THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

TIME INSURANCE COMPANY

AS OF

September 24, 2010

NAIC COMPANY CODE: 69477
NAIC GROUP CODE: 05586

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EXECUTIVE SUMMARY

A target market conduct examination of Time Insurance Company was performed to determine compliance with Florida Statutes and Florida Administrative Code.

The following represent general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
627.6515(2)(c), F.S & 627.6613, F.S.	Mandated Benefit-Mammograms-Underwriting Review (mandated benefit mammograms appear to be excluded for certain conditions)	231	1
627.6515(2)(c), F.S & 627.6575, F.S.	Failure to correctly pay a non-participating provider the in-network level of benefit in an emergency for the birth of a child- Complaints	113	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of Time Insurance Company pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of the target examination for mandated benefits, and guaranteed issue eligibility was January 1, 2008 through December 31, 2009, the scope period for Freedom to Travel compliance was January 1, 2006 to December 31, 2009. The scope period for the GAP Reporting Review was January 1, 2009 to December 31, 2009. The onsite examination began July 19, 2010 and ended September 24, 2010. The findings of the target examination are included in this report.

The purpose of the examination was to review the Company's business practices as relates to mandated benefits, HIPAA eligibility, anti-fraud compliance, GAP reporting, and freedom to travel.

The examination included the following procedures:

- The Company's underwriting guidelines and procedures were reviewed to determine whether the Company exercised reasonable diligence in reviewing and underwriting all applications relative to HIPAA eligibility in compliance with Section 627.6487, Florida Statutes, and Rule 69O-154.112, Florida Administrative Code.
- Master policies, policyholder certificates, and form filings were reviewed to determine if mandated benefits were inappropriately excluded or limited in violation of Section 627.6515, Florida Statutes.
- Applications denied, withdrawn, rescinded, terminated, issued with limitations or other than as applied for, and conversions were reviewed to determine the Company's compliance with laws regulating Out-of-State Groups regarding rating practices and mandated benefits, Section 627.6515, Florida Statutes.

- Claims processing procedures were reviewed to determine whether paid and denied were appropriately handled as regards mandated benefits pursuant to Section 626.9541, Florida Statutes.
- Underwriting practices for the issuing of life policies were reviewed to determine compliance with the Freedom to Travel laws, Sections 626.9541(1)(dd) and 626.9541 (1)(x)), Florida Statutes.
- The Company's procedures and complaint registers were reviewed to determine compliance with Section 626.9541(1)(j), Florida Statutes.
- The Company's anti-fraud plan, employee training procedures, and reporting procedures were reviewed to determine compliance with Section 626.9891, Florida Statutes, and Rule 69D-2.001 thru 2.005, Florida Administrative Code.
- Procedures and documentation were reviewed to determine the accuracy of information reported to the Department in the Company's GAP Report, which is filed pursuant to Section 627.9175, Florida Statutes

In reviewing materials for this report, the examiner relied on records provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners (NAIC) and/or consistent with the pre-determined market conduct program presented to and approved by the Office.

Sample sizes were determined using the Acceptance Samples Table of the NAIC Market Regulation Handbook or by the Audit Command Language (ACL) software. The handbook allows several methods for determining sample sizes. Two methods were used during the examination. For populations of less than 50,000 the Acceptance Samples Table was used and for populations over 50,000 ACL was used. In utilizing ACL to determine the sample sizes, the parameters consisted of a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% in accordance with the handbook.

COMPANY OPERATIONS

Time Insurance Company, a foreign Life and Health insurer domiciled in Wisconsin, was licensed to conduct business in the state of Florida on June 26, 1956. The Company is 100% directly owned by Interfinancial, Inc., which is directly owned by Assurant Inc., New York, NY, a holding company.

Total Direct Premiums Written in Florida for life and health insurance was as follows:

	Total Written Premium In Florida (Per Schedule T of the Annual Statement)	
Year	Accident and Health	Life
2008	86,574,176	2,618,812
2009	82,099,569	2,362,229

UNDERWRITING AND RATING - ACCIDENT & HEALTH

I. UNDERWRITING AND RATING PRACTICES:

The underwriting and rating practices review was performed to determine whether policies were issued other than as applied for, declined, terminated/cancelled, converted, withdrawn, or rescinded based on mandated benefits or lack of guaranteed issue eligibility.

A. Denied Applications

A sample of 115 denied applications, from a total population of 2,153, was reviewed to determine compliance with guaranteed issue eligibility and State mandated benefits. No exceptions were found.

B. Terminated Applications

A sample of 116 termination/cancellations applications, from a total population of 9,701, was reviewed to determine whether insureds were offered conversion policies. No exceptions were found.

C. Rescinded Applications

A sample of 79 rescinded applications, from a total population of 171, was reviewed to determine compliance with guaranteed issue eligibility and State mandated benefits. No exceptions were found.

D. Conversion Applications

A sample of 24 conversion applications, from a total population of 24, was reviewed to determine compliance with guaranteed issue eligibility and State mandated benefits. No exceptions were found.

E. Withdrawn or Issued Other Than Applied For Applications

A sample of 116 withdrawn applications, from a total population of 8,375, and 115 certificates issued "other than applied for," from a total population of 3,459, was reviewed to determine whether the reason for the rating or withdrawal was compliant with guaranteed issue eligibility or related to mandated benefit exclusions.

1.) **In 1 instance the Company attached a rider to a policy when an insured had a history of benign breast conditions. This rider excludes "any diagnostic procedures" related to benign breast conditions. This may cause an applicant or insured to conclude mandated benefit mammograms are not a covered procedure in violation of Sections 627.6515(2)(c) and 627.6613, Florida Statutes.**

1a.) Corrective Action:

The Company should amend this rider to reflect that it does not exclude Mandated Benefit baseline Mammograms. The Company should file the revised rider with the Florida Office of Insurance Regulation (OIR) for informational purposes. The Company is to provide a list to the OIR of all Florida policies which have the existing rider attached, and proof of mailing of the amended rider to these insureds. It is noted there were no related exam findings of a claim that was improperly denied.

1b.) Company Response:

The Company indicated that they pay all mandated benefits and no claims for mammograms have been denied. The Company respectfully maintains compliance with Sections 627.6515(2)(c) and 627.6613, Florida Statutes which requires coverage for baseline mammograms as the Company provides state mandated benefits for mammogram coverage with or without the presence of a Special Exception Rider. The Company agrees to amend limiting language in the rider issued to Florida residents and otherwise comply with the recommended corrective action.

II. FORM FILINGS:

The forms filing review included verification that all forms used were properly filed for informational purposes with the OIR, and verification that the mandated benefits are included in the Schedule of Benefits and certificates. No exceptions were found.

CLAIM HANDLING

I. CLAIM HANDLING

The claims review was limited to identifying whether mandated benefits were appropriately paid based on Section 627.6515, Florida Statutes.

A. Paid Claims:

A sample of 184 paid claims, from a total population of 221,961, was reviewed to determine compliance with mandated benefits. No exceptions were found.

B. Denied Claims:

A sample of 184 denied claims, from a total population of 83,327, was reviewed to determine compliance. However, it was determined that a more representative sample of mandated benefit denied claims was required in order to determine compliance. Therefore, an additional sample of 25 denied claims was reviewed. The additional claims in the sample were selected from a population of mandated benefit claims. No exceptions were found.

COMPLAINTS

I. Complaint Handling

From a population of 71 Department of Financial Services (DFS) complaints, 519 direct complaints, and 24 appeals, examiners reviewed a sample of 113 complaints to determine compliance with guaranteed issue eligibility and State mandated benefits. Reviews of the Company's complaint handling procedures were performed in addition to reconciliation of the Company's complaint register to consumer complaints filed with DFS.

1.) **In 1 instance, payment to a provider for a newborn hearing screening was incorrectly paid in violation of Sections 627.6515(2)(c) and 627.6575, Florida Statutes.** A baby was born in a non-participating hospital due to an emergency delivery. The Company's policies state that if a true emergency is determined, a member's expenses will be paid for at the in-network level of benefit regardless of where the services are performed. The Company agreed the delivery was an emergency but underpaid the provider by 42%.

1a.) **Corrective Action:**
The Company should pay the provider the correct sum (participating provider rates), with interest. The Company should confirm that procedures are in place to ensure proper payment of mandated benefits.

1b.) **Company Response:**
The Company indicated that they have practices in place to ensure proper payment of mandated benefits, stating the incorrect payment was a result of a manual error. The Company paid the provider the correct amount with interest.

ACCIDENT AND HEALTH PREMIUM AND ENROLLMENT REPORTING

I. GROSS ANNUAL PREMIUM (GAP) FILING

The Company is required to annually file a Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans issued to Florida Residents (GAP Report) pursuant to Section 627.9175, Florida Statutes.

The Calendar Year 2009 GAP Report that was due on April 1, 2009 was reviewed. The Company timely submitted its filing on March 31, 2010.

The Company submitted the following figures:

Description	Direct Premiums Earned	Direct Losses Incurred	New Direct Premiums Earned	Group Coverage	Primary Insureds	Dependents	Covered Lives	Days to Pay Claims
Major Medical and/or Hospital/Surgical/Medical Expenses								
Individually Underwritten	$782,383	$1,313,010	$141,861	-	417	36	453	7.55
Conversions	$30,022	$8,689	-	-	3	1	4	11.66
Major Medical and/or Hospital/Surgical/Medical Expense Coverages Issued to Out-of-State Group as defined by §627.6515, F.S.								
Guarantee Issue (HIPAA)	$539,329	$423,154	$44,730	-	35	1	36	7.55
Individually Underwritten	$62,280,954	$44,347,633	$11,736,092	3	14,906	8,949	23,855	7.55
Other Accident and Health Coverages								
Accident Only	$19,856	$6,066	$7,337	-	79	46	125	
Dental	$300,448	$64,185	$188,827	-	992	498	1,490	
Disability Income	$54,215	$84,166	$9,919	-	66	-	66	
Hospital Indemnity	$13,731	$5,367	$2,593	-	44	14	58	
Limited Benefit	$12,777	$7,536	$4,431	-	45	13	58	
Prescription Drug	-	-	-	-	-	-	-	
Student	-	-	$144	-	-	-	-	
Vision	-	-	-	-	-	-	-	
Short Term Medical	$3,398,608	$3,637,232	$2,485,988	-	1,536	308	1,844	20.01
Long Term Care	$14,873,515	$37,478,481	-	-	8,513	-	8,513	
Medicare Supplement	$14,839	$30,839	-	-	-	-	-	
Sickness	$3,790	-	$144	-	-	-	-	
Reconciliation								
Accident and Health Insurance Premiums, Including policy, membership and other fees	**$82,324,467**							

The Examiner reviewed work papers and source documentation to verify the accuracy of the 7 reporting areas required on the GAP submission. No exceptions were found.

ANTI-FRAUD PLAN

I. ANTI-FRAUD

The Company has filed its Anti Fraud Plan with the Office as required by Section 626.9891, Florida Statutes, and Rule 69D-2.001 through 2.005, Florida Administrative Code. All areas of the anti-fraud plan including the Company's employee training reporting procedures, and staffing of the Special Investigative Unit were reviewed. No exceptions were found.

FREEDOM TO TRAVEL

In June 2006, the Florida Legislature enacted the Freedom to Travel Act, which modified Florida's Unfair Trade Practices Act by placing prohibitions on life insurance limitations upon an individual based solely on the individual's past lawful foreign travel or future lawful travel plans. The Florida Unfair Trade Practices Act also prohibits the refusal to insure, or continue to insure, based on the individual's race, color, creed, marital status, sex, or national origin.

A review was performed to determine compliance with Sections 626.9541(1)(g), 626.9541(1)(x), 626.9541(1)(dd) and Rules 69O-125.003 and 69D-2, Florida Administrative Code.

The examination included the following procedures:

- Review policy application to determine if application was denied, issued in a manner other than applied for, had benefit changes or canceled solely on the individual's past lawful foreign travel experiences, or future travel plans, and compliance with Section 626.9541(1)(dd), Florida Statutes and Rule 69O-125.003, Florida Administration Code.

- Review policy application to determine if application was denied, issued in a manner other than applied for, had benefit changes or canceled based on national origin in compliance with Section 626.9541(1)(g) and (x), Florida Statutes.

LIFE APPLICATION REVIEW

I. FILE REVIEW

The examiners reviewed information contained in the Company's individual life underwriting files, which could have included but was not limited to the application, field underwriting guidelines, telephone interviews, questionnaires, underwriting notes, correspondence with agents and consumers, medical records, financial information, and the Company's Agent's training materials.

The Company did not use applications that contained travel related questions. The Company received 59 applications for life insurance coverage during the scope period. Applications were written as applied for, not taken, or declined. There were no cancelled applications or applications with benefit changes during the scope period.

Declined Applications:

The examiners reviewed all 11 declined applications. No exceptions were found.

Applications Not Taken:

The examiners reviewed all 27 applications that were not taken. No exceptions were found.

Issued Policies:

The examiners reviewed all 21 issued applications. No exceptions were found.

II. COMPLETENESS AND ACCURACY TEST

Due to the fact that all policies written during the scope of the examination were reviewed, the completeness and accuracy tests were not performed.

EXAMINATION FINAL REPORT SUBMISSION

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