TARGET MARKET CONDUCT EXAMINATION REPORT

ON

UNITED WISCONSIN LIFE INSURANCE COMPANY

as of

December 31, 1999

PREPARED FOR:

FLORIDA DEPARTMENT OF INSURANCE
BUREAU OF L & H INSURER SOLVENCY AND MARKET CONDUCT REVIEW
LIFE AND HEALTH MARKET CONDUCT SECTION
200 EAST GAINES STREET, THIRD FLOOR
TALLAHASSEE, FL 32399-0327

BY:

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Market Conduct Examiner

May 10, 2000

Honorable Bill Nelson
Treasurer and Insurance Commissioner
State of Florida
The Capital, Plaza Level Eleven
Tallahassee, FL 32399-0300

Re: Target Market Conduct Examination of United Wisconsin Life Insurance Company

Dear Commissioner Nelson:

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:

United Wisconsin Life Insurance Company
3100 AMS Boulevard
Green Bay, WI 54313
1-800-232-5432

at its home office location in Green Bay, Wisconsin. The report of our examination is herein respectfully submitted. If any further information is desired, please contact me at your convenience.

Kindest Regards,

Thomas L. Ballard
CIE, CFE, FLMI, ALHC, ASF

INTRODUCTION

United Wisconsin Life Insurance Company, hereinafter is generally referred to as "the Company" when not otherwise qualified.

This is a target Market Conduct Examination conducted by the Florida Department of Insurance, hereinafter generally referred to as "the Department".

This on-site target Market Conduct Examination commenced on March 1, 2000 and concluded on May 10, 2000 at the Department of Insurance in Tallahassee, Florida. Work was done at the home office of the Company from March 7, 2000 to May 4, 2000.

SCOPE OF THE EXAMINATION

This examination covers the period of the Company's operations in the State of Florida from January 1, 1997 through December 31, 1999; and where appropriate, transactions and affairs subsequent to the examination period.

The purpose of this target Market Conduct Examination was to determine if the Company's practices and procedures conform with the Florida Statutes and Administrative Code. The National Association of Insurance Commissioners' Examination Handbook standards of 7% error ratio for claim related subjects and 10% error ratio for other procedures are applied. Also, any error appearing to be a pattern or a general business practice has been included in this examination report.

The examination included, but was not limited to, the following areas of the Company's operation:

1. Policy forms and filings
2. Cancellations and non-renewals
3. Claims including those paid, denied, and pending
4. Verification of interest payments on late claim payments
5. Complaints including procedures for responding and resolving those complaints
6. Specific Department of Insurance complaint files

Files were examined on the basis of file content at the time of examination. Comments and recommendations were made in those areas in need of correction or improvement.

POLICY FORMS AND FILINGS

The Company maintains a file containing copies of policies, rates, riders, endorsements and correspondence of all forms filed and approved by the Department.

Company filings as far back as 1990 were presented for review to determine if policy forms being used by the Company had been filed or approved by the Department as required by Section 627.410, Florida Statutes. The examiner also reviewed those forms used in policies written in the "out-of-state group" arrangement to verify that they had been filed for informational purposes per Section 627.6515, Florida Statutes.

The examiner determined that the Company had used unapproved form PO 0010-12-1-00 (2/92) to write 342 certificates from January 1, 1996 to December 31, 1997. Upon finding this error, the examiner wrote the Company and asked for the total number of certificates written on this form. Per the Company agreement, they had written an additional 694 certificates from January 1, 1991 to December 31, 1996. This would be a total of 1,036 certificates written from January 1, 1991 to December 31, 1997 on an unapproved form. The Company used this form despite knowing it had been disapproved by the Florida Department of Insurance in correspondence between the Department and the Company during the filing process. This correspondence included a letter from the Department on April 4, 1992 advising the Company that the filing was incomplete, a letter from the Department dated June 26, 1992, advising the Company that the form was disapproved and a letter from the Department on July 14, 1992 again advising the Company of the disapproval. There was correspondence from the Company during this time frame to the Department on this matter acknowledging the difficulty in getting the forms approved.

The examiner determined that the original form was disapproved for several reasons by the Health Forms Section of the Department. These include the following:

- The form must contain an “insolvency clause”. This one did not.
- The form must contain a subrogation clause. This one did not.

The examiner also requested a copy of the "Filing Procedures" in place and being used by the Company. The procedures have been reviewed and appear to be adequate and are usually followed by the Company.

CANCELLATIONS/NON-RENEWALS

The examiner requested a listing of all policies cancelled or non-renewed during the time frame of the examination and the Company produced a listing of 11,662 non-renewals. All of these files had the same notification date to the insured of September 25, 1998. The effective date of each individual non-renewal would be the first anniversary date of the policy that was at least 180 days after the September 25, 1998, notification date. The examiner received a sample of policies from this listing and checked it for compliance. There were two criticisms noted on these files. Both criticisms involved the insured not receiving notice of the non-renewal as required by Section 627.6571(3)(b)(1)(a), Florida Statutes. In one case, the insured had been terminated for non-payment and then reinstated on the same date as the notices went out (9/25/98). Since the run for the mailing was completed one or two days prior to the actual mailing, the insured was not included in the non-renewal mailing. The second file concerned an insured that was manually non-renewed on January 31, 1999 verses January 31, 2000 as should have been the case. The Company agreed to both violations.

As mentioned in the **COMPLAINTS** section of this report, several complaints dealt with allegations of insureds not getting the notice from the Company. The Company says

these notices went to the insureds starting well over the 180-day limit before the first non-renewal took place. They also say these notices went to the same address as the premium statements and the insureds were able to get those statements and pay the premiums when due. However, the Company cannot clearly document the notification for these non-renewals.

The Company does not maintain a copy of the actual letter to an insured on any specific file. A form letter template and system record were provided as documentation supporting compliance with the notice requirements. The Company maintains one could refer to their system and it would indicate that the form letter was sent, and by procedure, it was sent to the address of record that is also located on the system. A further review of the system used by the Company also reveals the date the letter was sent as well as the person sending the letter. The Company failed to produce adequate and verifiable documentation that the letters were mailed timely to all affected insureds.

A review of information provided by the Company subsequent to the completion of fieldwork on the exam indicates actual mailing dates other than September 25, 1998, demonstrating discrepancies in the Company's records. The United States Postal Service documents related to the mailing of cancellation notices indicate the following:

DATE	NUMBER MAILED	PERCENT
September 25, 1998	822	7%
September 29, 1998	1,664	14%
September 30, 1998	2,582	22%
October 1, 1998	6,847	57%

As a result of the consistent mailing date of September 25, 1998 entered in the Company's computer records and the documented actual mailing dates stated above, the Company is in violation of Section 626.9541(1)(e)1.e.2., Florida Statutes, for inaccurate entries and/or recordings in its official Company records.

The examiner also asked for a copy of the letter sent to the Department of Insurance as required by statute when a company is withdrawing from a market. That letter was provided.

CLAIMS – DENIED

The examiner requested a data run of all denied claims for the time frame of the examination and the Company provided a listing of 76,120 claims. The examiner selected one hundred (100) files for review and the Company produced them.

There were three files noted as exceptions and agreed to by the Company. Two (2) of the files noted dealt with the fact they were not "Denied Claims", but rather paid and closed claims. The third claim concerned the failure of the Company to properly investigate a coding error so that payment could be made under the insured's contract. This is a violation of Section 626.9541(1)(i)(3)(d), Florida Statutes. The Company concurred and upon further investigation, authorized payment in the amount of $18.60.

A time study was completed on this category and it was determined that the average number of days from receipt of the claim to denial was 11.85 days with a median time of 8.5 days. This is within the statutory limitation of 45 days.

CLAIMS – PAID

The examiner requested a data run of all policies where claim payments were made during the time frame of the examination. A listing of 101,164 policies was produced and a random selection of 100 files was requested from the Company and provided for review by the examiner.

Out of the 100 files reviewed, the examiner initially identified four (4) criticisms to the Company concerning possible violations of Florida law. The Company produced clarifying information on two of the four violations.

Of the two files in violation, one was readily agreed to by the Company concerning the lack of investigation prior to denial of a claim involving a $30 payment. The Company concurred with the examiner and allowed the $30 to be credited to the annual deductible of the insured. No interest was paid as this policy was issued through the "out-of-state group" and not subject to Florida's interest payment statute. The other claim was concerning the payment of a prostate examination for a 42 year-old patient. The company originally denied the claim as not medically necessary as this type of procedure is not normally performed on a patient of this age. The coding was also incorrect on this file as to the reason for denial. After discussions with the Company, the claim was paid in the amount of $46.65.

A time study was done on this category and it was determined that the Company took an average of 12.25 days from the time the claim was received to the time it was paid. The median number of days to pay a claim was eleven (11) days. Both numbers are acceptable under Florida guidelines. None of the claims in the sample were over the 120 day limit as set by Section 627.613, Florida Statutes.

CLAIMS – PENDING

The examiner asked for a listing of claims not paid or denied but pending action during the time frame of the examination. The Company provided a listing of 1,775 claims from which a systematic selection was made and fifty (50) files were chosen for review and provided by the Company. There were no violations noted in the review of these files. While fourteen (14) of the fifty files were concluded from the time the selection was made to the actual review, it was apparent the files are being processed.

"CODE 38" DENIED CLAIMS

While reviewing the "Denied Claims" category, the examiner discovered a denial code 38 that was used to deny claims when a provider failed to give information to the Company concerning the patient. This could be the immediate provider of record or a provider to the patient at some point in his or her past. This would be very likely in a case of investigation for the purpose of denial based on misrepresentation of facts on the application or pre-existing illness or injury. This is also used to help determine if treatment is medically necessary. The concern the examiner has with the Company's use of this code is that during the course of the examination it was determined that the Company was denying those claims where they lacked the investigative material to justify payment. The unfair claims practice act dictates that the insurer is to conduct an investigation on the validity of a claim. However, in the absence of any reason to deny a

claim, it must be paid. During the time frame of this examination, it was determined that over 35,000 claims were denied under Code 38. Upon further review, the examiner asked for a run of those denials, and selected 100 files for review. Those files were presented for review by the examiner.

The examiner reviewed a sample of 100 "Code 38" files and determined that the company was taking an average of 120.74 days to conclude these files, with a median time of 101 days. The statutory standard for health claims in Florida is 120 days. (Health claims on out of state group health plans do not have a timeframe standard.) Of the 100 files sampled, 41 files were concluded in a timeframe in excess of 120 days.

The examiner issued a criticism outlining twelve (12) files that were denied by the Company due to lack of information provided by a provider. Section 626.9541(i)(3)(d), Florida Statutes applies to these losses, and there would be an error factor of twelve (12%) percent.

In these twelve (12) reviewed files, ten (10) insureds were not contacted by the Company in any form regarding additional information necessary for processing the claim. This is a violation of Section 626.9541(1)(i)3.f.g.h., Florida Statutes, which states “Failing to promptly provide a reasonable explanation in writing to the insured of the basis in the insurance policy, in relation to the facts or applicable law, for denial of a claim or for the offer of a compromise settlement; Failing to promptly notify the insured of any additional

information necessary for the processing of a claim; or Failing to clearly explain the nature of the requested information and the reasons why such information is necessary".

Information provided by the Company subsequent to the completion of fieldwork on the exam indicates that six of these twelve claim files reviewed resulted in payment of the claim. Only upon the intervention by the Department were the Code 38 denied claims revisited and paid. The Company is directed to revisit Code 38 denied Florida claims for the purpose of making additional claim payments and/or adjustments as warranted.

The examiner expressed concern to the Company about the degree of use of this code to avoid payment of claims. Another problem is with the coding of these claims. When a Code 38 is denied, it is closed. If it reopens at a later date, it receives a new claim number. This makes tracking these claims very difficult.

INTEREST PAYMENTS

The examiner requested the Company procedures for the payment of interest to Florida insureds as a result of late claim payments. It is the opinion of the Company that all policies issued under the "out-of-state group" arrangements are NOT subject to the payment of interest under Florida law. However, the Company is in agreement that all policies written under the Florida Basic, Standard, and Plus plans are subject to the interest requirement and is being followed by the Company. A data run on those policies for which interest has been paid revealed that the Company has paid $1,976.20 in interest on claims paid late under Section 627.613.

COMPLAINTS

For the complaint review, the examiner reviewed the complaints contained on the listing provided by the Company and also verified that files contained on the Department's complaint list were also on the Company list.

The examiner requested a run of all Florida Department of Insurance Complaints received by the Company during the time frame of this examination. A listing of 908 complaints was received and a random selection of fifty (50) files was made for review. The Company was able to produce all files for review. One file out of the fifty files reviewed was found to be in error.

The examiner then selected ten (10) files from the Department's listing of complaints and did a spot check to verify that these same complaints were contained in the Company list. All ten (10) files were provided and one exception was noted. The Company was cited for failing to provide notice of termination to the insured at the last known address. Originally, the Company disagreed with the examiner but when it was pointed out to the Company that the staff knew of the new address prior to termination but failed to send a notice to this address and instead depended on the Post Office to forward the old notice to the new address, the Company acknowledged the violation.

SPECIFIC CLAIM REVIEWS

Four files under investigation by the Department were incorporated into this target Market Conduct Examination. They will be commented on in this section of the report and referred to by the Department's file number for reference.

FILE # 256

The examiner reviewed this file and wrote two individual criticisms on the file. The first criticism concerned the use of forms not filed with the Department. The examiner cited the Company for the use of forms not filed and approved by the Department as a violation of Section 627.410, Florida Statutes. The Company confirmed that during the time frame of the examination, 342 policies were issued under form PO 0010-12-1-00 2/92. Prior to the time frame of this examination, 694 policies were issued which gives a total of 1,036 policies issued since January 1, 1991 to December 31, 1997.

The Company was also cited for four (4) separate violations of Section, 624.318(2), Florida Statutes. These violations concern the Company's failure to respond at all to four different Departmental inquires. The Company agrees with the examiner on the violation and says the inquires were not directed to the proper people for response within the Company upon receipt. This finding was also referenced in the POLICY FORMS AND FILINGS section.

FILE # 1308

The examiner wrote the Company asking for a general outline of activity during the withdrawal from the small group market and received a response from the Company outlining the activities undertaken. A copy of the letter from General Counsel Tim Moore to the Department outlining the plans of the Company was reviewed and it appears to meet the requirements of notification under Florida law. Our problem with the information provided concerns the documentation of how the notices were sent to the insureds. This was discussed in greater detail in the Cancellation/Non-renewal section of the report.

FILE # 1552

The examiner wrote the Company and inquired about any restrictions on its agents regarding what contracts they can and cannot sell. All Company agents in Florida can sell both group and individual policies with the exception of agents employed by Gary Beck. The Company has an agreement with Beck that he and his staff will sell individual policies only. In fact, the Company tailored a program for Beck's group and he has an exclusive right to sell the product. In this case (File # 1552), when the Company received the premium payment check (drawn on the company account of the insured employee), it was sent back to the insured and cancelled. The examiner did not find any violations in this file.

FILE # 1600

The examiner reviewed this file and made an inquiry to the Company concerning the refusal to pay the PPO rate on the claim verses the non-member provider rate, and the

choices available to the insured. The files indicate the insured had paid premiums through April and never advised the Company as to which plan he wanted. The notice refusing to pay the PPO rate went to the same address as the billing, and since the premiums were paid, the conclusion is that the notice was correctly mailed. The hospital had been a member of the PPO network in question but withdrew a couple of months prior to the insured son's treatment. The hospital was readmitted to the plan a month after the treatment. Unfortunately, the son was treated during this small window in which the provider was not a member of the PPO network. The examiner can find no violations in this file.

CONSUMER RECOVERY

As a result of this Target Market Conduct Examination of United Wisconsin Life Insurance Company, payments have been made to residents of the State of Florida in the total amount of $95.25 representing benefits which were wrongfully denied. The reprocessed code 38 claims amount due Florida consumers is approximately $1,500.

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners have been followed in performing the Market Conduct Examination of United Wisconsin Life Insurance Company as of December 31, 1999 except where noted, with due regard to the applicable laws of the State of Florida.

Respectfully submitted,

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Thomas L. Ballard, CIE, CFE, FLMI, ALHC, ASF
Independent Contract Analyst

FINDINGS AND RECOMMENDATIONS

The following findings and recommendations are made by this examiner as a result of the examination of this company. The Company is directed to:

Page 3 — Comply with Section 627.410, Florida Statutes – Obtain approval from the Department of Insurance prior to using policy forms in the State of Florida.

Page 5 — Comply with Section 627.6571(3)(b)(1)(a), Florida Statutes – Provide a 180 day notice to all consumers prior to withdrawing from any market in Florida.

Change procedures to allow correct data entry process for record retention of actual copy of all non-renewal and/or cancellation letters sent to an insured for verification purposes under Section 627.6571, Florida Statutes.

Page 7 — Comply with Section 626.9541(1)(e)1.e.2, Florida Statutes – To ensure that accurate entries and/or recordings are made in official Company records.

Page 8 — Comply with Section 626.9541, Florida Statutes – Unfair Trade Practices Act in the investigation and payment or denial of claims.

Cease the practice in place during the time-frame of this examination on the future use of Code 38 denials as a violation of Section 626.9541, Florida Statutes.

Change the Company practice of issuing new claim numbers to previously denied Code 38 claims and link all correspondence on one claim together to allow regulators and internal auditors to monitor these claims.

The Company is directed to review all claims denied for Code 38 from 1996 to present to ensure that the company is not “denying claims without conducting reasonable investigations based upon available information,” Section 626.9541(1)(i)(3)(d), Florida Statutes.

The Company is directed to notify insured of information necessary for processing of claims.