duplicate. However, the system is not designed to do this. Instead the second claim is listed as a claim "denial." Thus, most of the Medicare Supplement claim "denials" are not denials in the traditional sense – they are duplicates.

This is slowing down the claims process as true claim denials are subject to notification requirements. Duplicates are not. American Pioneer's claims processing would work much smoother (and faster) if the computer were programmed to differentiate duplicates from true claim denials.

Claims review analysis is presented below by line of business for claims paid. Claims denied were covered in the preceding section.

Major Medical Claims Paid

A random sample of one hundred (100) paid claim files, from a population of forty-three thousand seven hundred and ninety-seven (43,797), were selected for review. Of the requested sample, ninety-five (95) were actually reviewed, as five (5) have not yet been located.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
0 – 30	**80**	**84%**
31 – 60	**8**	**8%**
Over 60	**7**	**7%**
TOTALS	**95**	**100.0%**

Major Medical Claims Paid After 45 Days

A random sample of fifty (50) claim files, from a population of forty-nine hundred sixty-seven (4,967), was selected for review. Of the requested sample, forty-three (43) were counted in the review, seven (7) records were not located. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
45 – 60	**17**	**40%**
Over 60	**26**	**60%**
TOTALS	**43**	**100%**

The Company did not pay interest on claims paid after 45 days.

Dental Claims Paid

A random sample of fifty (50) claim files, from a population of eleven hundred forty-seven (1,147), was selected for review. Of the requested sample, forty-six (46) were counted in the review, four (4) were duplicates within the same category as there were

different portions of each claim that were paid. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
0 – 30	**30**	**65%**
31 – 60	**12**	**26%**
Over 60	**4**	**9%**
TOTALS	**46**	**100%**

Dental Claims Paid After 45 Days

A random sample of fifty (50) claim files, from a population of one hundred four (104) was selected for review. Of the requested sample, thirty-three (33) were counted in the review, ten (10) were duplicates within the same category as there were different portions of each claim that were paid, and seven (7) were actually paid within the 45-day time limit. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
45 – 60	**12**	**36.4%**
Over 60	**21**	**63.6%**
TOTALS	**33**	**100.0%**

The Company did not pay interest on claims paid after 45 days.

LTC/HHC Claims Paid

A random sample of one hundred (100) claim files, from a population of ninety-nine hundred (9,900), was selected for review. Of the requested sample, ninety-six (96) were counted in the review, as four (4) records could not be located.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
0 – 30	**62**	**64.5%**
31 – 60	**16**	**16.7%**
Over 60	**18**	**18.8%**
TOTALS	**96**	**100.0%**

LTC/HHC Claims Paid After 45 Days

A random sample of fifty (50) claim files, from a population of seventeen hundred eighty-six (1,786), was selected for review. Of the requested records, forty-seven (47) were actually reviewed, as one (1) record could not be located and two (2) records within the sample were duplicates.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
45 – 60	**10**	**21.3%**
Over 60	**37**	**78.7%**
TOTALS	**47**	**100.0%**

The Company did not pay interest on claims paid after 45 days.

Medicare Supplement Claims Paid

A random sample of one hundred (100) paid claim files, from a population of 1,422,521, was selected for review. Of the requested sample, ninety-three (93) were actually reviewed, as seven (7) documents could not be located.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. No exceptions were noted. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
0 – 30	**93**	**100%**
31 – 60	**0**	**N/A**
Over 60	**0**	**N/A**
TOTALS	**93**	**100%**

Medicare Supplement Paid Claims After 45 Days

A random sample of fifty (50) claim files, from a population of sixteen hundred sixty-four (1,664), was selected for review. Of the requested records, forty (40) were actually reviewed, as ten (10) records could not be located.

The review included claims paid for the period from January 1, 1999 through December 31, 2000. The table below represents the number of days between the date that Proof of Loss was received and payment was made.

Calendar Days	Number of Claims	Percentage
45 – 60	**4**	**10%**
Over 60	**36**	**90%**
TOTALS	**40**	**100%**

Violations:

- **Section 624.318, Florida Statutes** – Failure to maintain records, as the Company has been unable to produce thirty-four (34) requested records.
- **Section 627.613(2) and (4), Florida Statutes –** Failure to notify within 45 days if a claim or a portion of a claim is contested or denied.
- **Section 627.613(2), (3) and (6), Florida Statutes** – Failure to pay a claim and interest when due. The Company has failed to include interest in the payment of overdue claims to insureds/providers.
- **Section 627.6419, Florida Statutes** – Failure to cover breast disease by use of an exclusion made part of the policy. Policy #OM8050936, Peter C. Coxhead, contains an exclusion for "**Any** disease or disorder of the breasts <u>including</u> complications arising from capsule formation, implants and/or scars." Although it is appropriate for the Company in this case to exclude "complications arising from capsule formation, implants and/or scars," it is not within state laws to exclude breast disease such as cancer. **This exclusion should be reworded.** It should be noted that this exclusion was added based on post-claim underwriting.
- **Section 627.6487(1)(b), Florida Statutes –** Imposing any pre-existing condition exclusion with respect to HIPAA coverage. One policy **(#OM8046195)** should have been identified as a HIPAA policy, and as such issued without exclusions attached.

Exhibit C in the workpapers provides documentation regarding time-study for claims paid processing.

Exhibit D in the workpapers provides documentation relative to the Company's actual payment of claims and documents post-claim underwriting practices.

POLICY CONVERSIONS

There are no written procedures or guidelines in place for handling conversions.

A random sample of fifty (50) conversion files, from a population of one-thousand and fourteen (1,014), was selected for review.

The review included conversions for the period from January 1, 1999 through December 31, 2000. A time study was not completed as the conversions had effective dates for either the previous renewal date or the next renewal date. The findings showed that five (5) policyholders requested changes in long-term care/home health care policies; forty-three (43) policyholders requested changes in Medicare supplement plans; and two (2) policyholders requested major medical conversions.

There were no violations or exceptions identified in the sample reviewed.

CONSUMER COMPLAINT HANDLING

American Pioneer Life does have a procedures manual in place for the processing of policyholder/agent complaints as required by Section 626.9541(1)(j), Florida Statutes. It should be noted that the current procedures manual for complaint handling does not include a timeframe within which complaints must be handled. Consumer complaints were merged from one system onto another in 2000. Information regarding whether the complaint was received from the Department of Insurance is not always accurate. The Company received complaints for a specified period totaled 48. Department of Insurance complaints totaled 210.

The Company has maintained a complete record of all complaints received during the period under review, January 1, 1999 through December 31, 2000, as required by Section 626.9541(1)(j), Florida Statutes.

DOI Complaints

A random sample of 40 complaints (approximately 20%), from a total population of 210 complaints filed with the Department of Insurance during the period of January 1, 1999 through December 31, 2000, was selected for review to determine the number of calendar days taken to resolve a complaint from the time of receipt to the final disposition. Only thirty-nine (39) files were actually reviewed, as the examiner excluded one complaint relative to an investigation into the Company's failure to file forms and rates. Calendar days included workdays, weekends and holidays. Results are shown in the table below.

Calendar Days	# of Complaints	Percentage
1 – 15	**31**	**79%**
16 – 30	**5**	**13%**
31 and over	**3**	**8%**
TOTAL	**39**	**100%**

Non-DOI Complaints

A random sample of 16 complaint (approximately 20%) files, from a total population of eighty (80) non-DOI complaints, during the period from January 1, 1999 through December 31, 2000, was reviewed to determine the number of calendar days taken to resolve a complaint from the time of receipt to the final disposition. Calendar days included workdays, weekends and holidays. Results are shown in the table below.

Calendar Days	# of Complaints	Percentage
1 - 15	**4**	**25%**
16 - 30	**1**	**6%**
31 and over	**11**	**69%**
TOTAL	**16**	**100%**

Several of the complaints that were reviewed in the complaint sample were due to the late payment of claims, and the failure to pay interest on those late claims.

Violations:

- **Section 627.613(2), (3) and (6), Florida Statutes** – Failure to pay a claim and interest when due. The Company has failed to include interest in the payment of overdue claims to insureds/providers. The list of policyholders includes but is not limited to:

  Cathleen Capito, Policy #OM8069743
  Catherine Strandberg, Policy #01-8048309-0
  Charlene Sutherland, Policy #M8044224
  James Haberman, Policy #OM0905502
  Adon Taft, Policy #3-7008156

- **Section 627.6043(2), Florida Statutes -** Failure to pay premium refund in a timely manner. It is recommended that the Company pay interest on premium refunds paid in excess of 45 days. The list of policyholders found in the complaint files that had claims paid late includes:

  E. Lois Bush, Policy #018046443
  Frances Higel, Policy #018054372

- **Section 627.6487(1)(b), Florida Statutes -** Imposing any pre-existing condition exclusion with respect to HIPAA coverage. The list of policyholders includes but is not limited to:

  Donald D. and E. Louise French, Policy #OM1027723

OTHER ISSUES

Form and Rate Filings

Pursuant to Consent Orders #98-006-HI-JM and #22262-97-C, the Company was instructed to properly and timely file forms and rates for Medicare Supplement and Long-term Care products marketed to Florida residents. The examiner reviewed all form and rate filing documents to verify compliance by the Company relative to the consent orders.

All forms and rates had been properly filed in 1999 and 2000. Filings were not reviewed for 2001 as it was not within the scope of this examination.

Market Conduct Investigation #1754

Based on a referral from the Division of Consumer Services, the above named Market Conduct investigation was opened on March 7, 2001. The examiner made a thorough review of all the documents requested regarding the complaint and have determined the following:

- The policy was issued as an "Out-of-State" group Concept 21 policy to REGIONS BANK AS TRUSTEE. The certificate provided the consumer is clearly stamped with language regarding the coverage being governed primarily by the law of a state other than the state of Florida.

- Group Underwriters, Inc. administers the group policy, a Florida licensed third party administrator. They do not function in the capacity under the ERISA statute.

- Carlton Hall enrolled in the plan on March 30, 1998; the policy was effective on April 15, 1998 replacing a Bankers Life group policy. This is a group of one and does not qualify for COBRA that applies to groups of twenty or more.

- The Concept 21 Schedule of Benefits provided the insured does contain appropriate conversion information on pages 64 and 65. Pages 57 and 58 of the policy explain Florida Statutes relative to continuation of health insurance coverage for employers with less than 19 employees. The policy contains all Florida mandated benefits.

- Although the sample conversion policy sent to Ms. Hall was incorrect, the policy actually issued to Ms. Hall had all of the mandated coverages and was similar to the Concept 21 plan that was discontinued by American Pioneer. Ms. Hall's conversion coverage was effective on February 1, 2001 per the request of Ms. Hall. It was terminated at Ms. Hall's request effective May 1, 2001.

- In Florida, there were 157 employers with 119 dependents enrolled in the Concept 21 plan when American Pioneer withdrew it from the market effective December 31, 2000. A letter dated September 30, 2000 was sent to all participating employers informing them of the Company's intent to withdraw the Concept 21 plan from the market. The letter also included information regarding contacting Group Underwriters, Inc., if they were interested in a conversion policy. It stated that they must apply and pay the first premium by January 31, 2001. Only one other employer requested information on the conversion policy and they were provided the correct policy.

- The Company's withdrawal notification from Concept 21 was dated September 30, 2000, and had a non-renewal date of December 31, 2000. This is in compliance with Department of Insurance Bulletin #97-010 that requires 90-day notification prior to non-renewal. The Company is not required to notify or receive approval from the Department when discontinuing a policy form in the state of Florida.

American Pioneer has properly filed its intent to withdraw from the entire major medical market, along with the required form notifications to be sent to policyholders. Letters

were sent to policyholders beginning February 2, 2001. With withdrawal from the major medical market in the State of Florida, the Company is not required to offer conversion policies, as they do not have any policies available that are being marketed in Florida. They do have to provide Certificates of Coverage.

This examiner did not find that either American Pioneer or Group Underwriters, Inc. failed to properly notify or provide conversion options to employers enrolled in the Concept 21 plan. It is therefore my recommendation that this investigation be closed with the option to reopen should additional information warrant further action.

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC) were followed in performing this Target Market Conduct Examination of American Pioneer Life Insurance Company as of December 31, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Ann M. McClain, CIE, FLMI,
AIRC, ACS, AIS
Independent Contract Examiner

The following findings were made in the report:

Page 10, 15, 24	Comply with §626.318, Florida Statutes, by retaining and producing all necessary records.
Page 10, 28	Comply with §626.6043(2), Florida Statutes, by paying all premium refunds in a timely manner.
Page 15, 24, 27	Comply with §627.613(2)&(3)&(4)&(6), Florida Statutes, by notifying consumers within 45 days if their claim or a portion of their claim is being contested or denied.
Page 15, 24, 28	Comply with §627.6487(1)(b), Florida Statutes, by not imposing pre-existing conditions exclusions with respect to HIPAA coverage.
Page 16	Comply with §627.6741(2)(c)&(1)(b), Florida Statutes, by waiving any time periods to applicable pre-existing conditions for replaced policies.
Page 24	Comply with §627.6419, Florida Statutes, by waiving any time periods to applicable pre-existing conditions for replaced policies. *[This is not cited as a violation, but the company is recommended to change language in the policy form to make this clear.]*