FLORIDA DEPARTMENT OF INSURANCE

MARKET CONDUCT REPORT OF EXAMINATION

OF

BLUE CROSS and BLUE SHIELD of FLORIDA, Inc.
AS OF
December 31, 1996

DIVISION OF INSURER SERVICES

BUREAU OF LIFE AND HEALTH
INSURER SOLVENCY & MARKET CONDUCT

MARKET CONDUCT SECTION

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January 12, 1999

Honorable Bill Nelson
Treasurer and Insurance Commissioner
State of Florida
The Capitol, Plaza Level Eleven
Tallahassee, Florida 32301

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 Market Conduct Examination has been performed on:

BLUE CROSS and BLUE SHIELD of Florida, Inc.
4800 Deerwood Campus Parkway 100-7
Jacksonville, Florida 32256

at its Home Office in Jacksonville, Florida. The report of such examination is herein respectfully submitted.

INTRODUCTION

Blue Cross and Blue Shield of Florida, Inc., hereinafter is generally referred to as "the Company" when not otherwise qualified. The last Market Conduct Examination conducted by the Florida Department of Insurance, hereinafter generally referred to as "the Department", was as of December 31, 1993.

This Market Conduct Examination commenced on June 9, 1998, and concluded on January 11, l999.

SCOPE OF EXAMINATION

This examination covered the period of the Company's operation in the State of Florida from January 1, 1994, through December 31, 1996; and where considered appropriate, transactions and affairs subsequent to the examination period.

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

Statistical information was included in this examination report. The National Association of Insurance Commissioners' Examination Handbook standards of 7% error ratio for claim resolution procedures and 10% error ratio for other procedures were applied. Any error appearing to be a pattern or a general business practice was included in this examination report.

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

1. Sales Brochures and Advertisements

2. Appointment and Termination of Agents
3. Policy Forms, Rates and Underwriting
4. Claims and Complaints Handling Procedures

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 covered, Blue Cross and Blue Shield of Florida was domiciled in the State of Florida and was a not-for-profit mutual insurance company that was an independent licensee of the Blue Cross and Blue Shield Association. The Company was licensed to transact insurance business in the State of Florida on July 1, 1980.

Certificate of Authority

The Company was authorized to write the following lines of business in the State of Florida, subject to compliance with all applicable laws and regulations of Florida:

Code 450-Accident and Health

Organizational Chart

The Company's organizational chart is shown on the following page.

TERRITORY AND PLAN OF OPERATION

During the examination period reviewed, Blue Cross and Blue Shield of Florida, Inc., was authorized to transact business only in the state of Florida.

The Company marketed and serviced their products through the use of employee agents who were licensed and appointed by the Company, as well as agents employed by licensed general agencies, who were responsible for the training, licensing and appointment of the agent.

During the period under review, the lines written were:

1. Individual health
2. Group health
3. Medicare supplement
4. Long term care

During the period under review, the Company did not write any lines of insurance business for which they were not authorized on their Certificate of Authority, as required by Section 624.401 (2), Florida Statutes.

YEAR 2000 PREPAREDNESS PLAN

The Company's Year 2000 Preparedness Plan was reviewed in 1998 as part of the financial examination performed by the Florida Department of Insurance. The computer audit specialist consultant employed as part of the Financial examination found that the Company has a plan in effect to address Year 2000 Compliance. The plan is tested periodically with appropriate updates to the system being made as needed.

SALES AND ADVERTISEMENTS

Marketing materials utilized by the Company were examined to determine conformity with Rule 4-150, Florida Administrative Code.

The Company maintained an advertising file in accordance with Rules 4-150.018 (1), 4-150.217(1)(a), and 4-156.120(1), Florida Administrative Code.

The Company filed Certificates of Compliance for Advertising with its Annual Statement for 1994, 1995 and 1996 as required by Rules 4-150.018 (2), 4-150.217 (2), and 4-156.120 (2), Florida Administrative Code.

Thirteen (13) advertisements out of a population of more than five hundred (500) reviewed that were produced in quantity did not contain a form number or other identifying means as required by Rules 4-150.002(3) and 4-150.202(3), Florida Administrative Code.

Statistical data used in the advertisements reviewed identified the source in compliance with Rules 4-150.009, 4-150.209 and 4-156.111, Florida Administrative Code.

Representations of a commercial rating system about the Company indicated the purpose of the recommendation and the limitations of the scope and extent of the recommendation as outlined in Rules 4-150.016, 4-150.215 (2) and 4-156.118, Florida Administrative Code.

AGENT APPOINTMENT, RENEWAL AND TERMINATION

When the Company received the renewal list of agents from the Bureau of Agent and Agency Licensing, additions and deletions were

made as necessary. The renewal list of agents was returned to the Department with a Company check in compliance with instructions from the Bureau of Agent and Agency Licensing.

When an agent was terminated for cause, Florida Department of Insurance Form DI4-39 was completed by the Company and forwarded to the Department for cancellation of the agent's appointment in compliance with Section 626.511 (2), Florida Statutes, and Bureau of Agent and Agency Licensing's instructions.

Twenty-five (25) terminated agents' personnel files were examined to determine proper reporting by the Company. No discrepancies were noted.
Additional appointments were made as required by Section 626.341, Florida Statutes, when business was accepted from a licensed agent who was not previously appointed by the Company.

EXCESS OR REJECTED INSURANCE

The Company did not accept excess or rejected health insurance business from non-contracted agents, as defined by Section 626.837, Florida Statutes.

POLICY FORM AND RATE FILINGS

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

Company filings for 1994, 1995 and 1996, were reviewed to determine if policy forms being used by the Company had been

stamped "filed" or "approved" by the Department as required by Section 627.410, Florida Statutes. No discrepancies were noted.

UNDERWRITING AND RATE SURVEY

The underwriting and rate survey included an analysis of the following Company procedures:

1. Basic underwriting guidelines
2. Proper issuance of forms, riders and endorsements
3. Proper use of rates
4. Correspondence during the policy issue process
5. Unfair discrimination

APPLICATION REVIEW

Applications for Medicare supplement, long term care, group health and individual health insurance were surveyed.

A random sample of two hundred seventy-five (275) files, from a total population of greater than one hundred thousand (100,000) for 1994, 1995 and 1996, was reviewed.

The files reviewed revealed the agents were appointed as required by Section 626.112, Florida Statutes.

All applications reviewed contained the insurer's name on the first page of the form as required by Section 627.4085, Florida Statutes.

All applications reviewed contained the agent's name as required by Section 627.4085, Florida Statutes.

Fifty (50) applications did not contain the license identification number as required by Section 627.4085, Florida Statutes.

INSURED'S RIGHT TO RETURN POLICY

A random sample of fifty (50) individual health files for 1994, 1995 and 1996, was reviewed. No discrepancies were noted.

The review indicated that the company complied with Rules 4-154.003 and 4-157.018, Florida Administrative Code and Sections 627.674 (4)(d) and 627.9407(8), Florida Statutes. Refunds were handled in a timely manner.

REPLACEMENT OF INSURANCE

Copies of "Notice to Applicant" regarding replacement of individual health insurance were maintained as required by Rule 4-151.105(1), Florida Administrative Code.

Copies of "Notice to Applicant" were sent within the specified time to existing insurers whose policies were being replaced, with one exception noted below, as required by Rules 4-151.105(3) and 4-156.015 (7), Florida Administrative Code.

Fifty (50) files, from a total population of thirty-three thousand, four hundred and fifty-two (33,452) for individual health insurance for the years 1994, 1995 and 1996, were reviewed. No discrepancies were noted.

Eighty-five (85) files, from a total population of more than fifteen hundred (1,500) for Medicare Supplement insurance for the years 1994, 1995 and 1996, were reviewed. One discrepancy was noted regarding timely notice requirements to the existing insurer requiring eight (8) working days.

Copies of "Notice to Applicant" regarding replacement of Medicare Supplement were not maintained as required by Rule 4-156.015(4), Florida Administrative Code. Forty-three (43) discrepancies were noted.

Twenty-five files (25), for long-term care insurance for the years 1994, 1995 and 1996, were reviewed. The Company's long-term care venture partner, Mutual Protective Insurance Company, of Omaha, NE, was unable to provide sufficient documentation to determine the cycle time for notifying the existing insurer of replacement.

CANCELLATIONS AND NON-RENEWALS

A random sample of twenty-five (25) individual and twenty-five (25) group health cancellations and non-renewals was reviewed. All policyholder files reviewed were given at least forty-five (45) days advance written notice of cancellation, non-renewal or change in rates as required by Sections 627.6043(1) and 627.6645(1), Florida Statutes.

A random sample of twenty-five (25) Medicare Supplement policies from a total population of one hundred twenty-seven, three hundred and thirty-two (127,332) was reviewed. All Medicare Supplement policies were cancelled or non-renewed in compliance with Section 627.6741(2)(a), Florida Statutes.
In the event of cancellation, all files reviewed indicated that the unearned portion of premiums paid was promptly returned as required by Sections 627.6043 (2), 627.6645 (4) and 627.6741 (4), Florida Statutes.

A review of twenty-five (25) long-term care cancellation and non-renewal files were reviewed to determine compliance with Section 627.9407 (3)(a), Florida Statutes. No long-term care insurance policies were canceled, nonrenewed, or otherwise terminated on the

grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder.

CLAIMS ADMINISTRATION

The Company established an effective claims settlement procedure which maintained control of all claims from the time of receipt to the time of final payment. Claims were reported to and handled in the Home Office of the Company.

The Claims Managers certified that they read and understand Section 626.9541(1)(i), Florida Statutes, relating to unfair claims settlement practices.

TIME STUDY FOR PAID AND DENIED CLAIMS

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.

The population of processed paid and denied claims for the examination period reviewed is as follows:

Individual Health Claims - Paid

1994	496,828	Claims for	$ 92,388,922
1995	517,766	Claims for	$ 91,808,523
1996	541,450	Claims for	$ 94,015,241
Total	1,556,044	Claims for	$278,212,686

Individual Health Claims - Denied

1994	196,224	Claims
1995	203,292	Claims
1996	206,673	Claims
Total	606,189	Claims

Group Health Claims - Paid

1994	2,635,915	Claims for	$ 692,051,917
1995	3,108,242	Claims for	$ 856,558,879
1996	3,218,527	Claims for	$ 940,770,248
Total	8,962,684	Claims for	$2,489,381,044

Group Health Claims - Denied

1994	504,966	Claims
1995	570,356	Claims
1996	1,255,325	Claims
Total	2,330,647	Claims

Medicare Supplement Claims-Paid

1994	5,681,400	Claims for	$234,485,636
1995	5,631,310	Claims for	$259,655,629

1996	5,543,603	Claims for	$256,921,979
Total	16,856,313	Claims for	$751,063,244

Medicare Supplement Claims-Denied

1994	1,198,651	Claims
1995	983,194	Claims
1996	960,688	Claims
Total	3,142,533	Claims

Long-Term Care Claims-Paid

1994	3	Claims for	$ 3,692
1995	49	Claims for	$109,000
1996	90	Claims for	$168,373
Total	142	Claims for	$281,065

Long-Term Care Claims-Denied

1994	4	Claims
1995	8	Claims
1996	16	Claims
Total	28	Claims

Three hundred ninety (390) claim files from the above-listed population were reviewed. The results of the review are as follows:

CALENDAR DAYS/PERCENTAGE OF CLAIMS

Individual Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

The average time required to process a claim was eight (8) days.

Individual Health Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	25	100%
46-120	0	0%
121 and over	0	0%
Total	25	100%

The average time required to process a denied claim was seven (7) days.

Group Health Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%

46-120	0	0%
121 and over	0	0%
Total	100	100%

The average time required to process a claim was eight (8) days.

Group Health Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	25	100%
46-120	0	0%
121 and over	0	0%
Total	25	100%

The average time required to process a denied claim was six (6) days.

Medicare Supplement Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	100	100%
46-120	0	0%
121 and over	0	0%
Total	100	100%

The average time required to process a claim was ten (10) days.

Medicare Supplement Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	25	100%
46-120	0	0%
121 and over	0	0%
Total	25	100%

The average time required to process a denied claim was seven (7) days.

Long-Term Care Claims-Paid

Calendar Days	Number of Claims	Percentage
1-45	10	100%
46-120	0	0%
121 and over	0	0%
Total	10	100%

The average time required to process a claim was nine (9) days.

Long-Term Care Claims-Denied

Calendar Days	Number of Claims	Percentage
1-45	5	100%
46-120	0	0%
121 and over	0	0%

Total	5	100%

The average time required to process a denied claim was seven (7) days.

An analysis of the claim study revealed the following:

1. A random sample of three hundred ten (310) paid claim files from a total population of twenty-seven million, three hundred seventy-five thousand, one hundred eighty-three (27,375,183) was reviewed to determine if benefits were being allowed according to the policy contract as required by Section 626.877, Florida Statutes. No discrepancies were noted.

2. A random sample of three hundred ninety (390) claim files from a total population of thirty-three million, four hundred fifty-four thousand, five hundred eighty (33,454,580) was reviewed to determine if they had been processed in a timely manner as required by Sections 627.613 and 627.657(2), Florida Statutes. No discrepancies were noted.

3. A random sample of one hundred (100) individual health claims from a total population of one million, five hundred fifty-six thousand, forty-four (1,556,044) was reviewed to determine if the 10% interest due on certain claims was paid as required by Section 627.613(6), Florida Statutes. No discrepancies were noted.

4. A random sample of three hundred ninety (390) claim files from a total population of thirty three million, four hundred fifty-four thousand, five hundred eighty (33,454,580) was reviewed to determine if the required Fraud Statement was included on the claim forms as required by Section 817.234

(1)(b), Florida Statutes. Ten (10) discrepancies were noted resulting in an acceptable error ratio of 2.6%.

INSURER EXPERIENCE REPORTING

The Company did not timely file Consumer Guide Information Forms DI4-331 and DI4-333 as to polices of individual health insurance as required by Section 627.9175, Florida Statutes and Rule 4-137.004, Florida Administrative Code.

COMPLAINTS

The Company maintained complaint-handling procedures as required by Section 626.9541 (1) (j), Florida Statutes.

The Company maintained a complete record of all complaints received since the date of the last examination as required by Section 626.9541 (1) (j), Florida Statutes.

One hundred and ten (110) complaints, from a total population of more than two hundred thousand (200,000) for 1994, 1995 and 1996 were reviewed to determine the number of calendar days taken to resolve a complaint from the time of receipt to the final disposition. Calendar days included workdays, weekends and holidays.

The results of the review are as follows:

Calendar Days	Number of Complaints	Percentage
1-15	107	97%
16-30	3	3%
31 and over	0	0%
Total	110	100%

The average number of days to handle a complaint for the entire review period was five (5).

CONCLUSION

The customary practices and procedures promulgated by the National Association of Insurance Commissioners were followed in performing

the Market Conduct Examination of **Blue Cross and Blue Shield of Florida, Inc.** as of December 31, 1996, with due regard to the Insurance Laws of the State of Florida.

Respectfully submitted,

David E. Doxsee
Insurance Analyst II
Florida Insurance Department

FINDINGS AND RECOMMENDATIONS

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

Page 6 Comply with Rules 4-150.002(3), 4-150.202(3) and 4-156.102(3) by having a form number or other identifying means on all advertisements produced in quantity.

Page 9 Comply with Section 627.4085 and have all applications contain the agent's license identification number on all applications.

Page 10 Comply with Rule 4-156.015(7) relating to Medicare Supplement replacements and send a copy of "Notice to Applicant" within the specified time to existing insurer.

Page 10 Comply with Rule 4-156.015(4) relating to Medicare Supplement replacements and retain copies of "Notice to Applicant".

Page 11 Implement procedures to comply with Long Term Care replacement regulations relating to timely notice to the existing insurer and the maintenance of replacement records.

Page 20 Comply with Section 817.234(1)(b) and include the required Fraud Statement language on all claim forms.

Page 21 Comply with Section 627.9175, Florida Statutes and timely file Consumer Guide Information Forms DI4-331 and DI4-333 relating to individual health insurance.