FLORIDA DEPARTMENT
OF
INSURANCE

TARGET MARKET CONDUCT REPORT
OF
FREEDOM LIFE INSURANCE COMPANY OF AMERICA, INC.
AS OF
DECEMBER 31, 2000

DIVISION OF INSURER SERVICES
BUREAU OF MARKET CONDUCT
LIFE AND HEALTH SECTION

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May 16, 2005

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

Dear Commissioner Gallagher:

Pursuant to the provisions of Section 624.3161, Florida Statutes, and in accordance with the Agreement for Market Conduct Services dated December 7, 2000, a Target Market Conduct Examination has been performed on:

Freedom Life Insurance Company of America, Inc.
110 West 7th Street, Ste. 300
Fort Worth, TX 76102

The examination was conducted at the Company's Main Administrative Office in Fort Worth, Texas. The report of such examination is herein respectfully submitted.

Sincerely,

Debora Finn, AIE, FLMI
Independent Contract Analyst

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Scope of Examination

The Florida Department of Insurance (Department) conducted a limited scope market conduct examination of Freedom Life Insurance Company of America, Inc, hereinafter referred to as Freedom. Independent contract analyst, Debora Finn, AIE, FLMI, conducted the examination pursuant to §624.3161, Florida Statutes.

This examination covers the period from January 1, 1999 through December 31, 2000 and was conducted at the administrative offices of Freedom located at 110 West 7th Street, Fort Worth, TX 76102. The examination commenced on January 8, 2001 and the fieldwork concluded on March 16, 2001.

The purpose of this Target Market Conduct Examination was to determine if the Company's practices and procedures used to administer accident and health lines of business 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 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 applicable.

The examination assessed compliance and overall procedures used by the Company to administer health plans sold to Florida residents between January 1, 1999 and December 31, 2000. The primary areas reviewed were:

- Producer Training and Complaint Administration;
- Notices of Cancellation and Premium Refunds;
- Claim Denials;
- Claim Handling;
- Consumer Complaint Handling; and
- Health Underwriting and Discrimination.

Introduction

History

Freedom Life Insurance Company of America (Freedom) is a Texas Insurance Corporation originally organized under the laws of the State of Mississippi. Freedom was incorporated on March 28, 1956 and commenced business on June 1, 1956.

Freedom Holding Company (FHC), a Kentucky corporation, previously owned 100% of the capital stock of Freedom. On May 31, 1996, National Foundation Life Insurance Company (NFL) acquired 100% of the capital stock of FHC. Since August 2, 1983, NFL has been a part of the holding company system of its immediate parent, Westbridge Capital Corporation (WBC).

On September 16, 1998, WBC filed for reorganization under Chapter 11 of the United States Bankruptcy Code. On March 24, 1999, WBC emerged from Chapter 11 as Ascent Assurance, Inc. (AAI). With the prior approval of the Texas Department of Insurance, NFL sent, effective September 30, 2000, 100% of the capital stock of FHC to AAI via a dividend. Additionally, Freedom changed its state of domicile to Texas effective September 30, 2000 under Article 1.38 of the Texas Insurance Code.

Effective January 29, 2001 and with the prior approval of the Texas Department of Insurance, FHC was dissolved and its 100% ownership of the capital stock of Freedom was transferred to FHC's former immediate parent, AAI, pursuant to a plan of dissolution adopted by the boards of directors of AAI and FHC.

The Company stated that two events occurred during the scope period of the examination that could have impacted Freedom's performance. On March 28, 2000, a class 4 tornado struck downtown Fort Worth. Although Freedom's home offices and records

were unharmed, the Company reports its offices were closed for eight days following the tornado.

The Company also went through a computer conversion that affected policyholder files and claims files. These two events affected 9 of the 24 months (38%) of the survey period.

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/Health;
- Credit Disability; and
- Accident and Health.

The only business written by the Company in Florida between January 1, 1999 and December 31, 2000, was accident and health.

Premium volume written in Florida increased by more than 300% between 1999 and 2000.

Producer Training and Complaint Administration

The examiner conducted a review of Producer Training and Complaint Administration to determine if the Company properly trained agents to accurately represent and sell approved products, and properly monitored and addressed consumer complaints against agents.

Freedom markets products sold in Florida through NationalCare Marketing (NCM), a Delaware corporation. NCM is a captive insurance agency, and 100% subsidiary of Ascent Assurance Inc., the parent company of Freedom.

NCM is responsible for recruiting and training agents to solicit applications for Freedom's association memberships and health plans sold in Florida. NCM does not provide any other administration or claim services to Freedom.

The only health plans marketed and approved for sale in Florida are individual health certificates sold to members of an out-of-state association group. Because this is the first market conduct examination of Freedom conducted by the Department, a brief narrative of the procedures and agreements between companies involved in the sale of association health plans is being included to provide clarity to the findings and recommendations made in this report.

The products are marketed in Florida primarily to self-employed small employers. In order to obtain coverage; interested individuals must become a member of the association group: Consumers Independent Association (CIA). The CIA is an unrelated, non-profit Missouri corporation, formed for the purpose of providing goods and services, including insurance programs to members who enroll and join the membership and pay required fees and dues.

Agreements

Consumers Independent Association - National Association Consultants "Consulting and Administration Agreement"

On March 1, 1998, the CIA entered into an agreement with National Association Consultants Inc. (NAC), a Missouri corporation, to provide consulting and administrative services. The consultation and administrative services include:

- Locating and soliciting new members;
- Enrolling new members; and
- Daily membership administrative functions.

Marketing Agreement Between National Association Consultants, Inc., and NationalCare Marketing, Inc.

The marketing agreement effective March 1, 1998 by and between NationalCare Marketing (NCM), and National Association Consultants (NAC) requires NCM to provide the following services:

- Develop, market and sell health, life and/or specialty insurance products to the membership of the Association;
- Telemarketing, telesurvey and telelead services to locate new Association members;
- Solicit and enroll new members into the Association;
- Design, develop and print the Association membership application, Association brochures and related material;
- Recruit, train and motivate agents to enroll new Association members and offer insurance products to Association members and prospective members;
- Collect or cause to be collected any and all initiation fees and dues pertaining to Association membership from a newly enrolled member and transmit same to NAC or such third party as NAC may designate.

Effective March 1, 1998, in accordance with the agreement, CIA dues of $15.00 per month were distributed to the following:

- National Association Consultants (NAC)
- National Foundation Life (For group accident policy issued to member)
- NationalCare Marketing (NCM)

Effective March 1, 1999, the parties amended the agreement to reflect an increase in monthly CIA dues from $15.00 to $17.50 per month. Effective May 1, 1999, the parties amended the agreement to include a one-time initiation fee in the amount of $40.00 per Association membership. Effective July 1, 2000, the parties amended the agreement to increase the membership initiation fee from $40.00 to $55.00.

Association Insurance Agreement – Freedom Life Insurance Company and National Association Consultants, Inc.

The agreement dated March 1, 1998, between Freedom and NAC authorizes Freedom to provide individually underwritten association group health insurance for members of the Association, and to collect all associated membership fees and dues from members on a monthly, quarterly, semi-annually or annual basis.

Pursuant to the Marketing agreement between NCM and NAC, all agents are recruited and trained by NCM. A review of marketing materials as well as agent training presentations indicate that an agent receives a general overview of the health plans available for sale to association memberships.

Examination procedures included a review of agent terminations to determine if any agent had been terminated for cause during the survey period. Additional procedures included a review of policyholder complaints to determine if consumer complaints against agents were properly reviewed and responded to by the Company.

The findings indicated there were no agents terminated for cause. Freedom reviewed and responded to complaints from policyholders about agent misrepresentation.

A review of new business files submitted by agents indicated numerous incomplete or incorrect answers to questions regarding other prior/existing health insurance coverage; and errors related to the association fees, dues and the policy administration fee. A further discussion of the findings noted while reviewing new applications files is included in the Health Underwriting and Discrimination section of this report.

The Company should ensure that all agents have been properly trained and made aware that questions on the application regarding prior or existing health coverage must be answered completely so the Company can make appropriate decisions concerning eligibility related to guaranteed coverage, excluded coverage, and /or imposition of pre-existing condition limitations.

Notice of Cancellations and Premium Refunds

The Examiner conducted a review of cancellations and premium refunds to determine if the Company had provided timely notification of policy cancellations and promptly returned the unearned portion of premiums to the policyholder in accordance with §627.6645, Florida Statutes.

Examination procedures included tests on a random sample of 50 cancelled policies. The sample was extracted from a data file of 3,085 policies cancelled between January 1, 1999 and December 31, 2000, which include 569 policies that were identified as "Not Taken" during the free-look period.

All of the files included in the sample were cancelled at the request of the policyholder. Freedom does not cancel policies for reasons other than: death; policyholder request; or non-payment of premium. Policies cancelled for non-payment of premium are lapsed policies, and between January 1, 1999 and December 31, 2000, there were 2,271 lapsed policies. None of the 2,271 lapsed policies were included in the data file listing of cancelled policies provided to the examiner.

Freedom accepts either written or verbal requests from a policyholder to cancel a policy. The verbal requests come from calls made to a toll free number in the Policy Owner Service department. The caller has the option of leaving a recorded message to cancel a policy, or they can speak directly to a customer service representative. The sample of cancelled policies indicated 90% of the cancellations resulted from either direct or recorded phone call messages and 10% were written requests from policyholders. Cancellation requests are processed on a daily basis; however the review of cancelled policies indicated a lag time of 1 to 10 days for requests to be processed and another 1 to 4 days for processed refund checks to be mailed. In order to compute processing times, the Examiner added 3 days to adequately account for the lag times noted during the

review of cancelled policies. The processing time between a policyholder's request to cancel and the date the refund was mailed is depicted in the table below.

Processing Time	**Number of Files**
1-20 Days	25
21-30 Days	7
31-60 Days	5
61-90 Days	1
Policies cancelled without refund	12
Total	50

The examination findings indicated Freedom processed 6 out of 50 (12%) cancellation refunds more than thirty days after the request was received in violation of §627.6645(4) Florida Statutes that reads in part:

> In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid.

The refunds processed more than thirty days after the cancellation request was received, are considered to have been untimely processed. The late processed refunds are listed in the following table:

Audit No.	**Policy Number**	**Cancel Date**	**Reason**	**Cancel Request Date**	**Refund Process Date**	**Process Time**
2441	52A0528820	4/17/2000	Not Taken	5/17/2000	6/16/2000	33
3062	52C0628640	7/14/2000	Not Taken	8/28/2000	9/30/2000	36
903	52A0347100	7/15/1999	Cancelled	8/2/1999	9/7/1999	39
2730	52A0538540	4/1/2000	Cancelled	6/6/2000	7/12/2000	39
3145	52C0629950	6/14/2000	Not Taken	8/1/2000	9/6/2000	39
3203	52C0651990	8/3/2000	Not Taken	8/1/2000	10/27/2000	90

The Company should initiate a corrective action plan that addresses prompt payment of unearned premium refunds for all cancelled policies.

Claim Denials

The examiner reviewed claim denials to determine if the Company appropriately denied claims in accordance with the terms of the policy and in consideration of any state mandated benefits. In addition, the examiner conducted time studies to assess compliance with the provisions outlined in the certificate and §626.9541, Florida Statutes, with an emphasis on subsection (1)(i), Unfair Claim Settlement Practices.

The data file of denied claims included 16,849 claims denied between January 1, 1999 and December 31, 2000. The processing times noted for denied claims indicated 8,503 out of 16,849 (50%) claims were processed more than 45 days after the received date; and 2,245 out of 16,849 (13%) claims were processed more than 120 days after the received date. The processing time ranged from 1 to 441 days. The audit sample included 67 randomly selected claim files.

While reviewing the sample of denied claims, it was determined that 4 out of 67 (6%) claims were inappropriately denied as follows:

Claim No. 000911471 was received on March 31, 2000 and denied on June 29, 2000, with the reason listed: policy was not in-force. Upon Examiner inquiry regarding the actual coverage dates of the policy, on February 16, 2001, Susan Meek, Claims Manager, provided additional information that included evidence the claim had been reprocessed on August 22, 2000 for payment.

Claim No. 001680230 was received on June 16, 2000 and denied on July 18, 2000, with the reason listed: daily benefit level exceeded. Upon Examiner inquiry regarding the policy benefits, on February 16, 2001, Susan Meek, Claims Manager, provided a written note indicating the claim had been processed incorrectly; and could not be processed until additional information was received. This particular claim is related to other pended claims that are being investigated for purposes of determining whether the medical

condition is an excludable pre-existing condition. On February 21, 2001 the reason for denial was changed to BI, with a text message that read "will consider upon receipt of previously requested information." As of February 21, 2001, the total processing time was 250 days, and a determination regarding payment or denial had not been made.

Claim No. 001784096 was received on June 26, 2000 and denied on November 21, 2000, with the reason listed: policy cancelled at policyholder request. Upon Examiner inquiry regarding the cancellation, on February 16, 2001, Susan Meek, Claims Manager provided a note advising the claim had been denied improperly because of a processing error that occurred during a system conversion. The claim was reprocessed for payment including interest on February 20, 2001.

Claim No. 003350713 was received on November 20, 2000 and denied on December 19, 2000, with the reason listed: lapsed policy. Upon Examiner inquiry regarding coverage dates, on February 16, 2001, Susan Meek, Claims Manager provided a note advising the policyholder's coverage had been re-instated with no lapse in coverage, and the claim was reprocessed for payment including interest on February 20, 2001.
In addition to finding inappropriately denied claims, it was determined that 39 of the 67 (58%) sample claims were processed more than 45 days after they were received. The "Time Payment of Claims" section outlined in the GPPO policy certificate, reads in part:

Indemnities payable under the Group Policy for loss will be paid immediately upon receipt of due written proof of such loss. For a continuing claim, you may ask us to pay the benefits monthly. Any balance remaining unpaid upon our termination of liability will be paid within forty-five (45) days after we receive due written proof of such loss.

Benefits not paid within such forty-five (45) day period will be considered overdue if the claim is not denied for valid and proper reasons within such forty-five (45) day period. We will pay interest on accrued benefits at the rate of one and one-half percent per month on the amount of the overdue claim until it is finally settled or adjudicated.

Because neither Freedom's policy certificate or claim procedures provided specificity regarding claim processing times with respect to denied claims submitted for an in-force contract, the examiner selected the processing standard of 45 days as provided in the certificate and in §627.613(2), Florida Statutes, which reads:

Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is being contested or denied, within 45 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

The following table lists the denied claims, of the 67 reviewed, that were processed more than 45 days after the received date.

Audit Item	Claim Number	Policy Number	Notify Date	Incur Date	Processed Date	Process Time
1	000141145	52A0422380	1/14/2000	11/15/2000	6/12/2000	150
3	000391542	52A0349610	2/8/2000	1/4/2000	8/8/2000	182
6	000542649	52A0479940	2/23/2000	2/8/2000	6/14/2000	112
7	000672433	52A0407720	3/7/2000	2/25/2000	5/30/2000	84
8	000733246	52A0424680	3/13/2000	2/18/2000	10/18/2000	219
9	000741958	52A0449460	3/14/2000	3/8/2000	6/5/2000	83
10	000742002	52A0473800	3/14/2000	3/3/2000	8/28/2000	167
11	000802667	52A0467500	3/20/2000	2/29/2000	10/12/2000	206
12	000842212	52A0396990	3/24/2000	2/17/2000	11/6/2000	227
13	000873589	52A0483850	3/27/2000	3/10/2000	6/19/2000	84
14	000881558	52A0357590	2/28/2000	12/7/1999	5/24/2000	86
15	000911471	52A0367470	3/31/2000	3/15/2000	6/29/2000	90
16	000971615	52A0505720	4/6/2000	3/20/2000	9/18/2000	165
17	001011830	52A0396850	4/10/2000	3/31/2000	6/15/2000	66
18	001012395	52A0470760	4/10/2000	3/15/2000	7/10/2000	91
19	001081522	52A0287620	4/17/2000	3/16/2000	6/29/2000	73
20	001102508	52A0420360	4/19/2000	4/11/2000	7/18/2000	90
21	001251758	52A0534570	5/4/2000	4/28/2000	7/19/2000	76
22	001373073	52A0446510	5/16/2000	4/18/2000	9/13/2000	120
23	001434225	52A0419950	5/22/2000	5/12/2000	9/13/2000	114
24	001532021	52A0453360	6/1/2000	5/23/2000	11/30/2000	182

Audit Item	Claim Number	Policy Number	Notify Date	Incur Date	Processed Date	Process Time
25	001574014	52A0379630	6/5/2000	5/23/2000	10/23/2000	140
26	001662019	52A0465670	6/14/2000	6/7/2000	11/2/2000	141
28	001682597	52A0296690	6/16/2000	6/7/2000	8/22/2000	67
29	001784096	52A0479800	6/26/2000	8/29/2000	11/21/2000	148
30	001853770	52A0284110	7/3/2000	3/20/2000	9/19/2000	78
32	002001708	52C0629710	7/18/2000	6/28/2000	10/17/2000	91
37	002430368	52A0490460	8/30/2000	2/28/2000	11/6/2000	68
47	002912462	52C0671890	10/17/2000	9/26/2000	12/19/2000	63
54	991522675	52A0257950	6/1/1999	3/19/1999	2/28/2000	272
55	991522776	52A0302260	6/1/1999	5/6/1999	11/17/1999	169
58	992361533	52A0327940	8/24/1999	8/12/1999	11/7/2000	441
59	992361534	52A0327940	8/24/1999	8/12/1999	11/7/2000	441
61	992703021	52A0326730	9/27/1999	8/9/1999	3/27/2000	182
62	992781798	52A0379610	10/5/1999	9/16/1999	12/18/2000	440
63	992932264	52A0326430	10/20/1999	10/7/1999	8/10/2000	295
65	993544665	52A0419790	12/20/1999	12/2/1999	12/4/2000	350
66	993550487	52A0287700	12/21/1999	12/7/1999	3/8/2000	78
67	993640715	52A0350920	12/30/1999	12/21/1999	5/19/2000	141

It was noted that 8% of the denied claims listed in both the data file and the audit sample were denied for reason code “BI”; which includes the following text message: “will consider upon receipt of previously requested information.” Prior to the denial of these claims, Freedom conducted a review of these claims to determine whether medical information provided in the application was accurate; and/or to assess whether the medical condition listed on the claim could be excluded as a pre-existing condition. In numerous instances, these particular denials were processed more than 120 days after the claim receipt date. §627.613(4) Florida Statutes requires an insurer to pay or deny a claim no later than 120 days after the receipt date. The following two examples present typical claim activity noted for claims treated as an investigated claim, and later denied with reason code “BI”.

Example 1	Description of Claim activity (Claim 001662019 processed 141 days)
6/14/00	Receive Claim
8/22/00	New Investigation commenced
9/8/00	Freedom Letter to policyholder, requesting completed claim form, and certificate of prior coverage

11/2/00	Policyholder and Provider receive Explanation of Benefits which indicates claim denied with reason code BI – will consider upon receipt of previously requested information. Prior to this date, the provider has not been notified or made aware the claim is being contested.
12/14/00	Freedom receives claim form, other insurance information from policyholder
12/14/00	Freedom requests medical records from referring provider
1/11/00	Freedom sends 2nd request for medical records to referring provider, and a letter to policyholder to advise of claim delay
1/15/01	Freedom receives medical records from referring provider
1/31/01	Freedom processes payment to provider.

Example 2	**Description of Claim Activity (Claim 992932264 processed 295 days)**
10/20/99	Receive claim from Provider
11/20/99	Claim sent to review unit for Investigation
11/29/99	Freedom sends policyholder request to complete claim form, and requests medical records from Provider
12/30/99	Freedom receives medical records from Provider
2/5/00	Freedom reviews medical records sent by Provider. Freedom determines diagnosis is post issue according to records, however patient history indicates condition began 6-mo prior. Freedom sends 2nd request to applicant to complete claim form.
3/9/00	Freedom requests medical records from Doctor listed on the policy application
4/12/00	Review of application Doctor's records indicates patient seen on 3/30/99 complaining of back pain. Claim sent to process denial for pre-existing
5/15/00	Freedom sends request to policyholder to complete Insured's Statement and provide a certificate of prior coverage
6/21/00	Freedom sends 2nd request to policyholder to remit certificate prior coverage

8/10/00	Freedom sends Explanation of Benefits to policyholder and Provider that claim is denied with reason code BI – will consider upon receipt of previously requested information.

In both of the examples cited above, it is evident that processing delays were as a direct result of Freedom failing to process claims expeditiously. In the first example, 86 days expired prior to Freedom requesting any medical records. In the second example, 31 days expired prior to Freedom requesting any medical records; and then an additional 70 days expired from the date records requested and received are reviewed and additional medical records are requested from the doctor listed on the claimant's policy application. Because Freedom individually underwrites all applications for insurance; had a review of medical records been completed at the time of application, it is likely the claim processing delays would have been avoided in both examples cited above. Additionally, in both examples cited, processing delays resulted because Freedom failed to request and obtain the applicant's Certificate of Prior Coverage at the time of application, extending the processing delay to research whether the claim could be denied based on a pre-existing condition.

It was determined that procedures used to process denied claims resulted in unnecessary processing delays, and that Freedom committed or performed these procedures with such frequency that this constitutes violations of the following unfair claim settlement practices:

- §627.9541(1)(i)(3)(c) Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §627.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide 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 or for the offer of a compromise;
- §627.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and

- §627.9541(1)(i)(3)(h) Florida Statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

Claim Handling

The Examiner performed a claims review to determine if Company procedures complied with Florida laws as well as with provisions of the policyholder's contract. The examiner conducted tests on random samples of both paid and pended claims. The tests included:

- Time studies to assess compliance with provisions outlined in the certificate and §626.9541, Florida Statutes.
- Verification that overdue payment included interest in accordance with policy provisions; and
- Verification that claim payments were made to the correct provider, at the correct amount, and on the date indicated in the claim history.

Paid Claims

The "Time payment of Claims" section outlined in Freedom's GPPO policy certificate reads in part:

Indemnities payable under the Group Policy for loss will be paid immediately upon receipt of due written proof of such loss. For a continuing claim, you may ask us to pay the benefits monthly. Any balance remaining unpaid upon our termination of liability will be paid within forty-five (45) days after we receive due written proof of such loss.

Benefits not paid within such forty-five (45) day period will be considered overdue if the claim is not denied for valid and proper reasons within such forty-five (45) day period. We will pay interest on accrued benefits at the rate of one and one-half percent per month on the amount of the overdue claim until it is finally settled or adjudicated.

Because neither Freedom's policy certificate nor claim procedures provided specificity regarding claim processing times, the examiner selected the processing standard of 45 days as provided in §627.613(2), Florida Statutes, and the policy certificate which reads:

Health insurers shall reimburse all claims or any portion of any claim from an insured or an insured's assignees, for payment under a health insurance policy, within 45 days after receipt of the claim by the health insurer. If a claim or a portion of a claim is contested by the health insurer, the insured or the insured's assignees shall be notified, in writing, that the claim is being contested or denied, within 45 days after receipt of the claim by the health insurer. The notice that a claim is contested shall identify the contested portion of the claim and the reasons for contesting the claim.

The data file of paid claims included 27,644 claims paid between January 1, 1999 and December 31, 2000. The processing times noted for paid claims included in the data file indicated 11,474 out of 27,644 (41%) claims were processed more than 45 days after the received date; and 2,181 out of 27,644 (7%) claims were processed more than 120 days after the received date. The processing time ranged from 1 to 441 days. The audit sample included 75 randomly selected claim files.

It was determined that 28 out of 75 (37%) claims were processed more than 45 days after they were received, and, 4 out of 75 (5%), of the late processed claims were processed more than 120 days after they were received. File documentation provided no evidence of required interest payments on those claims paid more than 45 days after they were received.

The following table lists the claims paid more than 45 days after they were received and the interest due amounts computed as prescribed in §627.613(6), Florida Statutes.

Item	Audit No.	Claim No.	Notify Date	Processed Date	Benefit Paid	Process Time	Interest Due
1	1,103	000351242	02/04/00	03/21/00	$44.91	46	$0.01
2	1,175	000383125	02/07/00	04/06/00	$87.34	59	$0.34
3	1,987	000592993	02/28/00	04/20/00	$52.39	52	$0.10
4	2,105	000601683	02/29/00	10/13/00	$63.90	227	$3.19
5	2,260	000631102	03/03/00	06/13/00	$65.00	102	$1.02
6	2,406	000681974	03/08/00	06/19/00	$27.73	103	$0.44
7	2,417	000682084	06/28/00	08/23/00	$185.00	56	$0.56

8	2,523	000700940	03/10/00	05/23/00	$35.98	74	$0.29
9	2,976	000811124	03/21/00	08/04/00	$65.00	136	$1.62
10	4,457	001101569	04/19/00	07/24/00	$101.62	96	$1.42
11	4,712	001153171	04/24/00	07/17/00	$35.98	84	$0.38
12	4,794	001154234	04/24/00	07/25/00	$8.46	92	$0.11
13	4,892	001162544	04/28/00	07/20/00	$31.01	83	$0.32
14	5,266	001233213	05/02/00	07/31/00	$60.00	90	$0.74
15	5,868	001313900	05/10/00	11/06/00	$65.70	180	$2.43
16	5,917	001320616	05/11/00	07/13/00	$35.00	63	$0.17
17	6,095	001362682	05/15/00	09/12/00	$260.00	120	$5.34
18	6,365	001401310	05/19/00	07/13/00	$40.00	55	$0.11
19	6,610	001441594	05/23/00	07/13/00	$88.50	51	$0.15
20	6,991	001514200	05/30/00	08/23/00	$65.04	85	$0.71
21	7,462	001591587	06/07/00	07/31/00	$45.00	54	$0.11
22	7,714	001642275	06/12/00	09/11/00	$140.00	91	$1.76
23	8,553	001741279	06/22/00	10/23/00	$423.00	123	$9.04
24	12,016	002210907	08/08/00	11/02/00	$25.00	86	$0.28
25	14,597	002490233	09/05/00	10/31/00	$216.00	56	$0.65
26	24,462	992002040	07/19/99	09/22/99	$97.16	65	$0.53
27	26,113	993051240	11/01/99	02/15/00	$103.16	106	$1.72
28	27,426	993562283	12/22/99	03/22/00	$125.91	91	$1.59

Pended Claims

The sample of pended claims included 50 randomly selected files from the Company's pended claims inventory.

It was determined that 28 out of 50 (56%) of the pended claims were processed more than 120 days after the received date. The majority of claims included in the inventory were pended to investigate conditions that could be denied for a pre-existing condition. Many of the claims were pended when they were received because the claimant had an existing claim under investigation. That is, once an investigation has been initiated, all subsequent claims submitted on behalf of the claimant will automatically pend and become part of the investigation. The procedures used to conduct an investigation result in long processing delays.

Additionally, the procedures used by Freedom to investigate claims did not include notice to the insureds or the providers that a claim was being contested and did not provide notice of the reason(s) for contesting the claim. In most of the files reviewed, Freedom sent a claim form request letter to the insured advising a claim had been received, and additional information was needed to process the claim. In the letters, Freedom typically requested:

- Claimant's statement;
- Certificate of prior health coverage; and
- Patience while information requested from the provider was received and reviewed.

It was noted, that each time medical records were requested and received from a provider, it usually generated an additional request for records from a different doctor, prolonging the investigation. Generally, Freedom did send a delay letter to the insured advising that additional information had been requested. However, these delay letters often failed to identify the claim or claims being investigated, and none provided notice the claim was being contested or why it was being contested. None of the claims indicated the provider was notified of a contested claim. In a majority of the files reviewed, additional delays were encountered when medical record requests were made to doctors not involved in the initial claim. This resulted in Freedom soliciting additional records a second or third time. In all cases wherein a claim was submitted by an ancillary service provider such as a laboratory or x-ray services facility, and an existing investigation was being conducted, no notices were sent to advise of a claim delay, or that a claim was being contested. These claims were simply put aside to be processed upon completion of the investigation.

The following table lists the claims that were pended more than 120 days after they were received.

Audit No.	Policy No.	Claim No.	Notified Date	Process Date or O/S Pended Date	Process Time
5	52A0341970	000461280	02/15/00	1/19/2001	339
12	52A0435680	000951828	04/04/00	3/1/2001	331
6	52A0379780	001233126	05/02/00	1/19/2001	262
9	52A0424290	001390515	05/18/00	3/1/2001	287
31	52A0540430	001591526	06/07/00	2/27/2001	265
15	52A0478350	001802045	06/28/00	2/19/2001	236
37	52C0635670	002031759	07/21/00	3/1/2001	223
33	52A0544400	002140186	08/01/00	2/5/2001	188
25	52A0531850	002300505	08/17/00	1/18/2001	154
16	52A0478350	002440562	08/31/00	3/1/2001	182
17	52A0485180	002520114	09/08/00	3/1/2001	174
40	52C0638410	002551747	09/11/00	2/12/2001	154
24	52A0505590	002620549	09/18/00	1/22/2001	126
34	52A0580260	002632224	09/19/00	2/12/2001	146
38	52C0635670	002690808	09/25/00	3/1/2001	157
19	52A0493080	002781168	10/04/00	2/8/2001	127
3	52A0318360	002840850	10/10/00	3/1/2001	142

It was determined that procedures used to process denied claims resulted in unnecessary processing delays, and that Freedom committed or performed these procedures with such frequency that this constitutes violations of the following unfair claim settlement practices:

- §627.9541(1)(i)(3)(c) Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §627.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide 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 or for the offer of a compromise;

- §627.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and
- §627.9541(1)(i)(3)(h) Florida Statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The Company should pay interest on all late claims and provide the Department evidence that such interest has been paid. The Company should review the applicable statutes and develop policies and procedures that facilitate the timely review of claims. These policies and procedures should include a provision that assures interest is paid on those claims not paid within the statutory time frames. These policies and procedures are to be submitted to the Market Conduct Section of the Florida Department of Insurance for review.

The Company should immediately process claims in the pended inventory that are more than 120 days old, and to submit a corrective action plan to the Market Conduct Section of the Florida Department of Insurance. This plan should address the long processing delays experienced by claims put in a pended status.

Consumer Complaint Handling

The examiner conducted a review of consumer complaints to determine if the Company had procedures in place to record and resolve complaints in a timely manner.

Upon reviewing complaints, the examiner determined that Freedom maintains and processes complaints received from the Department separate from those received directly from policyholders and other non-Department sources.

The examiner conducted tests on a sample of complaints received from both the Department and other non-Department sources. A majority of complaints were inquiries related to claim delays, and or denials. As previously stated in the claims section of this report, Freedom conducts a lengthy investigation to determine whether a claim can be denied based on a pre-existing condition. Many of the complaints received were inquiries related to claims that were in the process of being investigated. Examination findings indicated Freedom had appropriately resolved complaints according to the terms of the consumers policy, however processing times for complaints received from non-Department sources took considerably longer than those received from the Department. The table below presents the processing times noted for consumer complaints.

Complaint Source	1-60 Days to Process	61-219 Days to Process
Department	100%	0%
Non-Department	42%	58%

The examiner determined that Freedom failed to acknowledge and act promptly upon communications with respect to claims, violating §627.9541(1)(i)(3)(c), Florida Statutes.

The Company should initiate a corrective action plan that addresses the timely processing of consumer complaints.

Health Underwriting and Discrimination

The examiner conducted a review of health underwriting practices to determine if the Company had based underwriting decisions on established guidelines that conformed to Florida laws and that such procedures were followed uniformly.

The examiner conducted tests on policy applications received and denied between January 1, 1999 and December 31, 2000. Separate random samples of new policies issued and denied application files were included in the review to determine if the Company had appropriately processed applications.

As was previously discussed in the Producer Training and Complaint Administration section of this report, agents had submitted numerous applications with incomplete or incorrect answers to questions regarding existing/prior insurance coverage. Question 8 on the application asks for current health insurance coverage that may be replaced upon issuance of a Freedom policy; Question 25 (a-f) asks questions about creditable coverage and requests a certificate of coverage. In response to question 8, several of the applications that indicated existing coverage would be replaced, however, these same applications failed to include answers to prior/existing coverage information asked for in question 25 (a-f), and none included the requested certificate of coverage. Because Freedom issues individual health certificates, it is imperative that an applicant's eligibility status be determined at the time of application in order to satisfy Florida law regarding guaranteed availability of individual health insurance coverage, and the imposition of pre-existing conditions. Section 627.6487, Florida Statutes reads in part:

(1) Subject to the requirements of this section, each health insurance issuer that offers individual health insurance in this state may not, with respect to an eligible individual who desires to enroll in individual health insurance coverage:

(a) Decline to offer such coverage to or deny enrollment of, such individual; or

(b) *Impose any preexisting condition exclusion with respect to such coverage. For purposes of this section, the term "preexisting condition" means, with respect to coverage, a limitation of benefits relating to a condition based on the fact that the condition was*

present before the date of enrollment of such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(2) For purposes of this section:

(a) "Health Insurance Issuer" and "Issuer" mean an authorized insurer or a health maintenance organization.

(b) *"Individual health insurance" means health insurance, as defined in s. 627.6561(5)(1)2., which is offered to an individual, including certificates of coverage offered to individuals in this state as part of a group policy issued to an association outside this state, but the term does not include short-term limited duration insurance or excepted benefits specified in s.624.6561(5)(b) or, if the benefits are provided under a separate policy certificate, or contract, the term does not include excepted benefits specified in s.627.6561(5)(c), (d), or (e).*

(3) For purposes of this section, the term "eligible individual" means an individual:
(a)1 For whom, as of the date on which the individual seeks coverage under this section, the aggregate of the periods of creditable coverage, as defined in s. 627.6561(5) and (6), is 18 or more months; and

2.a. Whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan, or health insurance coverage offered in connection with any such plan; or

b. Whose most recent prior creditable coverage was under an individual plan issued in this state by a health insurer or health maintenance organization, which coverage is terminated due to the insurer or health maintenance organization becoming insolvent or discontinuing the offering of all individual coverage in the State of Florida, or due to the insured no longer living in the service area in the State of Florida of the insurer or health maintenance organization that provides coverage through a network plan in the State of Florida.

The examiner determined that Freedom's underwriting process failed to include verification of an applicant's existing and/or prior insurance information and eligibility status, which may have resulted in violations of §627.6487, Florida Statutes as follows:

- Inappropriate denial of coverage;
- Imposition of pre-existing condition limitations; and/or
- Inappropriate benefit exclusions via policy amendments.

The Company should initiate a corrective action plan that includes modification of existing underwriting procedures to address verification of creditable coverage for all health plan applications.

The Company should conduct an audit to verify creditable coverage for all in-force policies to determine whether any of the applicants satisfied the 'eligible individual' criteria outlined in §627.6487, Florida Statutes, and to remove any inappropriate exclusion riders. The Company should conduct a claims audit on all policies found to have been issued with an inappropriate exclusion rider and re-process any claims that may have included denials for benefits that were inappropriately excluded.

The Company should conduct a claims audit on all policies found to have been issued to an 'eligible individual' and re-process all claims that denied benefits for a pre-existing condition.

Denied Applications

The denial notices for 34 of 50 (68%) of the denied applications indicated the applicant had been denied coverage based on the following:

- Medical records provided by Doctor;
- Information provided in phone interview; or
- Results of blood or urine profile.

The Company stated that it did not give more specific reasons as it did not want to violate an individual's privacy rights. The Company stated it would divulge a more specific reason upon request by the applicant.

Consumer Recoveries

The Examination resulted in recoveries to Florida consumers in the amount of $370.83.

Possible future recoveries consist of indeterminable amounts for unpaid interest on claims processed more than 45 days after they were filed, and additional amounts that may be due to consumers for benefits that may have been inappropriately denied.

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 Freedom Life Insurance Company of America, Inc., as of December 31, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

Debora Finn, AIE, FLMI
Independent Contract Analyst

Findings and Recommendations

The following findings were made in the report.

Page 6-9 Producer Training and Complaint Administration

The Company should ensure that all agents have been properly trained and made aware that questions on the application regarding prior or existing health coverage must be answered completely in order for the Company to make appropriate decisions concerning eligibility related to guaranteed coverage, excluded coverage, and or imposition of pre-existing condition limitations.

Page 10-11 Notice of Cancellations and Premium Refunds

The examination findings indicated Freedom processed 6 out of 50 (12%) cancellation refunds more than thirty days after the request was received in violation of §627.6645(4) Florida Statutes that reads in part:

> In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid.

The Company should initiate a corrective action plan that addresses prompt payment of refunds for all cancelled policies.

Page 12-18 Claim Denials

It was determined that 4 out of 67 (6%) claims were inappropriately denied. The processing error ratio indicates the inappropriately denied claims were processing errors that did not result in a violation.

It was determined that procedures used to process denied claims resulted in unnecessary processing delays, and that Freedom committed or performed these procedures with such frequency that this constitutes violations of the following unfair claim settlement practices:

- §627.9541(1)(i)(3)(c) Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §627.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide 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 or for the offer of a compromise;
- §627.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and
- §627.9541(1)(i)(3)(h) Florida statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The Company should initiate a corrective action plan that addresses late processed claim denials.

Page 19-24 Claims Handling

It was determined that procedures used to process claims resulted in unnecessary processing delays, and that Freedom committed or performed these procedures with such frequency that this constitutes violations of the following unfair claim settlement practices:

- §627.9541(1)(i)(3)(c) Florida Statutes – Failing to acknowledge and act promptly upon communications with respect to claims;
- §627.9541(1)(i)(3)(f) Florida Statutes – Failing to promptly provide 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 or for the offer of a compromise;
- §627.9541(1)(i)(3)(g) Florida Statues – Failing to promptly notify the insured of any additional information necessary for the processing of a claim; and
- §627.9541(1)(i)(3)(h) Florida statutes – Failing to clearly explain the nature of the requested information and the reasons why such information is necessary.

The Company should ensure appropriate payment of interest on late paid claims processed between January 1, 1999 and December 31, 2000, and submit a corrective action plan that addresses late processed claims.

The Company should immediately process claims in the pended inventory that are more than 120 days old, and to submit a corrective action plan to the Market Conduct Section of the Florida Department of Insurance that addresses the long processing delays experienced by claims put in a pended status, and show that they have been paid.

Page 25 <u>Consumer Complaint Handling</u>

It was determined that Freedom failed to acknowledge and act promptly upon communications with respect to claims, violating §627.9541(1)(i)(3)(c), Florida Statutes.

The Company should initiate a corrective action plan that addresses the timely processing of consumer complaints.

Page 26-28 Health Underwriting and Discrimination

It was determined that Freedom's underwriting process failed to include verification of an applicant's existing and/or prior insurance information and eligibility status, which may have resulted in violations of §627.6487, Florida Statutes as follows:

- Inappropriate denial of coverage;
- Imposition of pre-existing condition limitations; and/or
- Inappropriate benefit exclusions via policy amendments.

The Company should immediately draft a corrective action plan that includes modification of existing underwriting procedures to address verification of creditable coverage for all health plan applications.

The Company should immediately conduct an audit, to verify creditable coverage for all in-force policies to determine whether any of the applicants satisfied the 'eligible individual' criteria outlined in §627.6487, Florida Statutes, and to remove any inappropriate exclusion riders.

The Company should conduct a claims audit on all policies found to have been issued with an inappropriate exclusion rider and re-process any claims that may have included denials for benefits that were inappropriately excluded.

The Company is further directed to conduct a claims audit on all policies found to have been issued to an 'eligible individual' and re-process all claims that denied benefits for a pre-existing condition.