OFFICE OF INSURANCE REGULATION

TARGET MARKET CONDUCT REPORT

OF

LEGION INSURANCE COMPANY

AS OF

October 31, 2001

BUREAU OF MARKET CONDUCT

Thomas L. Ballard, CIE, CFE, FLMI, ALHC, ASF
Examiner-in-Charge

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March 11, 2003

Honorable Tom Gallagher
Chief Financial Officer
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 the Agreements for Market Conduct Services a Target Market Conduct Examination has been performed into the affairs and activities of:

Legion Insurance Company
One Logan Square, Suite 1400
Philadelphia, PA. 19103

NAIC Group Code 1192
NAIC Company Code 24422

The Accident and Health portion of the examination was conducted at their Home Office in Philadelphia, PA. The Property and Casualty portion of the examination was conducted at the company offices located at 111 E. Kilbourn Avenue, Milwaukee, WI., and at the office of one of their Third Party Administrators, Nu-Main, 8200 W. Sunrise Blvd., Plantation, FL.

Robert D. Flege, CIE, CFE, AIRC, ARA, FLMI, ALHC, ASF, LPCS, Independent Contract Analyst, conducted the Accident and Health portion of this exam.

The report of such examination is herein respectfully submitted.

Sincerely,

Thomas L. Ballard
CIE, CFE, FLMI, ALHC, ASF
Examiner-in-Charge

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Office of Insurance Regulation (OIR) (formerly known as the Florida Department of Insurance), selected Legion Insurance Company for a target market conduct examination for the period January 1, 2001 to October 31, 2001 based on issues related to complaints received relative to both Property and Casualty and Accident and Health lines of business.

The review of files determined that the Company is not maintaining a complaint log to include all complaints from consumers and others. The only complaints recorded are those received from the Division of Consumer Services with the Department of Financial Services.

Violations found in other areas confirmed the need for an examination and corrective action on the part of the Company.

Property and Casualty

This examination revealed that the Company has not complied with Section 627.4131, Florida Statutes, by placing a telephone number and the purpose for this number on their policies. This violation was noted in the last examination.

In the cancellation review, it was evident the Company is not sending cancellation notices when the cancellation was requested by the insured. In four (4) of the files reviewed the Company could not produce proof of mailing.

In the review of policies, it was clear the Company was not including the necessary PIP options form or the UM-UIM acceptance/rejection form. However, in about half of the files reviewed these forms were present. The Company was inconsistent in the use of the PIP option forms depending on which TPA wrote the business.

The claims review indicated two areas of concern to the examiner. The first involves the Company not securing salvage titles on vehicles as required by Section 319.30, Florida Statutes. The examiner noted two (2) files in error and the Company disagreed with both.

The second area concerns the issue of paying the full actual cash value for the insured unit when faced with a total loss. The Company does not pay sales tax on the destroyed unit until it is replaced and another claim is made to receive those funds. However, the Company does not verify if the unit is replaced, and in some cases, when the policyholder produces evidence of payment or replacement of the unit, that information is not accepted and the owner is sent to obtain other information before payment is made.

Accident and Health

Claims Processing

A review of the complaint files, denied claim files, paid claim files and data analysis of the eleven thousand three hundred eighty-six (11,386) accident and health claims paid and denied during the time frame of the examination indicate violations involving failure to act promptly in the payment and denial of claims. Ninety-six percent (96%) of the paid claims were not paid within forty-five (45) days of receipt. Fifteen percent (15%) of the denied claims were not denied within sixty (60) days of receipt. This failure to act promptly with respect to claims payment and denials has been committed with such frequency as to indicate a general business practice and therefore in violation of Section 626.9541(1)(i)(3)(c), Florida Statutes.

HIPAA

The Company does not guarantee issue policies to HIPAA eligible individuals and rejects applications received from applicants who do not meet the Company's standard underwriting guidelines. Applicants who meet the standard underwriting guidelines are issued coverage subject to a ten percent (10%) surcharge to compensate for the waiver of the pre-existing condition exclusion provisions in the contract for the first twelve (12) months of coverage. The Company maintains that they are not a guarantee issue HIPAA carrier, are not required to be a HIPAA carrier, and therefore all applications are underwritten on an individual basis. This is in violation of Florida Statutes.

SCOPE OF EXAMINATION

The Office of Insurance Regulation (OIR), hereinafter referred to as the "Office" or "OIR" conducted a limited scope market conduct examination of Legion Insurance Company, hereinafter referred to as the "Company." Independent contract examiners, Thomas L. Ballard, CIE, CFE, FLMI, ALHC, ASF and Robert D. Flege, CIE, CFE, AIRC, ARA, FLMI ALHC, ASF, LPCS, conducted the examination pursuant to Section 624.3161, Florida Statutes. Mr. Ballard conducted the Property & Casualty portion of the exam and served as Examiner-in-charge (EIC). Mr. Flege conducted the Accident and Health portion of the exam.

This examination covers the period from January 1, 2001 to October 31, 2001 and was conducted at the offices of Legion Insurance Company in Philadelphia and Milwaukee and the offices of one of their third party administrators, Nu-Main, located in Plantation, FL. The examination commenced on December 3, 2001, and concluded on February 16, 2002.

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

Procedures and conduct of the examination were in accordance with OIR's Field Examination Guidelines. The examination assessed compliance and overall procedures used by the Company to administer health insurance in-force policies and property and

casualty policies. The examination reviewed claim handling procedures and resolution of complaints covering the period from January 1, 2001 to October 31, 2001.

The primary areas reviewed were as follows:

- Claims Processing,
- Forms and Rates,
- Policy Conversions,
- HIPAA,
- Consumer Complaint Handling, and,
- Cancellation and Non-renewal Practices.

DESCRIPTION OF COMPANY

Legion Insurance Company was incorporated July 23, 1925, under the laws of the Commonwealth of Pennsylvania and began operations October 9, 1925, under the title of National Union Indemnity Company. Underwriting operations were discontinued in 1931, and not renewed until January 1946. On January 18, 1973, the company name was changed to National Independence Insurance Company and changed again on May 1, 1979, to Old General Insurance Company. The present name was adopted April 1, 1983.

Since November 23, 1987, all the outstanding common stock has been owned by Legion Financial Corporation, a wholly owned subsidiary of Mutual Group, Ltd., which is owned by Mutual Risk Management, Ltd., a Bermuda holding company. Mutual Risk Management Ltd. (MRM) was founded in Bermuda more than twenty (20) years ago.

The Combined Annual Statement for the year ended December 31, 2000 for Legion Insurance Company and its affiliated property and casualty insurers included Legion Insurance Company, Legion Indemnity Company, Villanova Insurance Company and U.S. Insurors Company.

The Company is licensed to write insurance in fifty (50) states, the District of Columbia, American Samoa, Guam, Puerto Rico, US Virgin Islands and Canada. In the 2000 Annual Statement, the Company reported direct written premiums for all of these jurisdictions except American Samoa, Guam, US Virgin Islands and Canada.

DIRECT PREMIUMS WRITTEN

The following is an analysis of the direct premiums written in the state of Florida by Legion Insurance Company and the percentage in respect to the total premium by line of business.

YEAR	LINES OF BUSINESS	FLORIDA PREMIUM	% OF TOTAL FLORIDA PREMIUM
2000	Fire & Allied Lines	$1,102,011	2%
	Commercial multiple peril (non-liability portion)	$2,273,424	4%
	Inland Marine	$846,548	1%
	Medical Malpractice	$2,597,484	4%
	Group Accident & Health	$8,608,739	14%
	Workers Compensation	$26,094,971	43%
	Other Liability	$5,736,580	10%
	Commercial auto	$8,629,718	15%
	Private Passenger auto physical damage	$3,740,472	6%
	All other lines	$527,674	1%
Total		**$60,157,621**	**100%**

The total direct premiums written in Florida, $60,157,621, represents five percent (5%) of the total direct premiums written in all states and territories, $1,124,559,636, for the year ended December 31, 2000.

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 regulation of Florida:

Fire	Other Liability
Allied Lines	Private Passenger Auto
Farmowners Multi Peril	Commercial Auto
Homeowners Multi Peril	Aircraft
Commercial Multi Peril	Fidelity
Ocean Marine	Surety
Inland Marine	Glass
Auto Warranties	Burglary and Theft
Medical Malpractice	Accident and Health
Workers' Compensation	Boiler and Machinery

PROPERTY AND CASUALTY

Introduction

The last property and casualty market conduct examination of this insurer by "OIR" was concluded in August 1999.

The prior examination report included the review of private passenger automobile, commercial automobile, other liability, medical malpractice, workers' compensation, agents/MGAs, cancellations/nonrenewals, claims, and complaints. Violations cited include the failure to provide a telephone number and statement of it is purpose on the policy, the failure to maintain necessary rating and underwriting documents, the use of an unfiled form, writing unstacked Uninsured Motorist coverage without a selection form in the file, using an unfiled Uninsured Motorist selection form, failing to document scheduled credits, requiring collateral business, writing Hired and Non-Owned coverage without charging a premium, failing to follow the filed rating plan in applying miscellaneous credits, using unfiled credits, failing to comply with the exchange of business requirements, failing to display either the Company name, agents name or ID number on the application, failing to issue a cancellation notice when the policy was cancelled at the request of the insured, making an incorrect return premium calculation and failing to maintaining a list of approved repair facilities when requested.

The purpose of the current property and casualty examination was to confirm corrective action had been taken to correct those items found in the previous examination, to verify

complaints filed against the Company were either justified or not justified, and verify the Company compliance with Florida Statutes and Administrative Rules.

This examination revealed that the Company has not complied with Section 627.4131, Florida Statutes, by placing a telephone number and the purpose for this number on their policies. This violation was noted in the last examination. The problem still exists in all lines reviewed.

The examiner also noted the failure to include the PIP option form and UM-UIM acceptance/rejection form in the file as cited in the earlier report. The Company also failed to send a cancellation notice to the insured in a timely fashion, or to even send one when the policy was cancelled at the request of the insured.

During the examination, records reviewed included policies, cancellations, claims, and complaints as reflected in the report. This report contains examination results addressing all areas of noncompliance found during the course of the examination. In all instances "OIR" requested that the Company take corrective action as required, issue appropriate refunds, and immediately cease any activity that continues to place the Company in noncompliance with Florida Statutes/Rules.

Anti-Fraud Plan

The Company provided a copy of the Guidelines for the Special Investigations Unit of the Company as the Anti-Fraud Plan in use by the Company.

Disaster Recovery Plan

The Company has developed a Disaster Recovery Plan for use with Florida Business. The plan has been put in place for use in the event of any disaster that may affect the company or the policyholders. The plan appears to be comprehensive in that it includes levels of command to be used in the event of any disaster, and how the program is to be put into action at any time.

Internal Audit Program

The Company has developed Internal Audit Procedures for use in reviewing Florida business. The examiner reviewed the procedures as well as two audit reports to verify the use by the Company of the Procedures as outlined.

Statistical Affiliations

Insurance Services Office acts as the Company's official statistical agent.

Credit Reports

The Company does not use credit reports or scales as an underwriting tool. During the review of policies, no indication was found to indicate that any type of credit rating was used by the Company in the writing of business in the state of Florida.

The Company provided a copy of the Guidelines for the Special Investigations Unit of the Company that serves as the Company's Anti-Fraud Plan.

Review of Policies

The examiner reviewed twenty-five (25) policies written in Florida within the timeframe of this examination. Those twenty-five (25) policies were found to contain fifty (50) violations. Declarations pages in files provided to the examiners did not contain a phone number and purpose. This is a violation of Section 627.4131, Florida Statutes. Thirteen (13) of the policies did not contain the Florida PIP option form in the file which would be a violation of Section 627.739, Florida Statutes. Twelve (12) of the files did not contain the UM-UIM acceptance/rejection form as required. This is a violation of Section 627.727, Florida Statutes.

The examiner noted an inconsistency in the use and retention of certain forms depending upon the TPA that administers the business. However, the issue of providing a phone number and statement of purpose as required by Section 627.4131, Florida Statutes, is a Company problem that was also brought to the attention of the Company in the previous Florida examination.

Cancellations

The examiner requested twenty-five (25) cancellations for Florida policies cancelled during the time frame of this examination. Fifteen (15) cancellations were provided for

review. Ten (10) more files could not be produced. This represented ten (10) violations of Section 627.318, Florida Statutes for failing to maintain records for review. In the fifteen (15) files that were produced, the following errors were noted:

1. Six (6) errors were due to a failure to send a cancellation notice to the insured within the timeframe requirements of Section 627.4133, Florida Statutes.

2. Four (4) errors were due to the Company not maintaining proof of mailing of the notice of cancellation, which is a violation of Section 627.728, Florida Statutes.

3. Seven (7) errors were found indicating the Company had no record of premium being returned to the insured as required by Section 627.7283, Florida Statutes. No checks were provided for review. The Company was asked to provide this information and forward it to the Office of Insurance Regulation. If proof could not be provided, then the Company was instructed to forward the refund amount to the insured with interest at eight percent (8%) per annum.

4. Seven (7) errors were cited for the failure to maintain records concerning the cancellation process so they could be provided to document the compliance with Florida law concerning cancellations. Files were incomplete and information was not available to confirm compliance with the provisions of Section 627.318, Florida Statutes.

Accordingly, ten (10) of the fifteen files reviewed contained twenty-four (24) violations. The ten (10) files not provided made a total of twenty files in error for an error ratio of eighty percent (80%). This is unacceptable under the guidelines set forth in Rule 4-142.011, Florida Administrative Code.

Claims

One hundred (100) claim files were reviewed as part of this examination. The review indicated eight (8) files contained twelve (12) violations. Two (2) files did not have a

salvage title in the name of the insurer as required by Section 319.30, Florida Statutes. The Company's response indicated this had nothing to do with payment being made to the insured and disagreed with the violation. The response did not address the absence of the title in the file. One (1) file had a violation of Section 626.9541(1)(i)(2), Florida Statutes. The Company refused to accept a copy of a sales agreement from an automobile dealer for the purpose of paying sales tax to the insured because it did not have the sales manager's signature on the contract.

There were five (5) violations of Section 626.9541(1)(i)(3)(a), Florida Statutes, noted by the examiner. This violation involves the Company procedures in place for the payment of sales tax as part of the loss on the insured automobile. The requirements are stated at the bottom of the Proof of Loss in small print. The claims agency handling claims for the TPA in Florida has developed its own form to further explain the steps necessary to recover the tax. The claims agency rationale is that the consumer may not understand or see the instructions on the Proof of Loss. (See Exhibit I & II) Presently, the Company disagrees with the examiner and takes the position that the Company has outlined procedures necessary to collect these monies and people are electing not to file a claim for the additional funds. From the review of the claim files, there was approximately two thousand four hundred ($2,400) to be returned to consumers in Florida plus interest at eight percent (8%) per annum. The Company has declined to make any of these payments. (See Exhibit III)

The Company is in violation of Section 626.877, Florida Statutes, in instances where the sales tax is not included in the payment of the actual cash value when required. In instances where the sales tax is not included in the actual cash value payment the Company must advise the insured in writing of the procedures necessary to recover the sales tax upon purchase of a replacement vehicle. The failure to do either of these functions is a violation of Section 626.877, Florida Statutes.

The examiner also noted two (2) violations of Section 626.9541(1)(i)(3)(b), Florida Statutes. In both cases, the Company sent a Reservation of Rights letter to the insured for late reporting when in fact the report was not late enough to jeopardize the rights of the Company. In one case, the loss was settled within thirty-five (35) days from the date of loss. As a matter of procedure, the letters were not signed and the Company position is that no requirement exists to have them signed. The examiner contends this a function the adjuster should perform and the only way to confirm that an adjuster sent the letter would be by signature. This would also be necessary to verify that adjuster licenses were secured for all parties performing these duties.

One violation of Section 626.9541(1)(i)(3)(c), Florida Statutes, was found concerning the payment of tax after the settlement of the loss. In this loss, the tax on the actual cash value of the insured unit was four hundred eighty-seven dollars and fifty cents ($487.50). The Company did not pay any tax as part of the settlement on the value of the automobile. The examiner requested that the Company pay the tax plus interest at eight percent (8%) per annum up to the date of payment. The Company has refused to make

any payments citing the language on the Proof of Loss and the language in a separate letter sent out by the adjusting firm. The examiner contends that this denial would be proper for the additional monies due on tax of the replacement unit, but not the actual cash value of the destroyed unit.

One (1) other violation of Section 626.9541(1)(i)(3)(f), Florida Statutes, concerned sending an unsigned denial letter to the insured. Again, this is a function performed by the adjuster and signature is needed to verify compliance with the adjuster licensing requirements. The Company disagrees.

The examiner performed a time study to analyze the timeliness of claim payments:

DAYS OPEN	**NUMBER OF CLAIMS**	**PERCENTILE**
0-45	75	75%
46-60	6	6%
61-120	14	14%
Over 120	5	5%
TOTAL	**100**	**100%**

With eight (8) files containing twelve (12) violations, this is unacceptable under the guidelines as set forth in Rule 4-142.011, Florida Administrative Code.

Complaints

The examiner reviewed fifty (50) complaints as part of this examination. All of these complaints came from the listing of complaints received by the Company from the Florida Department of Financial Services. This listing appears to be in order and contains all complaints as submitted by the Florida Department of Financial Services.

However, the Company cannot produce any records of complaints filed by consumers. Nu-Main, Inc., has agreed that they knew a list must be kept for consumer complaints. However, for the last eighteen (18) months, they show only one complaint on that list. They also have written the examiner and confirmed that this list has not been maintained as required in the last eighteen months. Therefore this is a violation of Section 626.9541(1)(j), Florida Statutes.

Of the fifty (50) complaints reviewed, six (6) files contained seven (7) violations. An analysis of these violations follows:

Complaints (6) – 12% of Total (50)

Reason	No.	Percentile
Failed to explain sales tax recovery	1	14%
Failed to pay ACV of unit including sales tax	1	14%
Failed to provide renewal notice	1	14%
Failed to provide timely refund to insured	3	44%
Failed to calculate pro-rata vs short rate on cancellation	1	14%
TOTALS	**7**	**100%**

A review of each complaint violation indicates the following statutory violations. The Company failed to forward to the insured a copy of the form letter used in the handling of total losses to explain the process of how to collect the sales tax due the insured as a result of this claim. This failure to explain the recovery process is a violation of Section 626.9541(1)(i)(3)(b), Florida Statutes. The resulting failure on the part of the Company to pay the sales tax to the insured constitutes a failure to pay the actual cash value of the auto. Since the Company failed to pay the actual cash value of the unit, this is a violation of Section 626.877, Florida Statutes.

The examiner also found that the Company failed to provide a renewal notice to the insured in a timely fashion, which is a violation of Section 627.728, Florida Statutes. There were three (3) separate violations noted for the failure to return premium to the insured within the statutory limits. These are violations of Section 627.7283, Florida Statutes. One (1) other error resulted in a violation of Rule 4-70.010, Florida Administrative Code, for failing to calculate pro rata premium return to the insured. The Company used its own short-rate table.

In summary, this review indicates six (6) files in error out of fifty (50) files reviewed. This is a twelve percent (12%) error factor. Also, the failure to maintain a complaint log that includes all consumer complaints is a violation of Section 626.9541(1)(j), Florida Statutes.

ACCIDENT & HEALTH

Conversions

Section 627.6675, Florida Statutes, provides,

> *"A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy which policy has been approved by the department under s. 627.410."*

The Company has contracted with Celtic Insurance Company to provide the required conversion program. Celtic Insurance Company made the required form and rate filing with the Office of Insurance Regulation and the filling was APPROVED.

An applicant for a conversion policy can select the Standard Indemnity Conversion Plan, which offers four different coverage options with deductibles ranging from $250 to $1,000, or the Alternative Conversion Plan, which offers four different coverage options with deductibles ranging from $100 to $2,000. The co-insurance provisions are the same for both plans.

The Company did not provide a Celtic policy to the examiner, so the examiner was unable to verify that the contract provisions in the Celtic policy were substantially similar to the contract provisions in the Legion policies.

The Company asserts that during the period that the policies were in effect, May 27, 1997 to June 30, 2001, there had not been any requests for a conversion policy.

HIPAA:

The Company processed applications from individuals who disclosed their HIPAA eligibility in accordance with the Company's standard underwriting guidelines. Individuals who met the Company's standard underwriting guidelines were issued a certificate with a ten percent (10%) surcharge assessed for the first year of coverage; individuals who did not meet the guidelines were declined. Accepted applicants were advised, *"In order to provide insurance to applicants qualifying for pre-existing credit due to The Health Insurance Portability & Accountability Act of 1996 (HIPAA) certification, a 10% monthly surcharge must be assessed during the first twelve months of the contract."* Applicants were further advised, *"Please be aware that insureds who are found to have not disclosed HIPAA eligibility when applying for coverage will be assessed the 10% surcharge retroactive to the effective date of the contract."*

The company's underwriting guidelines provide the following information:
"1. How are HIPAA individuals handled during the underwriting process?

a. If they are an eligible individual and they meet the underwriting qualifications, they would be issued with a 10% surcharge.

b. If they are an eligible individual and they do not meet the underwriting qualifications, they would be declined because the state mandates that someone coming off a group must be offered a conversion policy."

The statement in 1(b) above is not entirely correct inasmuch as certain HIPAA eligible individuals coming off a group cannot obtain a conversion policy due to the fact that a conversion policy is not available.

The Company maintains that this ten percent (10%) monthly surcharge is a modest increase given that carriers must waive the pre-existing condition provisions for an entire class of people. The Company reasons that the rate for this class is necessarily higher than that of the class of people for which pre-existing conditions are not waived.

The Company's position is reflected in the following response to the examiner: *"To address your more specific verbal question as to whether or not Legion individually underwrote HIPAA eligible individuals, the answer is no, Legion never knowingly individually underwrote HIPAA eligible applicants."* The Company's response to a complaint filed by a HIPAA eligible applicant who was declined coverage stated: *"Pursuant to your request, we have reviewed our above referenced file. Legion Insurance Company is not a HIPAA carrier for the State of Florida. As the State of Florida elected to be an Alternative Mechanism State and Legion is not a HIPAA carrier, we do not guarantee issue policies. Each applicant is evaluated according to our standard underwriting guidelines. If the applicant is approved for coverage, and they are HIPAA qualified, then credit is given for pre-existing. (Name omitted) contends that she should not be underwritten and issued a policy on a guaranteed issue basis. We thoroughly explained our position to (Name omitted), the client's agent. We also*

suggested that the client contact those companies in Florida that were HIPAA carriers and could issue regardless of health conditions. We have distributed a list of HIPAA carriers for the State of Florida from the Florida Department website for agents marketing in the state of Florida.

Due to the condition of Rheumatoid Arthritis, we decline to issue health coverage for (Name omitted) in accordance with our underwriting guidelines. We sent a letter dated (Date omitted) advising her of this decision."

Failing to offer coverage to eligible individuals constitutes violations of Section 627.6487, Florida Statutes. Surcharging HIPAA eligible applicants who meet the standard underwriting guidelines is a violation of Section 626.9541(1)(g)(2), Florida Statutes, in that the company imposes a rate increase based solely on the applicant's HIPAA eligibility and not on the applicant's health history.[1]

Underwriting and Rating

Under 45 CFR ' 148.126, an insurer must exercise reasonable diligence in determining if an applicant is HIPAA eligible. In Transmittal #99-02 issued by the United States Department of Health and Human Services, HCFA (Health Care Finance Administration) also defined an insurer's requirement to exercise "due diligence."[2] Applications and

[1] Pursuant to 29 USC 1182 ' 702, insurers "*may not require any individual to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual."*

[2] "An issuer does not exercise 'reasonable diligence' in making a determination whether applicants are eligible individuals unless it makes a reasonable effort to determine whether any applicant for any type of coverage in the individual market (including medically underwritten and conversion products) is an eligible

documentation in underwriting files do not support that that the Company exercised "reasonable diligence" to determine HIPAA eligibility and guarantee availability of individual health insurance as required by Section 627.6487, Florida Statutes.

The Company should re-examine all applications during the scope of the examination to determine HIPAA eligibility as well as the status of all individual applicants who were declined coverage due to the fact that they did not meet the standard underwriting guidelines and report their findings to "OIR".

Complaint Handling

The Company's log of complaints received by the Department matched the Department's list of complaints during the scope of the examination. The Company has a contract with Haney Group Services, Dallas, TX., a Third Party Administrator (TPA), that specifies that two complaint logs will be maintained: one listing insurance department complaints and one for all other complaints. However, neither the TPA nor the Company maintains a complaint log for consumer complaints that are made directly to the Company. Failure to keep a complete record of all complaints is a violation of Section 626.9541(1)(j), Florida Statutes. The Company agrees with this assertion. (This violation has also been cited in the Property and Casualty section of this report.)

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individual, regardless of whether the individual knows or believes he or she has this status, and regardless of whether he or she specifically applied for a HIPAA product."

The Department of Financial Services received twenty-nine (29) complaints during the period January 1, 2001 to October 31, 2001. The Company only records if a complaint involves a claims issue or an underwriting issue. The examiner prepared the following analysis indicating the specific reasons for the Department complaints:

Claims (16) - 55% of Total (29)

Reason	No.	Percentile
Justified Denial of claim	5	31%
Delay due to Pre-Existing Condition Investigation	4	25%
Denial due to Pre-Existing Condition	3	19%
Unreasonable delay in processing payment	2	13%
Denial of Covered Claim	1	6%
Unreasonable delay in authorization for covered surgery	1	6%
TOTALS	**16**	**100%**

The examiner reviewed the sixteen (16) files and documented the following violations:

4 Violations - Section 626.9541(1)(i)(3)(c), Florida Statutes. The Company failed to acknowledge and act promptly upon communications with respect to claims. The Company agrees with these assertions. Four (4) of the sixteen (16) complaint files involving claims issues were found to be in violation.

1 Violation - Section 626.9541(1)(a)(1), Florida Statutes. The Company initially denied a claim covered by the policy. The Company misrepresented the benefits payable under the policy. The claim was later paid.

Underwriting (13) - 45% of Total (29)

Reason	No.	Percentile
Request for Refund of Premium	5	38%
Company Declined to Insure Applicant	3	23%
Questioned Bank Draft and Billing Fees	2	15%
Questioned Effective Date of Coverage	1	8%
Alleged Misrepresentation at Point of Sale	1	8%
Rate Increase	1	8%
TOTALS	**13**	**100%**

No violations were noted in review of the complaints involving underwriting issues.

The average period of time for a response to the DFS was sixteen (16) days.

Complaint records maintained by the Company should be modified to identify the specific reason for all complaints received.

Claims Processing

The examiners reviewed the Company policies and procedures for the handling of all claims. The Company provided manuals containing adjustment guidelines and a copy of the Claim Handling Principles included in their Third Party Administrator contracts.

The Company provided computer generated reports for claims that had been denied and paid during the examination period from January 1, 2001 to October 31, 2001. The examiner selected random samples to verify compliance with Florida Statutes.

Section 626.9541(i)(3)(d), Florida Statutes, relates to the payment or denial of claims based on policy benefits. Generally, claims were appropriately paid based on coverage provisions.

The examiner conducted time studies and reviewed claim files to ascertain compliance with Section 626.9541(1)(i), Florida Statutes. The review was to determine whether the Company committed or performed with such frequency as to indicate a general business practice the failure to promptly and timely pay claims, conduct reasonable investigation of claims, and promptly notify in writing when a claim or a portion of a claim is being contested. The Company does not capture the date the Proof of Loss was received in their data system and, therefore, these time studies reflect the number of days between the date received and the date paid or denied.

Claims Paid

The examiner reviewed fifty (50) of the four thousand seven hundred fifty-one (4,751) claims paid during the time frame of the examination.

A time study indicates that 14% of the claims were not paid within forty-five (45) days of receipt. Failure to act promptly with respect to the payment of claims is a violation of Section 626.9541(1)(i)(3)(c), Florida Statutes.

DAYS OPEN	NUMBER OF CLAIMS	PERCENTILE
0-45	43	86%
46-60	3	6%
61-120	3	6%
Over 120	1	2%
TOTAL	**50**	**100%**

Data analysis of the entire listing of paid claims indicates the following.

DAYS OPEN	NUMBER OF CLAIMS	PERCENTILE
0-45	186	4%
46-60	0	0%
61-120	1,412	30%
Over 120	3,152	66%
TOTAL	**4,750**	**100%**

This time study indicates that 96% of the claims were not paid within forty-five (45) days of receipt. This is aggregate data and does not include legitimate reasons for payments made beyond 45 days. The Company does not capture the date that Proof of Loss and/or the date a "clean claim" is received. The delay could result due to pending investigations, requests for additional information and incomplete or incorrect medical information.

Claims Denied

The following analysis indicates the reasons for denial of the six thousand six hundred thirty-five (6,635) claims denied during the time frame of the examination.

Reason	Number	Percentage
Charges previously considered	1,089	16%
Routine physical exams, well baby care, immunizations and preventative medical care are not covered	763	11%
This claim was paid in accordance with PPO contract rate agreement. The Patient is not responsible for this discount	587	9%
Additional information requested to process claim has not been received. Therefore, we have no choice but to close our file. Consideration will be given upon receipt of medical information	551	8%
Charges are pending for investigation. Medical records are being requested from physician or hospital	488	7%
Charges not covered under policy	435	7%
Charges were incurred after coverage terminated	433	7%
Office visits and consultations not covered under rider	415	6%
Pre-existing condition	262	4%
Charges filed in excess of the 90 day filing provision are not allowable	198	3%
If expenses were incurred due to an accident, please advise how, when and where the accident occurred - No response	195	3%
Outpatient treatment and or testing for mental and nervous diagnosis not covered	130	2%
Coverage was terminated retroactive back to the original effective date of issue	144	2%
Maternity charges are not covered by this plan unless there are complication as defined in policy	76	1%
Hospital bills must include itemization of charges. For consideration please submit this information	67	1%
Charges related to maintenance care are not covered under this plan	58	1%
Divided among the other seventy-three (73) utilized reason codes	784	12%
TOTALS	**6,635**	**100%**

The examiner reviewed fifty (50) of the six thousand six hundred thirty-five (6,635) claims denied during the time frame of the examination. A time study indicates that ten percent (10%) of the claims were not denied within sixty (60) days of receipt. This represents a violation of Section 626.9541(1)(i)(3)(c), Florida Statutes and Section 626.9541(1)(i)(3)(e), Florida Statutes. The Company failed to act promptly with regard to claims and failed to affirm or deny full or partial coverage within the time frame required.

DAYS OPEN	NUMBER OF CLAIMS	PERCENTILE
0-45	42	84%
46-60	3	6%
61-120	5	10%
Over 120	0	0
TOTAL	**50**	**100%**

Data analysis of the entire listing of denied claims indicates the following.

DAYS OPEN	NUMBER OF CLAIMS	PERCENTILE
0-45	5,215	79%
46-60	419	6%
61-120	488	7%
Over 120	515	8%
TOTAL	**6,635**	**100%**

This time study indicates that fifteen percent (15%) of the claims were not denied within sixty (60) days of receipt. This represents a violation of Section 626.9541(1)(i)(3)(c), Florida Statutes. The Company failed to act promptly with respect to the denial of claims.

Interest on Late Claims

The Company advises that no interest was paid on any claims during the time frame of the examination. There is no provision in the policy relating to interest payable on a claim.

CONCLUSION

The customary practices and procedures promulgated by the Offices's Field Examination Guidelines, were followed in performing this Target Market Conduct Examination, when possible, of Legion Insurance Company as of October 31, 2001, with due regard to the Insurance Laws of the State of Florida and Rule 4-142.011, Florida Administrative Code.

Respectfully submitted,

Thomas L. Ballard
CIE, CFE, FLMI, ALHC, ASF
Examiner-in-Charge

Robert D. Flege
CIE, CFE, AIRC, ARA, FLMI, ALHC, ASF, LPCS
Independent Contract Analyst

FINDINGS AND RECOMMENDATIONS

The following is a summary of the examiners' findings and recommendations.

Page 16	Comply with Section 627.4131, Florida Statutes, and provide a phone number and purpose for the number on policy declaration pages. This violation was noted in the previous examination.
Page 16	Comply with Section 627.739, Florida Statutes, and provide the Florida PIP option form to applicants and policyholders.
Page 16	Comply with Section 627.727, Florida Statutes, and provide UM-UIM acceptance/rejection form to policyholders as required.
Page 17	Comply with Section 627.4133, Florida Statutes, and provide cancellation notices to policyholders within the specified timeframes.
Page 17	Comply with Section 627.728, Florida Statutes, and maintain proof of mailing of cancellation notices.
Page 17	Comply with Section 627.7283, Florida Statutes, and process premium refunds within the specified timeframes.
Page 17	Comply with Section 627.318, Florida Statutes. The Company is advised to maintain and produce records for review when requested by the Office of Insurance Regulation.
Page 18	Comply with Section 319.30, Florida Statutes, and secure required salvage titles on total loss vehicles.
Page 18	Violation of Section 626.9541(1)(i)(2), Florida Statutes. The Company misrepresented amount of claim recovery due to insured.
Page 20, Page 34	Violation of Section 626.9541(1)(i)(3), Florida Statutes. The Company committed and performed unfair claim settlement practices with such frequency to indicate a general business practice.
Page 21 & Page 28	Comply with Section 626.9541(1)(j), Florida Statutes, and maintain a log of all complaints received relative to Property and Casualty and Accident and Health insurance.
Page 19	Comply with Section 626.877, Florida Statutes, and adjust claims in accordance with the terms and conditions of the contract.

FINDINGS AND RECOMMENDATIONS (Cont'd)

Page 26	The Company is advised to comply with Section 626.9541(g)(2), Florida Statutes, as to non-discrimination, by removing the portability factor assessed HIPAA applicants based solely upon their eligibility and refund the premiums to those already assessed.
Page 27	The Company is advised to re-examine all applications from HIPAA eligible individuals for accident and health insurance that were declined due to the fact that they did not meet their standard underwriting guidelines and report the status of those applicants to the Office of Insurance Regulation.
Page 27	The Company should perform due diligence in determining the eligibility of HIPAA applicants pursuant to Section 627.6487(4)(b), Florida Statutes, and guarantee availability of health insurance to HIPAA eligible individuals.

EXHIBITS

SUBJECT	EXHIBIT NUMBER
Proof of Loss	I
Company Letter to Insured	II
Company Response to “OIR” Inquiry	III

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

JOHN KESSOCK, JR., PRESIDENT
LEGION INSURANCE COMPANY
One Logan Square, Suite 1400
Philadelphia, PA 19103
NAIC Company Code: 24422

Re: Market Conduct Examination
PERIOD ENDING OCTOBER 31, 2001

Dear Mr. Kessock:

Enclosed please find a copy of the filed final report of examination completed by the Office of Insurance Regulation (OIR), 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 Legion Insurance Company is in Rehabilitation, the fine of $75,000 normally assessed in conjunction with this report will be held in abeyance at this time. If Legion Insurance Company or any subsequent entity formed via merger/acquisition or name change begins writing business in Florida, OIR would expect that the fines would be paid and all outstanding issues contained in this report would be addressed. 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.

Sincerely,

Jack McDermott, CIE, CPM, FLMI, ARM

TREASURER • INSURANCE COMMISSIONER • FIRE MARSHAL

JACK MCDERMOTT, CIE, CPM, FLMI, ARM • I. & H EXAM COORDINATOR • BUREAU OF MARKET CONDUCT
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