FLORIDA DEPARTMENT OF INSURANCE

TARGET MARKET CONDUCT REPORT

OF

ULICO CASUALTY COMPANY

AS OF

MAY 8, 2000

DIVISION OF INSURER SERVICES

BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT

MARKET CONDUCT SECTION

BY TERRENCE J. CORLETT, AIE, FLMI
INDEPENDENT CONTRACTOR ANALYST

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September 13, 2000

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

Dear Commissioner Gallagher:

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

ULICO CASUALTY COMPANY
111 MASSACHUSETTS AVENUE NW
WASHINGTON, DC 20001

The examination was performed at the offices of the company's third party administrator, USA Benefits Group, 1164 Oakland Park Boulevard, Fort Lauderdale, Florida 33334.

The report of such examination is herein respectfully submitted.

Sincerely,

Terrence J. Corlett, AIE, FLMI
Independent Contractor Analyst

INTRODUCTION

ULICO Casualty Company, is hereinafter generally referred to as "the Company" or “ULICO” when not otherwise qualified.

USA Benefits Group is hereinafter referred to as “the TPA” when not otherwise qualified.

The Florida Department of Insurance, is hereinafter generally referred to as "the Department" when not otherwise qualified.

This targeted market conduct examination was conducted pursuant to **Section 624.3161**, Florida Statutes by Terrence J. Corlett, AIE, FLMI, an independent contract examiner representing the Florida Department of Insurance. The exam commenced on May 17, 2000 and concluded on September 13, 2000.

SCOPE OF EXAMINATION

The examination covered the period of the Company's operation in the State of Florida from October 1, 1997 through May 8, 2000; including any material transactions and/or transactions and events occurring subsequent to the examination period.

The purpose of this target market conduct examination was to determine if the Company's practices and procedures conform to the Florida Statutes and the Florida Administrative Code. Examination was performed on the small group health insurance line of business.

Procedures and conduct of the examination were in accordance with the Department's Field Examination Guidelines and the Market Conduct Examiners Handbook produced by the National Association of Insurance Commissioners (NAIC). The handbook standards of a seven percent (7%) error acceptability factor for claim resolution procedures and a ten percent (10%) error acceptability factor for other procedures were given consideration and applied where applicable.

The examination included, but was not limited to, the following areas of the Company's operation applicable to its health insurance business in Florida:

1. Premium Billing
2. Cancellations and Non-Renewals
3. Claims Handling
4. Complaint Handling
5. Conversion of Group Health Policies

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.

DESCRIPTION OF COMPANY

History

During the period under review, ULICO Casualty Company was domiciled in the State of Delaware and was a stock life insurance company that was a wholly-owned subsidiary of ULICO Inc. The Company maintains its headquarters in Washington , D.C.

The Company's Florida earned premium during the examination period came primarily from a small group health insurance book of business. The book of business was acquired through a block assumption from CNA effective October 1, 1997. The administration of the CNA business was handled by a Florida third party administrator, known as USA Benefits Group, based in Fort Lauderdale, Florida.

ULICO Casualty Company contracted to have USA Benefits Group continue administering the business per an administrative services agreement dated June 13, 1997. Administration services provided, included but were not limited to, policy issuance, premium billing, commission processing and claims handling.

ULICO Casualty Company notified the Florida Department of Insurance in 1999, that they had decided to withdraw from the small group health insurance market in the State of Florida. The Florida Department of Insurance required the Company to give the insured groups a 180 day minimum notice that their policies would not be renewed.

PREMIUM BILLING

A random sample of fifty (50) group health billing invoices was selected from a population of 5,942 policies effective at the time of review to determine timely posting of premium payments to policyholder accounts. No discrepancies were noted.

During the review of premium invoices, the examiner determined that the Company/TPA was improperly charging some groups a fee for reinstatement of their policies. The TPA provided a listing of nine (9) groups that had been charged a $50 fee for reinstatement of their policies during the period from September 20, 1999 up to the date of review.

This fee was previously ruled as an unapproved rate by the Florida Department of Insurance resulting in issuance of a consent order (#29921-99-CO) on September 20, 1999 for imposing unapproved rates ($25 monthly administration fee and $50 reinstatement fee). The continued use of unapproved rates(reinstatement fees) is a willful violation of **Section 627.410(6)(a)**, Florida Statutes. These fees should be refunded to the policyholders and are detailed in the Consumer Recoveries Section of the report.

CANCELLATIONS AND NON-RENEWALS

Group Health Non-Renewals

A random sample of one hundred (100) group health policy files, from total population of 5,942, was reviewed to determine if policyholders were given at least one hundred eighty (180) days advance written notice of non-renewal as required by the Florida Department of Insurance. No discrepancies were noted.

CLAIMS ADMINISTRATION

Claim Settlement Procedures

The Company, as previously stated, had contracted with USA Benefits Group (TPA) to administer the claims handling process. The TPA had adopted claims processing procedures as outlined in the Trilogy claims manual.

Claims are processed in the Fort Lauderdale, Florida headquarters of the TPA. Claimants are instructed to send claims directly to the TPA. Claims are to be processed in accordance with the administrative services agreement between the Company and the TPA and ultimately in accordance with Florida Statutes.

As a result of the Company's decision to withdraw from the Florida insurance market, a dispute arose between the Company and the TPA as to the processing responsibility of "run-off" claims on terminated groups. Arbitrators ruled on May 26, 2000 that USA Benefits Group was responsible for the administration of the "run-off" claims associated with the block of business and must continue to process those claims in accordance with the agreement signed in June of 1997.

Upon notice that the Company was withdrawing from the Florida small group health market, the TPA began forwarding "run-off" claims on terminated/non-renewed groups from its Fort Lauderdale, Florida office to the Company headquarters in Washington, D.C. Both the Company and TPA agreed that approximately 10,000 "run-off" claims were forwarded from the TPA to the Company headquarters during the dispute in the first half of the year 2000. Beginning on May 26, 2000, these claims were sent back from ULICO headquarters to the TPA as a result of the arbitrator's ruling that the TPA was responsible for the processing of the claims.

The claims referenced above were not included in the data listing of "claims received" provided to the examiner upon commencement of the examination. This prevented the examiner from including

these claims in his review of received/paid claims. To ensure that these "run-off" claims were being processed, the examiner independently reviewed one hundred (100) of these claims. The findings associated with this review are shown separately from the examination of the paid/received claims and are detailed under the heading "Run-Off Claim Review".

ANALYSIS OF CLAIM STUDY

Claims were randomly selected and reviewed for compliance with:

1. Contract provisions
2. Timeliness and accuracy of payments
3. Supporting documentation
4. Unfair claim settlement practices

A time study for paid and denied claims was conducted to determine the "calendar days" required to process a claim after receiving proper proof of loss.

The term "calendar days" included Saturday, Sunday and holidays. Cycle time used in the analysis was for the following groups of days: 1-45, 46-120, 121 and over.

Paid Claims Review

A random sample of one hundred (100) claim files from a total population of 1,377,857 claims received during the review period was reviewed to determine if claims had been processed correctly

and in a timely manner as required by **Sections 627.613 and 627.657(2)**, Florida Statutes. Of the one hundred (100) claims selected for review, only sixty-six (66) of the claims required payment. Thirty-four (34) of the claims did not require payment due primarily to duplication of a previously paid claim or denial of benefits.

Time Study-Group Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	40	60.7 %
46-120	19	28.7 %
121 and over	7	10.6 %
Total	66	100.0 %

The average time required to process a paid claim was 60.5 days.

Findings:

Twenty-six (26) claims were not paid within forty-five days of receipt of written proof of loss. This represents an error rate of 39.4% (26 of 66 of claims paid late). This is a violation of **Section 627.613(2)**, Florida Statutes.

One (1) claim was improperly denied benefits. Upon investigation of the claim by the examiner, the TPA agreed that the claim was improperly denied and benefits were paid in the amount of $27.96 on 7-10-00.

Claims that are not paid within 45 days of written proof of loss are required to be paid interest at a rate of 10% per year in accordance with **Section 627.613(6)**, Florida Statutes. The examiner identified six (6) claims, of the twenty-six (26) paid late, which would be due interest in excess of $5.00. These claims are detailed in the Consumer Recoveries Section of the report. This represents an error rate of 23% (6 of 26 claims paid late without interest).

The Company/TPA demonstrated a general business practice of late payment of claims as evidenced by the 60.5 day average to pay claims and the 39.4 percentage of claims paid late. This is a violation of **Section 626.9541(1)(i)(3)**, Florida Statutes.

Denied Claims Review

A random sample of one hundred (100) claim files, from a total population of 217,756 claims denied during the review period, was selected to determine if claims had been processed correctly and in a timely manner as required by **Sections 627.613 and 627.657(2)**, Florida Statutes.

Of the one-hundred (100) claims selected for review, only seventy-seven (77) of the claims requested by the examiner were provided by the TPA for review during the exam period. The review of denied claims was performed on those seventy-seven (77) claims. The failure to provide twenty-three (23) of the claims requested by the examiner is a violation of **Section 624.318(2), Florida Statutes**.

Time Study-Group Health Denied Claims

Calendar Days	Number of Claims	Percentage
1-45	49	64.1 %
46-120	27	34.6 %
121 and over	1	1.3 %
Total	77	100.0 %

The average time required to process a denied claim was 44.2 days.

Findings:

The examiner identified nine (9) claims that were improperly denied benefits upon the original submission of written proof of loss. This represents an error rate of 11.69 %.
(9 of the 77 claims reviewed were improperly denied upon original submission).

One (1) claim was improperly denied benefits due to a clerical error of entering an incorrect loss date. This is a violation of **Section 627.613(2)**, Florida Statutes. This claim is detailed in the Consumer Recoveries Section of the report.

Eight (8) claims were denied without conducting a proper investigation. These claims were denied benefits before the TPA/Company acquired reasonable proof to deny the claims. This is a violation of **Section 626.9541(1)(i)(3)(d)**, Florida Statutes.

Three (3) of the eight (8) claims referenced above were also found to be in violation of **Section 627.613 (2)**, Florida Statutes for failure to pay a claim on which an adequate proof of loss was received. These claims are detailed in the Consumer Recoveries Section of the report.

Claims that are not paid within 45 days of written proof of loss, are required to be paid interest at a rate of 10% per year in accordance with **Section 627.613(6)**, Florida Statutes. The examiner identified five (5) claims, of the nine (9) claims improperly denied, that are due interest in excess of $5.00. These claims are detailed in the Consumer Recoveries Section of the report.

"Run-Off" Claims Review

A random sample of one hundred (100) files from a population estimated at 10,000 "run-off" claims received during the review period was reviewed to determine if these claims were being processed correctly and in a timely manner as required by **Sections 627.613 and 627.657(2)**, Florida Statutes. Of the one hundred (100) claims selected for review, fifty-one (51) of the claims required

payment/deductible credit. Forty-nine (49) of the claims did not require payment due primarily to duplication of a previously paid claim or denial of benefits.

Time Study - "Run-Off" Claims

Calendar Days	Number of Claims	Percentage
1-45	14	27.5 %
46-120	32	62.7 %
121 and over	5	9.8 %
Total	51	100.0 %

The average time required to process the "run-off" claims was 72.8 days.

Findings:

Thirty-seven (37) claims were not paid within forty-five days of receipt of written proof of loss. This represents an error rate of 72.5% (37 of 51 of claims paid late). This is a violation of **Section 627.613(2)**, Florida Statutes.

Claims that are not paid within 45 days of written proof of loss are required to be paid interest at a rate of 10% per year in accordance with **Section 627.613(6)**, Florida Statutes. The examiner identified nine (9) claims, of the thirty-seven (37) paid late, that would be due interest in excess of $5.00. These claims are detailed in the Consumer Recoveries Section of the report.

Group Health – Interest on Claims

The original examination data request issued by the Florida Department of Insurance, included a request for a listing of all claims paid that included interest for late payment. The TPA advised the examiner that no claims were paid interest during the examination period. The failure to pay interest on late paid claims is a violation of **Section 627.613(6),** Florida Statutes.

COMPLAINTS

Complaint Handling Procedures

The Company provided the examiner with complaint handling procedures in a memo style format dated 7-27-00.

Record of Complaints

Review and cross-referencing of twenty-five (25) complaint files indicated that the Company maintained a complete record of all complaints received during the period under review as required by **Section 626.9541(1)(j)**, Florida Statutes.

Complaint Processing

Complaints were reviewed to determine if they were appropriately resolved. Generally, the examiner determined that a reasonable resolution to the complaint had been reached. However, final

resolution of the complaints reviewed often resulted in payment or additional payment on claims that should have been paid upon original submission of proof of loss. Though the resolution may have resulted in a late claim payment, no interest payments were included in the claim settlements.

Work Days to Resolve Complaints

Fifty (50) complaint files from a total population of 194 were selected for review to determine the Company's timeliness in responding to DOI complaint inquiries. These complaints covered the period from October 1997 through April 17, 2000. The average number of days to handle a complaint for the entire review period was 18.5 days. Review indicated that the Company made their initial response to the Florida DOI within the time specified on the complaint notice. No discrepancies were noted.

CONVERSION OF GROUP HEALTH POLICIES

Forty-two (42) certificate holders requested conversion of their group health policies into individual policies during the period under review. The examiner reviewed all forty-two (42) conversion requests to ensure that proper conversion into the individual health policies was conducted. No discrepancies were noted.

AGENT'S COMMISSIONS

A review of agent's commissions was performed as a result of the number of complaints received by the Florida Department Insurance regarding non-payment of agent's commissions on the ULICO Casualty small group health business. The examiner's findings are detailed below:

An administrative agreement outlining both the TPA's and the Company's duties regarding payment of commissions was in effect during the period under review.

Though agent's commissions and licensing on the small group health business are a financial responsibility of ULICO, the TPA handled all of the administrative duties associated with marketing of the business. Services included contracting with agents appointed by ULICO Casualty Company to market business for ULICO through the TPA's marketing subsidiary now known as USA Wholesale Marketing Services, formerly FirstStar Marketing.

The TPA's marketing subsidiary had terminated all but seventeen of its contracts with agents as of September 9, 2000. Most of the contracts were terminated by February 29, 2000.
The TPA has ceased paying commissions to terminated agents on the ULICO small group health business. They continue to pay renewal commissions on the ULICO business to the agents that have not had their contracts terminated.

ULICO accounting records indicate that they have paid funds representing commissions to the TPA in the amount of $1,689,514.59 since March 1, 2000.

The TPA states in a memo dated September 11, 2000, "USABG received fees and commissions from ULICO during 2000. As a result of ULICO's decision to terminate the in force groups and exit the state, USA Wholesale, a/k/a FirstStar Marketing, terminated its agent contracts. About 20 agent contracts were retained. All other agent commissions earned were directed to Mark Blocker, a

licensed agent, performing the duties as agent. There is no vesting of renewal commissions provision in the contract with former agents."

Mark Blocker holds the positions of Chairman of the Board of USA Benefits Group, Chairman of the Board of USA Services Group, President of USA Wholesale Agents, President of Professional Business Owners Society and President of FirstStar Holdings.

Wire transfer confirmation records were reviewed and both parties agree to the amount of funds transferred from ULICO to USABG during the period from January 1, 2000 to August 8, 2000.
An arbitration hearing was held on September 20, 2000 to settle the dispute regarding administrative fees and commissions between ULICO and the TPA. The arbitration panel scheduled a decision for November. Based on a letter from Ullico, Inc. dated December 4, 2000, the outcome of this hearing has not been communicated to the affected parties.

No violations of Florida Statutes were identified as having been committed by ULICO during the review of agent's commissions.

CONSUMER RECOVERIES

As a result of this targeted market conduct examination of ULICO Casualty Company, the following payments have been or will be made to residents of the State of Florida.

Policyholder/Group	Group #	Claim # if applicable	Recovery
Ricks Auto Tint	PO 285	n/a	$50.00
Tants 60 Min. Cle.	PO 462	n/a	$50.00

John Wright III	PN 1494	n/a	$50.00
Surgical Associates	PN 3033	n/a	$50.00
Sun Valle Distrib.	PS 1514	n/a	$50.00
Keys Bobcat & Light	PN 3057	n/a	$50.00
Auto Electric	PN 1021	n/a	$50.00
Florida Printing	PB 83	n/a	$50.00
Siesta Harbor	PO 378	n/a	$50.00
156604669	PB 689983440456		$42.94
622289330	PS 0697	983450014	$5.90
417134285	PS 0660	983450112	$14.11
229449548	PS 0658	983450185	$8.80
451528776	PS 1598	000241784	$6.59
363409001	PN 2661	001080523	$16.42

Policyholder/Group	Group #	Claim # if applicable	Recovery
069360894	PS 1885	000151272	$27.96 **
154623658	PS 0247	993010612	$6.34
266952350	PS 1201	993140741	Benefits + Int.
131507237	PN 0534	993230993	$281.03
265199251	PS 0291	991021284	Benefits + Int.
044542231	PR 0102	000760651	Benefits + Int.
267582718	PS 0445	990150029	$5.13

373486851	PN 2443	000430429	Benefits only
172441683	PN 1024	001790262	$17.44
266952350	PS 1201	001600154	$12.92
386469468	PN 1074	001630034	$57.08
263232251	PS 0958	001551012	$9.37
313528752	COBRA	001580035	$8.14
261952997	PS 0610	001560307	$10.36
120287323	PN 2143	002010066	$5.60
595031965	PN 1519	001560309	$5.82
047505757	PO 284	001680780	$5.02
131341433	PN 1933	001690567	$25.08
TOTAL CONSUMER RECOVERIES			**$1,022.05**

(Excluding the four (4) claims with no amount given)

** = Claim Benefits paid while examiner was on exam site, no further payment by the Company is necessary.

The Company is instructed to issue adjustment checks in the amount noted above as a result of the findings of the target market conduct examination. For recoveries listed without an amount, the Company is instructed to review the file and determine the appropriate benefit, plus any interest (at 10% per year), if interest from the date of proof of loss to the date of claim payment exceeds $5.00.

These adjustment checks are to be issued along with a letter stating that the checks represent refunds due to policyholders, as a result of an examination of the insurer by the Florida Department of Insurance.

Copies of the checks and letters are to be forwarded to the Florida Department of Insurance within ten days of the issuance of the finalized examination report. The copies should be sent to the attention of:

Kim McClellan, Field Insurance Regional Administrator
Bureau of Life & Health Solvency & Market Conduct Review
200 East Gaines Street
Tallahassee, FL 32399-0327

FINDINGS AND RECOMMENDATIONS

The following findings were made in the preceding pages of this report. The Company is directed to:

Page 7 Cease charging a fee for reinstatement of small group health policies. This fee represents an unapproved rate and is a violation of **Section 627.410(6)(a)**, Florida Statutes.

Page 11 Comply with **Section 627.613(2)**, Florida Statutes, by adopting and implementing standards to assure claims are paid within forty-five days of written proof of loss.

Page 11 Comply with **Section 627.613(6),** Florida Statutes, by establishing claim handling procedures to assure that interest is paid on all overdue claim payments.

Page 12 Comply with **Section 624.318(2)(3)**, Florida Statutes. The Company should maintain adequate and make freely available to the department or its examiners, the accounts, records, documents, files, assets, and matters in their possession or control relating to the subject of the examination.

Page 13 Comply with **Section 626.9541(1)(i)(3)(d),** Florida Statutes. The Company should Adopt and implement standards for the proper investigation of claims. (Error ratio – 10.3%)

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners were followed in performing the Market Conduct Examination of ULICO Casualty Company as of May 8, 2000, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

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Terrence J. Corlett AIE, FLMI
Independent Contractor Analyst