

FLORIDA DEPARTMENT

OF

INSURANCE

MARKET CONDUCT EXAMINATION REPORT

OF

WORLD INSURANCE COMPANY

11808 Grant Street  
Omaha, NE 68164  
NAIC Code 70629

EXAMINATION

AS OF

MARCH 31, 2002

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

NELSON AYLING, CIE, FLMI  
INDEPENDENT CONTRACT ANALYST  
730 S. HANOVER ST. # F  
BALTIMORE, MD 21230

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

Dear Commissioner Gallagher:

Pursuant to the provisions of section 624.3161, Florida Statutes, and in accordance with the agreement for Market Conduct Services dated March 22, 2002, a Market Conduct Examination has been performed on:

World Insurance Company  
11808 Grant Street  
Omaha, Nebraska 68164

The examination was conducted at the Company's Home Office located in Omaha, Nebraska. The report of such examination is herein respectfully submitted.

Sincerely,

Nelson Ayling, CIE, FLMI  
Independent Contract Analyst

## TABLE OF CONTENTS

I. Executive Summary .....	4
II. Scope of Examination .....	7
III. Company History .....	9
IV. Application Review .....	10
a. Overview .....	10
b. Short term major medical new issue applications.....	10
V. Claims .....	11
a. Overview .....	11
b. Short-term Major Medical .....	14
c. Major Medical .....	16
d. Medicare Supplement .....	18
e. Coverage waiver.....	18
f. HIPAA Compliance.....	19
g. Life Claims.....	19
VI. Complaints.....	20
a. Overview .....	20
b. Complaint Register .....	21
c. Grievance Procedures and Appeals.....	22
VII. Forms and Rates .....	25
a. Rates .....	25
VII. Findings and Recommendations .....	27
Acknowledgments .....	30
Exhibit A.....	<b>Error! Bookmark not defined.</b>
Application Review Chart.....	<b>Error! Bookmark not defined.</b>
Exhibit B.....	<b>Error! Bookmark not defined.</b>
Claims on which interest is due .....	<b>Error! Bookmark not defined.</b>
Exhibit C.....	<b>Error! Bookmark not defined.</b>
Interest paid on life claims .....	<b>Error! Bookmark not defined.</b>
Exhibit D.....	<b>Error! Bookmark not defined.</b>
Complaint Chart.....	<b>Error! Bookmark not defined.</b>
Exhibit E.....	<b>Error! Bookmark not defined.</b>
Grievances.....	<b>Error! Bookmark not defined.</b>

# **I. Executive Summary**

## Purpose of the Examination

The Department selected World Insurance Company for a limited market conduct examination because of the complaint-to-premium ratio and because the Company stated they had no out-of-state group (OSG) policies in-force as of September 12, 2001. The Company submitted a filing to the Forms and Rates section that indicated the Company wanted to begin writing this business in Florida in 2002. The purpose of the examination was to determine the reasons for the number of complaints and to review, analyze, and record the Company's underwriting and marketing strategies for its new out-of-state association group business in Florida. Subsequent to the examiner's arrival on-site, World Insurance rescinded the OSG filing.

The examiner reviewed the following areas of the Company's operations:

## New Business Issues

The examiner selected a random sample of new business written in Florida in year 2001 to determine if association group business was being written in Florida, and to determine if the applications and plans of insurance were the source of the complaints. The Company wrote 4,400 short-term major medical policies and three life insurance policies in Florida during 2001. There were no applications for association group coverage. Consequently, the sample consisted entirely of short-term major medical applications.

The short-term major medical application form informs the applicant that if any answer to a health question is answered "yes," the insurance cannot be issued. The high number of claims denied for a pre-existing condition suggests that some applicants for insurance, who wanted or needed the insurance, may have answered "no" to one or more of the health questions when the correct answer should have been "yes."

## Claims

The examiner reviewed 612 paid and denied life and health claims adjudicated during the term of the examination to determine if claims were being paid timely and accurately.

Furthermore, the examiner tried to determine if the claims were the source of the complaints, and to determine if there were any association group claims. Most of the claims were Medicare supplement claims and short-term major medical claims. There were 49 life claims and no Company association group claims.

The Department did not initially target life insurance claims in its March 22, 2002 call letter. However, during the examination, the examiner noted that the Company had completed an audit in April 2002, (within one month of the call letter) of its life claims for the period of June 30, 2000 to December 31, 2001. The Company's audit resulted in 27 life claim beneficiaries being sent a check for interest on the claims. (The failure to pay interest on claims on the settlement date is a violation of Florida law.) The total amount of interest paid was \$246.03. In view of these interest payments, the examiner reviewed the death claims for the period covered by the examination for other possible violations.

Claims reviewed included a random sample from denied, paid, and paid with interest claim categories. The health claims selected were representative of the health plans issued or administered by the Company, including short-term major medical, major medical, and Medicare supplements. All of the life claims were reviewed.

The processing time for the major medical claims averaged 17 calendar days, for Medicare supplements the average processing time for paid claims was five calendar days and 10 calendar days for denied claims; for short-term major medical claims the average processing time was 40 calendar days for paid claims and 21 calendar days for denied. Interest was due but not paid on 34 health claims; the amount of interest owed on these claims is \$8,323.47. Claims denied for pre-existing conditions were the primary source of complaints and grievances.

#### Complaints and Grievances

All of the complaints and grievances were claim related and many of them concerned a claim denial for a pre-existing condition. None of the complaints involved an association group. Five of the complaints involving a claim denial were reversed as a result of the

intervention of the Florida Insurance Department. In addition, 21 of 42 grievances involving a claim denial were reversed upon appeal and another six denied claims were modified to pay part of the claim upon appeal.

#### Forms and Rates

Generally, the Company filed all of its forms and rates prior to utilization in Florida. However, the examiner did note one form that was used without the Florida Insurance Department's approval. Insureds were notified of a rate increase 45 days or more before the increase in rates took effect. There were no association group form or rate filings made during the term of the examination. However, in May 2002, the Company made a filing for health forms designed to be used for out-of-state group associations. The filing indicated that the forms were to be initially marketed to members of the National Consumer Alliance Association (NCA) and the Small Business Association of America (SBA). The Company informed the examiner that it will develop marketing materials and begin marketing to NCA and SBA members, after Florida has approved the forms.

While the examiner was on site, the Company terminated its contract with its third party administrator, Health Plan Administrators.

## II. Scope of Examination

The Florida Department of Insurance conducted a limited scope market conduct examination of World Insurance Company, hereinafter referred to as World, or the Company. Independent contract analyst, Nelson Ayling, CIE, FLMI conducted the examination pursuant to Section 624.3161, Florida Statutes.

The purpose of the examination was to determine the basis for the complaint-to-premium volume ratio in Florida and to determine if the Company's practices and procedures conform to Florida Statutes and Administrative Code. Prior to the examination, the examiner reviewed the Florida Department of Insurance's investigation reports, form and rate filings, complaints, and other documents concerning the Company.

Because all of the complaints received by the Florida Department of Insurance concerned health insurance, the examination focused on World's health insurance products issued in Florida and covered the time period from January 1, 2000 through June 30, 2002. However, the scope was expanded to include a review of life claims because the examiner discovered the Company had performed an audit of these claims one month after receiving the Department's call letter. The examination was conducted at the Company's Home Office at 11808 Grant Street, Omaha, Nebraska 68164.

The Annual statement for the year 2001 shows the Company is licensed to operate in 46 states and the District of Columbia. The Company is not licensed in Alaska, Massachusetts, New Jersey and New York.

Schedule T of the Company's 2001 year end Annual Statement shows the Company did a significant amount of business (3% or more of its premium income) in the following states:

State	Life Premiums	Health Premiums	Annuity Premiums	Percent of all Premiums
Colorado	\$56,307	\$ 21,992,106	\$1431	10.2%
Florida*	\$161,710	\$5,265,392	\$796	2.5%
Georgia	\$ 174,453	\$6,323,634	\$600	3.0%
Minnesota	\$69,492	\$20,023,529	\$450	9.3%
North Carolina	\$1,185,065	\$23,621,719	\$13,463	11.6%
South Carolina	\$410,677	\$17,826,319	\$25,342	8.5%
Texas	\$34,374	\$18,718,356	\$240	8.7%
Wisconsin	\$11,372	\$8,271,478	\$0	3.8%
All Others	\$3,548,831	\$87,668,458	\$75,766	42.4%

\*Florida is included in the chart to show its premium volume in relation to other states.

### **III. Company History**

World was founded in 1903 in Omaha, Nebraska, as the World Accident Association. The Company began hiring agents in 1925 and became World Insurance Company in 1929. In 1943, World mutualized and was authorized to sell life insurance as well as accident and sickness policies. World was licensed in Florida on September 1, 1942.

World used general agencies throughout the 1960's and 70's. In 1982, the Company adopted a brokerage distribution system and by the end of the decade had more than 5,000 agents. The Company focused its sales on major medical products during this decade.

The Company developed new life products, including term, whole life, and final expense whole life. In 1997, Mid America Mutual Insurance Company of Roseville, Minnesota merged into World. Other acquisitions in 2000 included a major medical block of business from Central States Health & Life Company of Omaha and the acquisition of Mid-South Insurance Company, which sold individual major medical business predominately in North Carolina, South Carolina and Georgia. In 2000 and 2001, World also did claims administration work for other insurers such as Anthem Life Insurance Company and Business Men's Association (BMA).

The total annual premiums written in 2001 for all states and the District of Columbia was \$ 215,484,889. Accident and health insurance premiums accounted for \$ 209,710,991 or 97.3% of the total premiums, life \$5,652,281 or 2.6%, and annuities \$121,617 or 0.1%.

## **IV. Application Review**

### **a. Overview**

The primary focus of the examination was to determine the cause of the complaint-to-premium volume ratio in Florida and to determine if one of the causes of the complaints was due to the sale and marketing of association group products. The examiner reviewed new issue application forms to ascertain the insurance plans currently being marketed by World. The purpose was to determine if the forms and rates have been approved, to determine if the applications are accurately completed, dated and signed, and to determine if the applications and accompanying marketing materials are a cause of complaints. Since, according to the Company, only short-term major medical policies are being marketed in Florida, the examiner limited his review of new issue applications to that one health insurance plan.

### **b. Short term major medical new issue applications**

The examiner randomly selected and reviewed 44 of approximately 4,400 short-term major medical applications written in 2001. The purpose of the review was to determine if the applications were dated and signed, if the agent's name and identification number appeared on the applications, if all questions were answered, and to determine if the applicants were charged the correct premium.

Three applications did not have the agent's name and license identification number which is a violation of Section 627.4085, Florida Statute.

Alterations were made in two of the applications without the written permission of the applicant. The applicant's name had been crossed out on one application but the alteration was not initialed; the premium was changed but not initialed on the second. The Company is in violation of Section 627.407, Florida Statute which prohibits the alteration of any written application for any life or health insurance policy by any person other than the applicant, without his or her written consent.

In addition to the alterations and missing agent license number in the applications, fifty percent (22 of 44) of the applications are missing data, or contain incorrect premiums, or contain incorrect data such as the applicant's sex and the identity of the persons to be insured. Exhibit A attached to this report contains the detailed findings of the application review.

The Company's practice of accepting incomplete and inaccurate applications from its agents is an unacceptable business practice. Accepting applications with omissions or errors is a violation of Section 626.9541(1)(k), Florida Statutes, misrepresentations in applications. Furthermore, the blank sections of the applications provide an opportunity for the application to be altered without the applicant's knowledge and agreement in violation of Section 627.407, Florida Statutes. The examiner recommends that the Company review each application received from its agents for accuracy and completeness.

## **V. Claims**

### **a. Overview**

The principal objectives of the claim review were as follows:

- To review the Company's claim handling procedure;
- To assess the accuracy and consistency of claim processing;
- To review eligibility standards;
- To calculate processing time;
- To verify accuracy of co-pays and deductibles;
- To verify waiting periods were met and enforced consistently;
- To verify that Explanation of Benefit (EOB) letters were sent timely;
- To verify that claim forms were sent within 10 days;
- To verify that interest was paid accurately and appropriately; and
- To verify that PPO members were not balanced billed.

The examiner randomly selected 618 of approximately 68,000 health claims and 49 of 49 life claims adjudicated by the Company or its administrators during the examination survey period.<sup>1</sup>

Particular attention was paid to the payment of mandated health insurance benefits. Claims denied because the policy did not cover a particular medical condition or procedure were carefully analyzed to determine if the condition or procedure was a Florida mandated health benefit. A review of the Company's list of Florida's mandated health benefits was also made and compared to the mandates contained in Florida law. The examiner noted one claim involving child wellness that was denied by the Company. Out-patient psychotherapy claims covered by Medicare were also denied by the Company in several instances but subsequently paid after the claims were reviewed by a supervisor. Additional comments on these claims are contained in the Major Medical and Medicare sections of the report.

Many of the health claims were line item medical expenses from Medicare explanation of benefit forms (EOB). As a rule, if Medicare paid its portion of the claim, the Company paid the balance of the Medicare approved claim. In some instances, Medicare paid the entire claim in which event the Company paid nothing. For claims in which the provider required payment from the patient, the Company would pay 115% (the maximum percentage permitted by the Federal Government) of the Medicare allowed amount less the Medicare payment as its payment under the Medicare supplement policy.

There were also numerous paid, denied, and partially paid short-term major medical claims. Claims were denied primarily because of pre-existing conditions, deductibles, co-pays, use of a non-participating provider, coverage not in force or because the treatment was not covered by the plan. Claims partially paid were often the result of the claim being paid at the usual, customary rate (UCR) level or because the plan would pay part of a medical procedure but not all of it. The examiner also verified that no member of a preferred provider organization (PPO) was balance billed by a participating provider. The denial codes and reasons were reviewed and found to be accurate and appropriate.

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<sup>1</sup> The sample population was determined using NAIC sample selection guidelines and the skip interval statistical method.

During the time frame covered by the examination, the Company's administrator, Health Plan Administrators (HPA), adjudicated World's short-term major medical claims. World adjudicated the life, Medicare supplements, and major medical claims. Many of the Medicare supplement policies and certificates were written by Anthem Life Insurance Company. World is the administrator for Anthem claims and is also a co-insurer for some of Anthem's insurance. Most of the claims received by the Company or HPA were from providers or from Medicare recipients.

The Company adjudicated claims based on the bill submitted by the provider or based on a copy of the EOB Medicare sent to the claimant. All bills and EOBs were considered to be a claim form and were date stamped when received. (Generally, claim forms were not used.) However, if a claim form was requested it was promptly sent to the claimant. Batched claims, especially pharmaceutical claims representing up to one year's accumulation of claims, were considered as received on the date the batch was date stamped by the Company. Each claim in the batch, regardless of the service date, had the same received date. Interest on a pharmacy claim, if payable, is calculated from the date the claim is received and not the date of service. For many of the pharmacy claims the date of service occurred months prior to the date of payment but because the pharmacy chose to batch the claims and send them in on the same date there is no interest due if the claims are adjudicated within 45 days of receipt by the Company.

Processing times in calendar days were as follows:

File	Number of Claims	Range of days to process a claim	Average number of days to process a claim
2300 HPA denied	31	1-324	35
2300 HPA paid	45	7-200	62
2400 HPA denied	51	1-29	15
2400 HPA paid	41	8-64	30
2401 HPA denied	72	1-73	17
2401 HPA paid	84	6-116	33
World denied *	122	1-82	10
World paid *	172	1-43	5
Life paid	49	1-40	6

\*The majority of these claims were Medicare supplements written by Anthem Life and administered by World.

The Company’s claim adjudication computer program “ATLAS” is set up to pay interest at 61 days for claims that need additional information or investigation. Any interest due on clean claims not paid within 45 days is handled administratively.

**b. Short-term Major Medical**

Processing Time

During the period covered by the examination, the Company processed 9,371 short-term major medical claims including 4,778 paid and 4,593 denied claims. The examiner randomly selected and reviewed 170 paid claims and 154 denied claims. Processing time for paid claims ranged from six calendar days to 200 calendar days, averaging 40 calendar days. For denied claims, processing time ranged from 1 to 329 calendar days, averaging 21 calendar days. Some of the claims were not adjudicated until after the policy terminated.

The processing times for paid claims are as follows:

Number of Days	Number of Claims
0-30	98
31-60	40
61-90	20
91and over	12

#### Delays in Processing Claims

The Company post underwrites all short-term major medical claims causing delays in the adjudication process because of the amount of time involved in contacting physicians and other medical providers for medical records. When a claim is received, the Company does a thorough investigation and review of the claimant's medical history prior to adjudicating the claim. A letter is sent to the health provider requesting medical information. If a claimant or provider does not provide the documentation necessary to adjudicate the claim within 90 days after the letter is sent, the claim is pended and only re-opened upon receipt of the information. Once the documentation is received from the providers, HPA paid the claims within 30 days. Because of the delays in obtaining information, the review of some claims was not completed until after the termination of the insurance.

#### Pre-existing Conditions

If the claim is for a pre-existing medical condition, the claim is denied or the policy is rescinded for misrepresentation of the claimant's health condition in the application. During the period covered by the examination, the Company rescinded 10 policies because medical records disclosed that the insured had medical conditions such as diabetes and the insured was taking glucophage to control it, or a heart condition such as paroxysmal artrial fibrillation, or ventricle hypertrophy and aortic insufficiency. The examiner reviewed all of the files and noted that all of the rescissions were for misstatements made in the application. The examiner also noted that 55 of the 154 (36%) denied claims mentioned above were denied because of a pre-existing condition that the insured failed to note in the application.

The Company has no specific underwriting guidelines for determining the risk materiality of a misrepresentation of a health question in the application. Therefore, the examiner questioned why some policies are rescinded for misstatements made in the application and other policies are permitted to remain in force. According to Company management, rescissions are appropriate in cases of material misrepresentations. The examiner is of the view that all misstatements of health are material to risk and that all policyholders misstating their health should be treated the same. The Company's practice of rescinding some policies for material misrepresentations and not others is discriminatory and a violation of Section 626.9541(1)(g), Florida Statutes.

#### Interest Not Paid on Claims

Exhibit B attached to this report lists 34 short-term major medical claims that were not paid within 61 days after the additional information needed to process the claim was received. The examiner, using the information and dates contained in the Company's EOBs and using Florida's late payment of a claim interest rate of 10%, calculated the interest due on the 34 claims as \$8,323.27. The Company should pay interest on each of the claims and should provide the Florida Department of Insurance with a copy of the interest payment letter sent to each of the claimants.

The Company is in violation of Section 627.613, Florida Statutes. The Company should pay interest on all health claims not paid within 61 days after the receipt of proof of loss.

#### **c. Major Medical**

According to Company management, no individual major medical policies were issued in Florida since 1996. Nevertheless, there were 36 major medical claims from Florida insureds in the sample selected by the examiner, including 27 paid and 9 denied major medical claims. All 36 of the claim files were reviewed. The processing times for the paid claims were as follows.

Number of Calendar Days	Number of Claims
0-30	21
31-60	6
61-90	0

Processing time ranged from 1 calendar day to 48 calendar days, averaging 17 days.

Claims were denied for the following reasons.

Denial Reason	Number of Claims
Service not a covered expense	3
Policy not in force at time of service	3
Treatment not covered	1
Medical condition waived	1
Pre-existing	1

The following exceptions were noted:

Policyholder # 593-89-0068-This claim for \$246.00 was denied because the medical procedures were not covered under the policy. This is a child wellness claim and it is payable under the policy. The Company is in violation of Section 627.6416, Florida Statutes. The Company should pay all benefits covered by its policy.

Policyholder #000001696046(EOB000150525982)-This claim was approved. However, the claim payments were applied towards the calendar year 2002 deductible. The insured complained that the procedures occurred in the previous calendar year 2001 and consequently the claim payments are not subject to a new calendar year deductible. The insured also complained that she had previously brought the “carry-over” deductible problem to the Company’s attention but nothing was done.

The examiner recommends the Company program its claim system to recognize claims for which a deductible has been paid.

**d. Medicare Supplement**

Most of the Medicare supplement claims (270 of 287) were claims under an Anthem Life Insurance Company policy administered by World. Processing times for the paid claims ranged from 1 to 43 calendar days, averaging 5 calendar days.

The examiner noted that the following World claim was initially denied but subsequently paid after the Company became aware that it was a Medicare approval expense:

World Policyholder #01511998 (Medicare Supplement)-These claims (040601700173, 0131601700201, and 041301700189) were denied because the out-patient psychotherapy service is not programmed in the Company's claim system as a covered expense for major medical policies. However, it is payable for Medicare Supplement policies. The Company paid the claim after Medicare approved it.

The examiner recommends that the Company program its claim payment system to recognize Medicare approved procedures for payment.

**e. Coverage waiver**

The examiner reviewed the Company's procedures for assigning a health condition waiver, such as a waiver for asthma, or varicose veins, or diabetes, to a policy for the purpose of determining if the waivers were needed and if the waiver covered a specific health condition. There are 108 Florida individual health policies in force with a coverage waiver. All of the waivers appear to have been assigned for specific health conditions. No exceptions were noted.

The waiver is not necessarily for the life of the policy. Policyholders can petition the Company to remove the waiver. In reviewing the claim files, the examiner did notice one instance where the Company agreed to remove the waiver because the waived health condition had been corrected by medication.

**f. HIPAA Compliance**

The Company stopped writing individual health insurance policies (other than short-term major medical) in Florida in 1996 and notified the Florida Department of Insurance of its withdrawal from the individual health insurance market. Consequently, the Company has no individual health policies available for individual HIPAA conversions in Florida.

However, the Company did supply the examiner with a copy of the approved rider forms used to bring the Company's existing health insurance policies into HIPAA compliance.

**g. Life Claims**

The Company received 49 life claims during the period of July 31, 2000 to May 13, 2002. Processing time for 44 paid claims ranged from one to 40 calendar days, averaging 6 calendar days. Five claims are still pending receipt of death certificate.

The examiner reviewed 44 death claim files and verified that the correct amount of death benefit proceeds were paid including the payment of the policy face amount less any loans, interest if applicable, additional death benefits such as accidental death, paid up dividend additions, return of unearned premiums, dividends due, and dividend accumulations. The Company paid interest at 8% on eight claims at the time of the claim settlement, and on 27 other claims after the claim settlement date. (The interest was calculated from the date of death to the date of settlement.) No interest was due and/or calculated on the remaining nine claims because either the claim was promptly paid or the claim file is still open pending receipt of the Death Certificate.

The post settlement interest payments were paid in April 2002 as a result of an audit. The total amount of interest paid was \$246.03; the detailed breakdown is shown in Exhibit C. The Company is in violation of Section 627.4615, Florida Statutes, for failing to pay interest due on the claim settlement date. The Company should implement procedures to ensure that interest is paid on claims at settlement when they are settled.

## VI. Complaints

### a. Overview

The Company supplied the examiner with a copy of its complaint/grievance handling procedures and with a list of its complaint codes. The Company defines a grievance as a telephone call or written communication from any person, provider, company or organization expressing or implying distress, injustice, dissatisfaction, etc., with an aspect of the business of insurance. Any written grievance transmitted to the Company by a state Insurance Department is considered a complaint. Complaints from policyholders concerning a claim payment or claim denial are labeled as a grievance and are subject to the grievance procedures.

Grievances and complaints are forwarded to the Compliance Unit of the Company for recording and assignment to the appropriate Company personnel for answering.

Grievances are answered directly to the insured. Complaints are answered to the state Insurance Department unless instructed by the Department to communicate with the insured.

The Company used Health Plan Administrators (HPA), a third party administrator, to administer its short-term major medical policies. The administrator is required under the TPA contract to forward to the Company for review and resolution all complaints originating from an Insurance Department or from an attorney. Complaints not involving a state insurance department or an attorney are resolved by the TPA. However, the Company may not be aware other complaints exist because the Company does not formally audit the complaint records of its administrator. According to management, the Company does make frequent visits to the TPA to reconcile claim accounts but does not produce an audit report.

The examiner has informed the Company that this is an unacceptable business practice because the TPA could have received non-insurance department complaints involving fraud, agent misconduct, and misleading sales and claims practices, issues of vital importance to the operations of the Company. In addition, without a formal audit, the

Company would not know whether or not the TPA had submitted all of the complaints from a state insurance department or from an attorney.

During the period of the examination, the Company informed the examiner that it had terminated its agreement with HPA. The examiner recommends that the Company institute a formal audit program for the review of the business administered by a third party administrator.

**b. Complaint Register**

The Company maintains a complaint register as required by Section 626.9541, Florida Statutes. The register contains the following data:

- Complainant's name
- Complainant's address
- Policy number
- Claim number
- Insurance Department's file number
- Function code
- Reason code
- Line code
- Disposition
- Justified
- Date received
- Date closed

During the period covered by the examination, the Company received 28 complaints including 27 from the Florida Insurance Department and one from a policyholder. Processing time ranged from 2 calendar days to 61 calendar days, averaging 12 calendar days. All of the complaint files were reviewed. Nineteen complaints concerned a claim denial, three complaints concerned a rate increase and two complaints concerned the failure of the Company to pay a premium refund upon the death of the insured. Four other complaints involved a request for information, claim payments made to a Preferred

Provider Organization, a misdirected claim payment and a delay in a claim payment. The Company's complaint register indicates the Company determined that five of the 28 complaints were justified. Each of these five complaints concerned the denial of a claim that was paid or partially paid after the Florida Department of Insurance became involved.

The reasons for the complaints are as follows:

Reason for complaint	Number of complaints
Claim Denial	19
Rate Increase	3
Premium Refund	2
Claim Handling	4

A table showing the policy numbers, the reason for each complaint, and the disposition of each complaint is contained in the report as Exhibit D.

The dispositions of the complaints were found to be accurate and verification was made that, where needed, corrective action was taken.

### **c. Grievance Procedures and Appeals**

The purpose of the review was to determine:

- if the grievance/appeals were handled in a timely manner;
- if the grievance/appeals were in accordance with the appeals/grievance procedures;
- if adverse grievance/appeal trends existed; and
- if the claimant was treated fairly.

The notice of the right to appeal an adverse claim decision is contained in the policy. An appeal process information packet is sent to the insured at the time an appeal is received.

The packet contains information about how to appeal decisions made by the insurer. In general, there are three levels of appeals available to the insured:

- Informal reconsideration- In lieu of requesting a formal grievance review, the insured may attempt to resolve the claim problem by contacting the Customer Service Department at a toll free telephone number contained in the Grievance Procedures document given to each insured at time of purchase of the policy.
- First level grievance review- The grievance may be submitted by an insured, a representative of the insured, or a provider acting on behalf of the insured. The person or persons reviewing the grievance will not be the same person or persons who initially reviewed the claim. Within three working days after receiving the grievance, the insured is provided with the name, address and telephone number of the grievance coordinator. Within 20 working days after receiving the grievance, a written decision will be issued to the insured containing among other things, a statement of the reviewer's understanding of the grievance, the reviewer's decision in clear terms, and a statement advising the insured of his or her right to a second level grievance review. If the reviewer cannot make a decision in 20 days due to circumstances beyond the insurer's control, the insurer may take up to an additional 10 days to render a decision.
- Second level grievance review- The second grievance level is a review of the grievance by a panel. The insured may attend the review meeting but his/her presence is not required. A written decision will be issued within seven days after the panel completes their review. An expedited second level grievance review is also available when medically justified.

Each grievance level is reviewed by a different claims analyst. A grievance decision can be affirmed, meaning that the Company will not make a change in its original claim decision; reversed, meaning the Company will pay the claim; or modify, meaning the Company will pay part, but not all, of the claim. A detailed description of the grievance process and grievance levels is contained in the grievance/claim packet given to the policyholder at time of purchase of the insurance.

The grievance procedures require the Company to send the covered person a written decision within 20 working days after receipt of the grievance. However, this was not done for grievances that were reversed or modified. For these grievances, the Company did not send a written letter to the covered person explaining its decision but instead sent a new EOB to that person.

The Company's position is that the EOB constitutes a written statement. This means that the term "written decision" as it appears in the grievance procedures manual, has two meanings, i.e., an EOB for modified and reverse decisions and a written letter for affirmed decisions. This process should be changed. Each person with a grievance must be treated the same.

Generally, the grievance letter sent to a claimant whose appeal was affirmed was clear and precise as to why the Company was affirming its position. However, the grievance procedures require that the letter specify the professional qualification and licensure of the person or persons reviewing the grievance and contain a statement advising the Covered Person of his or her right to request a second-level grievance review. None of the letters advised the Covered Person of the right to a second-level review and most of the letters did not specify the professional qualifications and licensure of the reviewer.

The examiner reviewed all 42 grievances/appeals, including one informal grievance, processed by the Company and/or its administrator during the period covered by the examination. The grievances usually originated from the insured, a relative, or a provider and did not involve a state insurance department. All of the grievances concerned the denial of a claim or the denial of part of a claim. In only one case did the Company require a 10 day extension to resolve the grievance. All of the other cases were resolved in less than 20 working days. Twenty-one grievances were reversed, fifteen affirmed, six modified. There were no discernable patterns in the kinds of claims that were reversed, modified or affirmed.

The number of appeals/complaints processed by Company and or its third party administrator HPA is as follows:

Grievance Action	Number of Grievances	Percentage
Reverse	21	50%
Modify	6	14%
Affirm	15	36%
Total	42	100%

A table containing the policy number, reason for the grievance, and decision for each of the 42 grievances is contained in the report as Exhibit D.

The Company should follow its procedures and send written decisions on all of its grievance decisions and amend its letters to contain both the reviewers qualifications and licensure and a statement informing the Covered Person of his or her rights to a second-level review.

## **VII. Forms and Rates**

### **a. Rates**

The Company supplied the examiner with a copy of the rate filings required by Section 627.410, Florida Statutes. All of the filings had been approved prior to utilization by the Company. The examiner also selected 12 rate increase notification letters contained in various Major Medical and Medicare claim files and verified that the rate increases for nine of the policies had been approved. Three of the rate increases were for policies that were not issued in Florida and were not filed with the Florida Department of Insurance. The policyholders had, subsequent to the rate filing, moved to Florida and the rate notification letter was mailed to the Florida addresses. No exceptions were noted.

The examiner also verified that policyholders were given at least a 45 day notice of the rate change.

**b. Forms**

The Company currently issues short-term major medical, whole life insurance and annuities in Florida. The application, form G2300-FL (3-01), used to issue the short-term major medical policies was approved. However, the Company's administrator, HPA, added a solicitation and application section for a discounted pharmacy benefit plan to the bottom of the form that was not approved by the Florida Department of Insurance. Because the application form with the added language at the bottom of the form becomes a part of the contract, the form with the added language is subject to review and approval by the Florida Insurance of Department. The Company is in violation of Section 627.410, Florida Statutes, which states in part:

*“No basic insurance policy or annuity contract form, or application form where written application is required and is to be made a part of the policy or contract, ...shall be delivered in this state, unless the form has been filed with the department at its offices in Tallahassee by or in behalf of the insurer which proposes to use such form and has been approved by the department.”*

The Company should file all forms prior to utilization.

## **VII. Findings and Recommendations**

### **III. Application Review (Pages 10-11)**

- a. Alterations in Application Forms (2 instances)-The examiner noted two applications that were altered without the written consent of the applicant. The Company is in violation of Section 627.407, Florida Statutes.
  
- b. In addition to the alterations and missing agent license number, fifty percent (22 of 44) of the applications are missing data, or contain incorrect premiums, or contain incorrect data such as the applicant's sex and the identity of the persons to be insured. The Company's practice of accepting incomplete and inaccurate applications from its agents is an unacceptable business practice. Accepting applications with omissions and errors is a violation of Section 626.9541(1)(k), Florida Statutes, misrepresentations in applications. Furthermore, the blank sections of the applications provide an opportunity for the application to be altered without the applicant's knowledge and agreement in violation of Section 627.407, Florida Statutes. Finally, missing information could indirectly facilitate the denial of claims due to pre-existing conditions. The examiner recommends that the Company review each application received from its agents for accuracy and completeness.

### **IV. Claims (Pages 11-19)**

- a. Short-term major medical-Interest is not paid on claims (34 instances). The Company did not pay interest on claims not paid within 61 days after the additional information needed to process the claim was received, in violation of Section 627.613, Florida Statutes. Interest due totals \$8,323.47. The Company should pay interest on all claims not paid within 61 days after receiving all of the information needed to adjudicate the claim. The Company should pay interest on each of the 34 claims in Exhibit B and should provide the Florida Department of Insurance with a copy of the interest payment letter sent to each of the claimants.

b. The company's current policy leads to discrimination in underwriting for short-term major policies. The Company does not have written procedures or guidelines to determine when a policy should be rescinded for misrepresentations made on an application. The Company currently rescinds some policies for misrepresentations and not others. Due to the unfairly discriminatory nature of this practice, the Company is in violation of Section 626.9541(1)(g), Florida Statutes.

c. Major Medical-The examiner noted one mandated health benefit that was not paid by the Company. This is a violation of Section 626.6416, Florida Statutes.

One other claim was charged a deductible twice because the date of service occurred in the previous calendar year. The examiner recommends that the Company program its claim adjudication system to recognize claims for which a deductible has already been paid.

d. Life-Interest is not paid on claims (27 instances). The Company did not pay the interest due on the claim payment date. The Company is in violation of Section 627.613, Florida Statutes. The Company should pay any interest due on the claim on the date the claim is paid.

## V. Complaints (Pages 19-25)

a. The Company does not require its third party administrator to audit its claims or complaint files. This is an unacceptable business practice. The examiner recommends that the Company implement an audit program for all its third party administrators.

b. Grievance letters- The grievance letters do not advise the covered person of the right to a second-level review and do not specify the professional qualifications and licensure of the reviewer. In addition, grievance letters are only sent to Covered Persons whose

grievances are affirmed. The Company should follow its procedures and send written decisions on all of its grievance decisions and amend its letters to contain both the reviewers qualifications and licensure and a statement informing the Covered Person of his or her rights to a second-level review.

## VI. Forms and Rates (Page 25)

The examiner noted one form that was used without the prior approval of the Florida Insurance Department. The Company is in violation of Section 627.410, Florida Statutes.

## **Acknowledgments**

The target market conduct examination report on World Insurance Company is respectfully submitted to the Honorable Tom Gallagher, Insurance Commissioner of the State of Florida.

The courtesies and cooperation extended to the examiner by the Officers and employees of World Insurance Company is appreciated. In addition to the examiner, Jack McDermott, CIE, Examination Coordinator, and his staff, participated in the examination and preparation of the report.

Respectfully submitted

Nelson Ayling, CIE, FLMI