FLORIDA DEPARTMENT OF INSURANCE

TARGET MARKET CONDUCT REPORT OF EXAMINATION

OF THE

LIFE AND HEALTH INSURANCE COMPANY OF AMERICA

AS OF JUNE 30, 2000

DIVISION OF INSURER SERVICES

BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT REVIEW
MARKET CONDUCT SECTION

Jack McDermott, CIE
Examination Coordinator
200 E Gaines St
Tallahassee, FL 32399

April 10, 2002

Honorable Tom Gallagher
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32399-0300

Dear Commissioner Gallagher:

Pursuant to the provisions of **Section 624.3161, Florida Statutes**, and in accordance with your Letter of Authority and the resolutions adopted by the National Association of Insurance Commissioners (NAIC), a Target Market Conduct Examination has been performed on:

Life And Health Insurance Company Of America
2200 Walnut Street
Philadelphia, PA 19103

The examination was conducted at the Company's home office at 2200 Walnut Street, Philadelphia, Pennsylvania. Lou Penn, CIE, preformed the fieldwork.

Sincerely,

Jack McDermott, CIE
Examination Coordinator
Florida Department of Insurance

Table Of Contents

EXECUTIVE SUMMARY

Introduction

The Department called an examination of Life & Health of America (the "Company") due to the number of complaints received and pursuant to an investigation of internal replacement of policies. The examination focused primarily on long-term and home health care policies.

Claims

The Company admitted to making claim handling errors in 17 of the 31 (55%) files reviewed. Of primary concern is the lack of written guidelines and standards concerning the adjudication of home health care claims, specifically the amount of time the Company authorized for accomplishing the Activities of Daily Living (ADLs). The Company relied solely on the opinion of its Medical Consultant who merely noted the number of hours "allowed" for a particular claim. Furthermore, the Company did not immediately notify the insured that the claim would be reviewed for concurrence with the insured's attending physician regarding the amount of time that would be allowed to accomplish the ADLs. This lack of notification does not provide the insured a timely opportunity to control his or her out-of-pocket expenses nor to quickly appeal the Company's decision.

The Company overturned its initial benefit allowance in three of the 10 claims in the sample files that had ADL reductions. Additionally, the Company admitted to denying covered benefits in three of the sampled files, paying the incorrect UCR in three, failing to pay or deny claims within 45 days in six, and failing to promptly respond to an insured's communication in two. The

Company should improve its claim handling performance by implementing policies and procedures that ensure prompt and consistent claim adjudication. The Department further recommends that the Company have an independent medical consultant audit all claims that had benefits reduced during the scope period of the examination for medical appropriateness based on the diagnosis and age of the insured. To the extent the audit identifies inappropriate benefit reductions, reparations should be made to the appropriate party. This audit should be made available to the Department for review.

Complaints

The majority of DOI complaints (45 of 76) were on the Company's long-term/home health care policies. Premium issues accounted for 26 of the 76 complaints, agent issues were involved in 16 and claims issues in 20. The Company increased benefit allowances in two of the eleven complaints that involved benefit amount differences.

The examiner reviewed a sample of 25 complaint files from a total population of 233 complaints. Nine of the sampled complaints involved premium issues. In five of the nine, the Company failed to return the unearned premium within 45 days after the receipt of the insured's request to cancel.

Replacements

Prior to the examination, the Department had opened an investigation due to a consumer's complaint that the Company was replacing policy form LHA-64 with form LHA-5100, which excluded the home making services covered in LHA-64. The Department and the examiner

requested lists of Florida policyholders who converted from LHA-64 to LHA-5100 during the years 1996 – 1999, and lists of Florida agents who sold these products. The Company has stated they are unable to provide these list due to upgrading their computer systems for Y2K compliance. The Company should develop and provide the requested lists to the Department.

Advertising

The examiner cited the Company for failure to include the words "insurance policy" on its brochures. The Company has notified the Department that it plans to re-file the brochures.

Rate Certification

The examiner found that the Company submitted the required annual rate certifications in conflict with a letter the Company provided the Department that stated the Company "… did not file such certifications." Irrespective of the contradiction, the Company should furnish the Department with current Annual Rate Certifications as per the requirements of Section 627.410(7).

INTRODUCTION

Life and Health Insurance Company of America, is hereinafter generally referred to as "the Company" when not otherwise qualified. The Florida Department of Insurance, is hereinafter generally referred to as "the Department" when not otherwise qualified.

The last Market Conduct Examination was conducted by Donald R. Koelker of the Florida Department of Insurance as of December 31, 1991.

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.

Statistical information is included in this examination report. The National Association of Insurance Commissioners' Examination Handbook standards of 7% error ratio for claim resolution procedures and 10% error ratio for other procedures are applied. Any error appearing to be a pattern or a general business practice has been included in this examination report.

Certificate of Authority

The Certificate of Authority issued by the Florida Department of Insurance authorizes the Company to write the following lines of business:

400 Life
410 Group Life
450 Accident and Health

The only area of business examined in this target exam was the accident and health line of business.

COMPANY PROFILE

History and Organization

The Company was incorporated under the laws of the State of Pennsylvania on July 14, 1902, as the Keystone Aid Society and the present name of the Company was adopted in 1979. The Company commenced operations in the State of Florida on June 28, 1984.

The Company is currently licensed in twenty-six (26) states plus the District of Columbia and the U.S. Virgin Islands. The Company markets its products through an independent agent force that, as of December 4, 2000, numbered approximately 290 in the State of Florida.

During the period of the examination, the Company sold the following types of policies in the State of Florida:

HEALTH

LHA-5100 (FL)	Home Health Care
LHA-AIMC(LTC) FL	Stand-Alone Nursing Home Policy
LHA-CQLTC(98) FL	Qualified LTC Policy (Comprehensive)
LHA-NCQLTC(98) FL	Non-Qualified LTC Policy (Comprehensive)
LHA-6000 (FL)	SHIELD Hospital Indemnity
LHA-70 (FL)	Cancer Expense Plan
LHA-51 (FL)	Disability Income
LHA-61 (FL)	Home Service Hospital Indemnity

LIFE

LHA-WL (94) FL	Traditional Whole Life - Time for Certainty
LHA-MWL (94) FL	Modified Whole Life - Time for Certainty
L86-100	Traditional Whole Life (Easy Life)
LHA-35-95 (MD)	Individual Whole Life
LHA-35-95-FP (MD)	Family Plan Whole Life
LHA-99-95 (MD)	Individual 20 Pay/Life Paid at 65 Policy
LHA-99-95-FP (MD)	Family Plan 20 Pay/Life Paid at 65 Policy
LHA-38-95 (MD)	Modified Benefit Whole Life Policy

Melvyn K. Miller is the President and Chairman of the Board of the Company.

SCOPE OF THE EXAMINATION

The examiner conducted the target market examination to ensure compliance with the Florida insurance statutes and regulations that are embodied in the following departmental standards:

AUDIT PROGRAM

- Claims should not be improperly denied for mandated benefits or coverage provided in the policy contracts.

- Claims are handled in a timely manner in accordance with policy provisions, and state law.

- The Company has adequate complaint handling procedures in place.

- The Company complies with Florida Statutes and regulations regarding health insurance replacement and conversion.

- The Company's and agent's advertising materials and training materials ensure that products sold to consumers are fairly represented and suitable.

- The Company properly trains agents to accurately represent and sell products, and properly monitors consumer complaints involving agents.

- The Company complies with Florida Statutes regarding health insurance annual rate certification filings.

The examination covered the period of the Company's operation in the State of Florida from January 1, 1997, through June 30, 2000; including any material transactions and/or transactions and events occurring subsequent to the examination period.

The examiner conducted his review in accordance with the procedures provided by the (1) Florida Departmental Examination Guidelines, (2) National Association of Insurance Commissioners, and (3) The Insurance Regulatory Examiners Society. Sample sizes were chosen based on procedures developed by the National Association of Insurance Commissioners. After each file was reviewed, a criticism form was delivered to the Company for comment. The Company was advised of the examiner's finding as contained in each criticism form and was asked to respond. For each finding, the Company was asked to agree, disagree or otherwise justify the Company's action as noted on the criticism form. Error ratios were based on Florida's Penalty Rule (FAC 4-142.011) to determine if the violation is subject to an error ratio, and if so, whether the violation exceeds the established error ratios: 7 % claims; 10 % for all other areas.

CLAIM REVIEW

The examiner, and subsequently the Department, reviewed claims submitted by thirty-one policyholders to determine if Company procedures comply with Florida statutes and regulations as well as the provisions of the insured's contract. The files were reviewed to ascertain overall compliance with the audit standards to ensure that the Company did not improperly deny coverage for mandated benefits, and that claims were handled in a timely manner in accordance with policy provisions, and state law. In addition to the above standards, the following tests were conducted on the sample:

- Verification of the timely payment, denial, and interest due on claims so that it was in accordance with Section 627.613, Florida Statutes.
- Verification that the Company accepts the use of the Uniform Health Insurance Claim Form per Section 627.647, Florida Statutes and FAC 4-161.004.
- Verification that the Company is complying with the unfair claim settlement practices in Sections 626.9541 (1)(i)(1) through (3)(a) to (h), Florida Statutes.
- Verification that the Company is providing the reason for denial of an insurance application in accordance with Section 627.4091, Florida Statutes.
- Verification that the Company is maintaining adequate claim file documentation as required by Section 624.318, Florida Statutes.
- Verification that the Company is providing its insureds with the claim forms and necessary information to file a claim in accordance with Section 627.611, Florida Statutes.
- Verification that the Company is making timely refunds of premium in the event of the death of a claimant as required by Section 627.6043 (2), Florida Statutes.
- Verification that the Company complies with all requests for information during the course of the examination as required by Section 624.418 (2)(b), Florida Statutes.

Time Study of Paid Claims

The Company provided the examiner with a list of claims paid during the scope period. The Company processed 2,061 claims from 323 policyholders, 2,051 claims were coded as paid (even if a check was not issued), and ten claims were coded as denied. The Department compared the received date to the check/response date to determine the timeliness of the Company's response. Of the 2,061 claims submitted, 214 (10.4%) were not paid, denied or responded to within 45 days. This percentage exceeds the established error ratio of 7% and is a violation of Section 627.613(2), failure to pay or deny claims within 45 days of receipt. Exhibit A lists the policy and claim numbers where claim payments exceed 45 days; the amount of interest due is $3,620.30. Failure to pay interest on overdue claims is a violation of Section 627.613(6), Florida Statutes. The Company should perform an audit on the identified claims and remit payment of interest due.

Claims Examination Overview

The examiner, and subsequently the Department, reviewed the files of thirty-one policyholders who submitted claims during the examination period of January 1, 1997 to June 30, 2000. (Two of the policyholders did not appear on the paid claims list referenced above: one was properly and timely denied and the second was submitted in June 2000 and paid in September 2000.) The examiner made a general observation that the Company was deficient in organization regarding payments, correspondence, and documentation for all necessary claim information. Each file had to be reconstructed to determine the overall chain of events relating to the essential functions of claim processing. The Company indicated that the condition of the files was due to the large turnover of claim managers and claims personnel, and the installation of a new computer system. The Company's Claim Department consisted of a Claims Manager and three (3) additional claim personnel.

The claims manual provided by the Company revealed a lack of comprehensive claims organization and uniform procedures. Although not officially part of the claims manual, the

company required the General Counsel to personally review and approve all claim payments over $500.

The availability and production of records was difficult since the majority of the claim records were computerized and read-only access was not provided to the examiner. This caused the examiner delays in conducting the examination. As a result, the Company agreed to an extension of the time budget anticipated for the examination.

Company Claim Practices

Claim Payment Reductions - In 10 of the 31 files reviewed (32%**)**, the Medical Director or other Company claim personnel reduced benefit amounts either by denying coverage for homemaker services (an excluded benefit on some policies) or reducing the amount of time provided to the insured to accomplish the Activities of Daily Living (ADLs). The Medical Director did not explain the basis of his time allowance for each specific case; the files merely indicated the number of hours that had been "allowed." Furthermore, there was no evidence in the files that the Medical Director contacted the physician, home health care provider or insured about the level of care needed at the outset of the claim. In six of the 10 files, the Company's initial benefit decision remained unchanged at the end of the examination. In consideration of the lack of documentation from the Company's Medical Director justifying these benefit reductions, the lack of ADL adjusting guidelines or standards, and the fact that these policyholders (Claim Reviews 15, 17, 19, 27, 28, and 32) incurred out-of-pocket expenses ranging from $440 (Claim Review 15) to $23,000 (Claim Review 27), an audit of these files should done by an independent medical consultant. The audit should determine if the decisions were medically appropriate and based on accepted standards of case management for ADLs based on the age of the claimant and the diagnosis. It would be advisable for the Company's Medical Director to record the justification for any reduction in benefits as the absence of such justification may infer arbitrary and unsupported adjustments.

Claim Payment Readjustments - In three of the 10 files with benefit reductions, the Company later agreed to increase the allowance for the ADLs:

1. Claim Review 21: The 80-year old policyholder had been hospitalized for 80 days due to complications from surgery. The attending physician authorized eight hours of home care beginning July 23, 1999. The homecare provider's daily records document assistance with bathing, transfers, walking, toileting and eating; daily homemaker services consisted of maintaining a safe environment, making beds, and cleaning the kitchen. The Company initially paid for only two hours of care. In March, the Company increased the ADL allowance to four hours per day and made the adjustment retroactive to July 23. The policyholder received the eight hours of care per day throughout the period of care and incurred $10,488.50 in expenses as a result of the benefit reduction. An independent medical consultant should audit this file for the medical appropriateness of the Company's authorization. Reparations should be effected as appropriate.

2. Claim Review 25: This policyholder needed care for just three days. The Company initially paid for two of the four hours of care for these three days but overturned the decision, paying the full amount of the claim plus interest.

3. Claim Review 26: The 92 year old policyholder received assistance with bathing, dressing, ambulation, and toileting. The attending physician authorized seven hours of care from October 28, 1998 to December 28, 1998. The Company initially authorized two hours of care. In February 1999, the Company increased the allowance to six hours and made the adjustment retroactive to October 28. The policyholder exhausted the twelve-month benefit period. The insured incurred a minimum of $569 of out-of-pocket expenses due to the October to December reduction (the insured received $66 of the $75 her daily maximum and received seven hours of care at $11 per hour). An independent medical consultant should audit this file for the medical appropriateness of the Company's authorization. Reparations should be effected as appropriate.

The Company failed to adopt and implement standards for the proper investigation of claims with respect to the benefit reductions in violation of Section 626.9541 (1)(i)(3)(a), Florida Statutes. The Company made material misrepresentations with the intent of effecting settlement

of claims on less favorable terms than provided in, and contemplated by, the policy, in violation of Section 626.9541(1)(i)(2), Florida Statutes.

Denying Claims without Conducting a Reasonable Investigation - The Company admitted in emails to the examiner that claims personnel denied covered benefits in Claim Reviews 4, 13 and 24. Claim Review 24 was paid during the course of the claim, Claim Review 13 was paid with interest during the exam, and Claim Review 4 was to be paid plus interest subsequent to the exam ($550.10 plus $55.01). The Company denied claims without conducting a reasonable investigation based upon available information in violation of Section 626.9541(1)(i)(3)(d), Florida Statutes.

Claim Payments at the Usual and Customary Rate (UCR) – The Company admitted in emails to the examiner that claims personnel paid the incorrect UCR rate in Claim Reviews 22, 27 and 29. Claim Review 27 was corrected during the course of the claim. The Company agreed to pay an additional $2,448 plus interest on Claim Review 22. The Company owes the provider for Claim Review 29 an additional $1,035.60 plus $10.36 in interest. The Company failed to adopt and implement standards for the proper investigation of claims with respect to the benefit decisions in violation of Section 626.9541(1)(i)(3)(a), Florida Statutes.

Late Payments and Denials – The Company admitted in emails to the examiner that claims personnel failed to pay or deny claims within forty-five days in Claim Reviews 8, 11, 17 19, 23 and 24. Failure to pay or deny claims with 45 days of receipt is a violation of Section 627.613(2), Florida Statutes. Failure to pay interest on overdue claims is a violation of Section 627.613(6), Florida Statutes.

Prompt Response to Claims Communication - The Company admitted in emails to the examiner that it failed to respond to an insured's claim in a timely manner in Claim Reviews 15 and 18. In Claim Review 14, there is no documented response to the insured's son's letters or phone calls. In Claim Reviews 16 and 28, there are no responses to the insureds' letters. Failure to acknowledge and act promptly upon communication with respect to claims is a violation of Section 926.9541(1)(i)(3)(c), Florida Statutes.

Maintenance of Adequate Documentation – The Company was inconsistent in date stamping correspondence placed in the file because multiple documents did not have any date stamp. This makes it difficult for the Company to establish compliance with several statutes relating to timely payment of claims, and timely correspondence to the insured. The Company should implement policies and procedures to establish clear and uniform date stamping for all correspondence received by the Company.

Timely Refund of Unearned Premium – In two of the files reviewed, the Company did not promptly return the unearned premium to the insured. In Claim Review 23, the Company returned the unearned premium 103 days after request for cancellation. In claim review 24, the company returned unearned premium 84 days after the request for cancellation. Failure to make a timely refund of unearned premium is a violation of Section 627.6043(2), Florida Statutes. The examiner recommends that the Company implement procedures to improve the timeliness of refunds of unearned premium.

Notification of the insured of any additional information necessary for the processing of a Claim – In Claim Review 5, the claimant sent a letter dated April 4, 1997 stating that she was in an auto accident and nursing home pursuant to an injury on September 20, 1996. The letter sought advice on premiums due and also provided notice of claim. The Company responded regarding the necessary payment of premium, but failed to include a date. In an email to the examiner, the Company admitted that the adjuster should have sent a claim form for completion. Failure to promptly notify the insured of additional information necessary to process a claim is a violation of Section, 626.9541(1)(i)(3)(g), Florida Statutes.

Provide Specific Reasons for Denying an Application - In Claim Review 1, the applicant was denied reinstatement of her policy. The Company did not provide a reason for this denial to the applicant. The Executive Vice President, Gretta Wilson, advised that the Company would not provide this information to the examiner due to “privacy considerations.” Failure to provide the specific reason for denial to the applicant is a violation of Section 627.4091(1), Florida Statutes.

Provide the right of secondary addressee and provide reinstatement for unintentional nonpayment – In all of the policy files reviewed, the insured was not notified of his or her right to have the policy reinstated if non-payment was due to cognitive impairment or the loss of functional capacity. The Executive Vice President advised that the applications and the policy forms used were in violation of Section 627.94073(2) & (3), Florida Statutes. The was due to the fact that the application and policy forms had not been revised in accordance with the requirements mandated by this statute, effective on July 1, 1996. In an email to the examiner, the Company agreed to determine if the policy in Claim Review 1 had lapsed for either of these reasons. Failure to provide the right of secondary addressee and reinstatement is a violation of Section 627.94073(2) & (3).

Claim Review Summary

The Company admitted to committing claim handling errors in 17 of the 31 (55%) files reviewed. This level of errors indicates a systemic problem in the adjudication of claims. The Company should perform a comprehensive evaluation of its claim handling policies and procedures, as well as the training of its claims personnel, to ensure that policyholders' claims are processed in an efficient and timely manner, and in accordance with governing regulations and policy provisions. The Company should develop written guidelines to ensure a consistent review and application of time allowed for ADLs, or consider contracting with a case management company with expertise in this field. Furthermore, the Company should implement procedures to immediately notify insureds upon receipt of a bill or proof of loss, that their bills are being reviewed and may be reduced. Evidence of the review and implementation of standards for the proper investigation of claims should be submitted to the Department.

COMPLAINTS

DOI Complaints

The Department received 76 consumer complaints, excluding duplicates, during the scope period of the examination: 45 (59%) were long-term/home health complaints, 18 (24%) were life insurance, four (6%) were disability income, four (6%) were major medical, three (4%) were industrial and small value, and 1 (1%) was Medicare supplement.

Twenty-six of the complaints (34%) related to premium issues and refunds: 14 of the 26 questioned the timeliness of the refund and 7 questioned the amount of the refund. Sixteen complaints referenced the agent's handling, and twenty related to claim payments and denials. Seven consumers had questions related to policies that the Company assumed from Conger Life.

Of the 45 long-term/home health related complaints, 11 questioned the benefit reductions allowed by the Company to accomplish the ADLs, or questioned the amount of time the Company applied towards home making services. The Company later increased the benefit allowance in two of the eleven reductions (18%).

Complaint Sample Review

The examiner reviewed a sample of 25 complaint files from a total population of 233 complaints. Of these complaints, six were DOI complaints and 19 were complaints made directly to the Company. The purpose of this review was to determine if the Company was utilizing complaint handling procedures and applying these procedures uniformly, and that the Company responded to these complainants in a timely manner consistent with Section 626.9541(1)(j), Florida Statutes. No violations will be cited.

Nine (9) of the 25 complaints reviewed pertained to the return of the insured's unearned premium. In five of the nine instances, the Company failed to return the unearned premium by

45-days after receipt of the request to cancel. Failure to promptly return unearned premium is a violation of Section 627.6043(2), Florida Statutes. The Company paid $249.10 for interest due in Complaint Review 18. The Company should make interest payments on Complaint Reviews 5, 10, 22, and 23, and review all other cancellations where interest on unearned premium is applicable.

REPLACEMENTS

Prior to commencement of this target exam, the Florida Department of Insurance initiated an investigation to determine if the Company was intentionally recommending that Home Health Care policy form LHA-64 be replaced with new Health Home Care policy form LHA-5100 (FL), which excluded homemaker benefits included in the LHA-64 policy. The investigation was opened due to a consumer complaint. Misrepresentation for the purpose of inducing the conversion of any insurance policy is a violation of Section 626.9541(1)(a)(6), Florida Statutes.

Pursuant to the investigation, the Department requested the Company to provide the Department with copies of completed applications written on Florida residents who converted their LHA-64 policies to LHA 5100 from 1996 to 1999, and a list of Florida agents who carried out the conversions. The Company responded that it was unable to provide either list due to upgrading the Company's computer hardware and software systems for Y2K compliance. The Company failed to respond to a subsequent letter from the Department relative to these records. The Company failed to produce these documents to the examiner on site. Failure to produce documents in their possession or control at the request of the Department is a violation of Section 624.318(2), Florida Statutes.

While researching the investigation on-site, the examiner obtained a copy of a letter from agent Mike McLaughlin to the Company's General Counsel dated December 27, 1999. The agent wrote that "…back in 1994 (apparently), Jon (Jon Miller, the vice president of sales) sent us a list of several LHA-64 Policyholders that he wished to have converted to LHA-5100. To the best recollection, this was my only meeting with Mrs. …" (the subject of the investigation). This letter supports the inference that the Company was targeting the replacement of policy form LHA-64.

The Company should provide the Department with the lists of policyholders and agents referenced in paragraph two of this section. The Department reserves the right to re-open an investigation based on the information provided.

ADVERTISING REQUIREMENTS

The examiner reviewed the Company's advertising materials to ascertain compliance with advertising standards regarding company and agent advertising, training materials, and products sold to consumers. The review was to determine that such advertising materials were fairly represented and suitable.

The sales brochures referenced below were provided to the Company's sales force for use in their sales and solicitation of business. The Company has not done any newspaper or other insurance publication advertising or used these brochures in any other manner. The following brochures were reviewed:

Brochure Numbers	Policy Form Numbers
LHA-5000-1 (BR)	LHA-5000 (FL)
LHA-5001 BR (1)	LHA-5001 (FL)
LHA-5100 (10/94)	LHA-5100 (FL)
LHA-5101 (8/93)	LHA-5101 (FL)
LHA-LTC(AIM) 4/96 FL	LHA-LTC-AIMC (FL)
LHA-CQUAL 698 (FL)	LHA-CQLTC (98) (FL) & LHA-NCQLTC (98) (FL)

Form LHA-5000-1 (BR), Form LHA-5100 (10/94),
Form LHA-5101 (8/93), Form LHA-LTC(AIM) 4/96 FL

These forms do not include the word ***insurance policy*** after the name of the plan. The advertisement does identify this plan as an insurance policy in the MIB Disclosure Notice, but this is not sufficient to comply with FAC 4 -150.005(3)(a) and (b). Subsequent to the examination, the Company informed the Department that it plans to re-file the brochures to include the words "Insurance Policy."

AGENT TRAINING

The examiner reviewed a list of 59 terminated agents to determine if the Company utilized form DI4-39 to notify the Department of these terminations within the required time frame. No discrepancies were found. The examiner also reviewed Company records to determine if the Company properly trained its agents to accurately represent and sell products, and properly monitored consumer complaints against agents.

In the information provided by the Company for review, the Company stated that, "The Company does not have a formal training program to train its agents and relies on whatever training is provided and required by the state." On September 6, 2000, the Company provided a listing of dates when company representatives visited Florida for training purposes. During these visits, products and Company procedures were reviewed. The dates were as follows:

Date	Training
1997	Four (4) training sessions
1998	Five (5) training sessions
1999	Three (3) training sessions
2000	One (1) training session

The examiner was unable to validate that consumer complaints were addressed in the training of the Company's agents. The Company should implement policies and procedures to document the content of any and all agent training sessions.

RATE CERTIFICATION AND FRAUD STATEMENT

The examiner asked the Company to provide all copies of annual rate certifications for each of the Company's products sold in Florida during the examination scope period to ensure compliance with Section 627.410(7), Florida Statutes, that requires the filing of annual rate certifications, or rate change for all health insurance products. The examiner also reviewed Company forms to determine compliance with Section 817.234(1)(b), Florida Statutes, to verify the use of the required fraud statement in forms.

The examiner concluded that the Company submitted the required annual rate certifications to the Department and has received the Department's acknowledgement. The Company includes the required Fraud Statement on all policy applications used in the State of Florida during the examination scope period.

Under a separate investigation, Florida File # 1383, initiated by the Department prior to the Market Conduct Target Examination, the Department obtained information from the Company, that implied the Company was using an application, LHA-APP(HHC)-FL (approved 10-15-93), that does not include the Fraud Statement required per Section 817.234(1)(b), Florida Statutes.

Within this same investigation, Florida File # 1383, the Department requested copies of the company's Annual Rate Certifications for the years 1996, 1997, 1998, and 1999 for policy form LHA-64, and for years 1994, 1995, 1996, 1997, 1998, and 1999 for policy form LHA-5100(fl), required to be filed per Section 627.410(7), Florida Statutes. The company's response stated in part, "—we did not file such certifications."

Because the evidence in the above two paragraphs might be considered circumstantial, no penalties will be assessed. However, the Company should:

a) Review application LHA-APP(HHC)FL, and all other applications used by the Company for compliance with Section 817.234(1)(b), Florida Statutes and the Florida Administrative Code.

b) Furnish the Department with rate filings or current Annual Rate Certifications (ARC's) for policy forms LHA-64 and LHA-5100(fl) as per the requirements of Section 627.410(7), Florida Statutes.

CONSUMER RECOVERIES

As a result of this target market conduct examination, the Company made the following payments to Florida policyholders, during the examination

Claim/Policy Review #	Recovery
2	$2.00
13	$437.14
25	$126.63

Complaint Review #	Recovery
18	$249.10
Total	$814.87

FINDING AND RECOMMENDATIONS

The following findings were made in this report

Page No.	Description
13, 16	The Company failed to pay, deny or respond to claims within 45 days in violation of Section 627.613(2), Florida Statutes.
13, 16	The Company failed to pay interest on overdue claims in violation of Section 627.613(6).
14, 15	The Company should have an independent medical consultant audit all claims that had benefits reduced during the scope period of the examination for medical appropriateness.
15, 16	The Company failed to adopt and implement standards for the proper investigation of claims in violation of Section 626.9541(1)(i)(3)(a), Florida Statutes.
15, 16	The Company made material misrepresentations with the intent of effecting settlement of claims on less favorable terms than provided in, and contemplated by, the policy, in violation of Section 626.9541(1)(i)(2), Florida Statutes.
16	The Company denied claims without conducting a reasonable investigation based on available information in violation of Section 627.9541(1)(i)(3)(d), Florida Statutes.
16	The Company failed to acknowledge and act promptly upon communications with respect to claims in violation of Section 626.9541(1)(i)(3)(c), Florida Statutes.

17, 20	The Company failed to make a timely return of unearned premium in violation of Section 627.6043(2), Florida Statutes.
17	The Company failed to promptly notify the insured of additional information necessary to process a claim in violation of Section 626.9541(1)(i)(3)(g), Florida Statutes.
18	The Company failed to provide the right of secondary addressee and reinstatement in violation of Section 627.94073(2) & (3), Florida Statutes.
18	The Company should perform a comprehensive evaluation of its claim handling policies and procedures, and the training of its claims personnel, to ensure that policyholders' claims are processed in an efficient and timely manner, and in accordance with policy provisions.
21	The Company failed to produce documents in their possession or control at the request of the Department in violation of Section 624.318(2), Florida Statutes.
21	The Company should provide the Department with the lists of policyholders who replace policy form LHA-64 with policy form LHA- 5000 or LHA-5100 during the years 1996 – 1999, and a list of the agents who sold those products.
22	The Company failed to include the words "insurance policy" after the name of any of the Company's health insurance products in violation of FAC 4-150.005(3)(a) & (b).
25	Furnish the Department with rate filings or current Annual Rate Certifications for policy forms LHA-64 and LHA-5100(fl) as per requirements of Section 627.410(7), Florida Statutes.

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners were followed in performing this target market conduct examination of the Life and Health Insurance Company of American as of December 6, 2000, with the due regard to the Insurance statutes and regulations of the state of Florida.

Respectfully submitted:

_____

Jack McDermott, CIE
Examination Coordinator

JEB BUSH
GOVERNOR

TOM GALLAGHER
CHIEF FINANCIAL OFFICER

CHARLIE CRIST
ATTORNEY GENERAL

CHARLES BRONSON
COMMISSIONER OF
AGRICULTURE

DEPARTMENT OF FINANCIAL SERVICES
FINANCIAL SERVICES COMMISSION
OFFICE OF INSURANCE REGULATION

KEVIN M. MCCARTY
DIRECTOR

MARCH 11, 2003

CERTIFIED: RETURN RECEIPT REQUESTED

MELVIN KENNETH MILLER, PRESIDENT
LIFE & HEALTH INSURANCE COMPANY OF AMERICA
220 W. Germantown Pike
Plymouth Meeting, PA 19462-4000
NAIC Company Code: 77887

Re: Market Conduct Examination
PERIOD ENDING JUNE 30, 2000

Dear Mr. Miller:

Enclosed please find a copy of the filed final report of examination completed by the Office of Insurance Regulation, formerly known as the Florida Department of Insurance.

If the examination report affects your substantial rights, you may request a hearing pursuant to Chapter 120, Florida Statutes. Further information is provided in the enclosed Notice of Rights.

Since Life and Health of America is suspended from writing insurance in the State of Florida, the fine of $18,000 normally assessed in conjunction with this report will be held in abeyance at this time. If Life & Health of America or any subsequent entity formed via merger/acquisition or name change reapplies to write insurance in the State of Florida, the company would first have to enter into a consent order to pay the fine and address all outstanding issues contained within this report. The Office would afford the company rights at that time. No further action is required by the company at this time.

Your continued cooperation in concluding this matter will be appreciated.

[redacted]
Jack McDermott, CIE, CPM, FLMI, ARM

TREASURER • INSURANCE COMMISSIONER • FIRE MARSHAL

JACK MCDERMOTT, CIE, CPM, FLMI, ARM • L & H EXAM COORDINATOR • BUREAU OF MARKET CONDUCT
200 EAST GAINES STREET • TALLAHASSEE, FLORIDA 32399-4210 • (850) 413-5083 • TELECOPIER (850) 922-5680
E-Mail: mcdermottj@doi.state.fl.us
Affirmative Action / Equal Opportunity Employer