

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

Houston, Texas

**AS OF
March 25, 2004**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: May 24, 2004

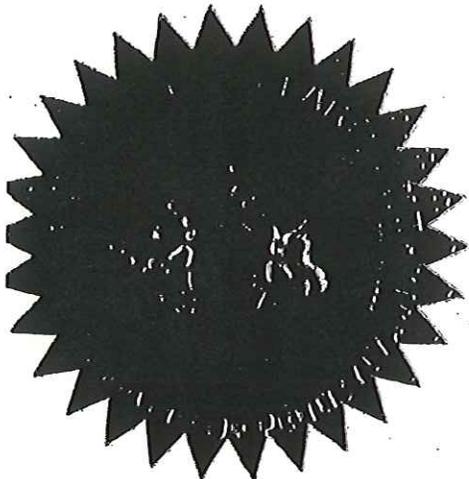
**PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY
TABLE OF CONTENTS**

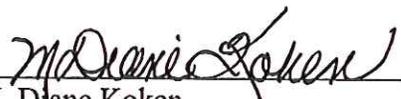
ORDER		
I.	Introduction	1
II.	Scope of Examination	3
III.	Company History and Licensing	4
IV.	Advertising	5
V.	Forms	6
VI.	Agent Licensing	10
VII.	Complaints	11
VIII.	Underwriting/Rating	12
	Small Business Association	
	A. Certificate Issued	14
	B. Certificate Declined	15
	Group Coverages	
	C. Group Accounts Issued	16
	D. Certificates Issued	17
	E. Group Accounts Declined	18
	F. Group Accounts Terminated	19
	G. Group Accounts Not Taken	20
	Individual Coverages	
	H. Medicare Supplemental Policies Issued	21
	I. Medicare Supplemental Policies Declined	23
	J. Medicare Supplemental Policies Terminated	24
	K. Medicare Supplemental Policies Not Taken	25
	L. Conversion Policies	26
IX.	Internal Audits and Compliance Procedures	27
X.	Claims	28
	A. Clean Provider Claims Paid Over 45 Days	30
	B. Life Claims	33
	C. Direct Individual Medical Claims	36
	D. Mandated OB/GYN Claims	37
XI.	Recommendations	39
XII.	Company Response	41

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 29 day of April, 2002, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Randolph L. Rohrbaugh, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





M. Diane Koken
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
PHILADELPHIA AMERICAN LIFE	:	Sections 605 and 903 of the
INSURANCE COMPANY	:	Insurance Department Act, Act of
200 Westlake Park Boulevard	:	May 17, 1921, P.L. 789, No. 285
Houston, TX 77079	:	(40 P.S. §§ 235 and 323)
	:	
	:	The Health Care Insurance Portability
	:	Act of June, 1997, P.L. 295, No. 29
	:	(40 P.S. § 1302.4)
	:	
	:	Sections 2166(A) and 2166(B) of
	:	the Act of June 17, 1998, P.L. 464,
	:	No. 68 (40 P.S. §§ 991.2166)
	:	
	:	Section 405-A and 411B of the
	:	Insurance Company Law, Act of May
	:	17, 1921, P.L. 682, No. 284 (40 P.S.
	:	§ 625-5 and 511b)
	:	
	:	Section 633 of Act 20 of 1994,
	:	Chapter 2 (40 P.S. § 1571-1575)
	:	
	:	Section 631 of Act 98 of 1998,
	:	Chapter 2 (40 P.S. § 764(e) and (f))
	:	
	:	The Medical Foods Insurance Coverage
	:	Act, No. 191 (40 P.S. § 3904)
	:	
	:	Title 18, Pennsylvania Consolidated
	:	Statutes, Section 4117(k)
	:	
	:	Title 31, Pennsylvania Code, Sections
	:	89.784, 154.18(c), 146.3, 146.5(a),
	:	146.6 and 146.7
	:	
Respondent.	:	Docket No. MC04-04-029

CONSENT ORDER

AND NOW, this 24th day of *MAY*, 2004, this Order is hereby issued by the Deputy Insurance Commissioner of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Deputy Insurance Commissioner finds true and correct each of the following Findings of Fact:

(a) Respondent is Philadelphia American Life Insurance Company, and maintains its address at 200 Westlake Park Boulevard, Houston, Texas 77079.

- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2001 through December 31, 2001, unless otherwise noted.
- (c) On March 26, 2004, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on April 26, 2004.
- (e) The Examination Report notes violations of the following:
- (i) Section 605 of the Insurance Department Act, No. 285 (40 P.S. § 235) (now repealed), which required that: (1) no agent shall do business on behalf of any entity without written appointment from that entity, (2) all appointments shall be obtained by procedures established by the Insurance Department's regulations, (3) insurance entities authorized by law to transact business in this Commonwealth shall, from time to time as determined by the Department, certify to the Department the names of all agents appointed by them, and (4) each appointment fee, both new and renewal, shall be paid in full by the entity appointing the agent;

- (ii) Section 903(a) of the Insurance Department Act (40 P.S. § 323.3), which requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily verify the financial condition of the company, and ascertain whether the company has complied with the laws of this Commonwealth;

- (iii) The Health Care Insurance Portability Act of June, 1997, P.L. 295, No. 29 (40 P.S. § 1302.4), which requires insurers comply with Section 2701(e) of The Health Insurance Portability and Accountability Act of 1996 (HIPAA), requiring the certification of a period of creditable coverage. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide the certification: (1) at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision; or (2) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

- (iv) Section 2166(A) of Act 68 (40 P.S. § 991.2166), which requires a licensed insurer or managed care plan to pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim;

- (v) Section 2166(B) of Act 68 (40 P.S. § 991.2166), which requires that if a licensed insurer or managed care plan fails to remit the payment as provided under subsection (A), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid;
- (vi) Section 405-A of the Insurance Company Law, No. 284 (40 P.S. § 625-5), which requires every insurer shall institute and maintain internal audit and compliance procedures which provide for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising and filing and approval requirements for life and annuities;
- (vii) Section 411B of the Insurance Company Law, No. 284 (40 P.S. § 511b), which states that life insurance death benefits not paid within 30 days after satisfactory proof of death submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than 180 days after the death of the insured, and the death benefits are not paid within 30 days after the satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which

satisfactory proof was submitted to the date on which the benefits of the policy are paid. This applies to all life insurance policies except variable insurance policies;

- (viii) Section 633 of Act 20 of 1994 (40 P.S. § 1571-1575), which requires coverage for annual gynecological examinations and routine pap smear testing;
- (ix) Section 631 of Act 98 of 1998 (40 P.S. § 764e), which requires policies to provide coverage of the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. These benefits may be provided through a combination of policies, contracts, certificates or riders, including major medical contracts;
- (x) Section 3904 of Act No. 191 (40 P.S. § 3904), which requires health care policies to include coverage for the cost of nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician;

- (xi) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”
- (xii) Title 31, Pennsylvania Code, Section 89.784, which requires application forms to include questions designed to elicit information as to whether, as of the date of application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other policy presently in force. A supplementary application or other form to be signed by the applicant and agent containing these questions and statements may be used;
- (xiii) Title 31, Pennsylvania Code, Section 154.18(c), which requires interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be

added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim;

- (xiv) Title 31, Pennsylvania Code, Section 146.3, which allows the claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed;
- (xv) Title 31, Pennsylvania Code, Section 146.5(a), which requires upon receiving notification of a claim, shall within ten working days acknowledge receipt of such notice unless payment is made within such a period of time;
- (xvi) Title 31, Pennsylvania Code, Section 146.6, which requires complete investigation of a claim within thirty days after notification of a claim. If such investigation cannot reasonably be completed within such time, provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected, within thirty days and every forty-five days thereafter; and
- (xvii) Title 31, Pennsylvania Code, Section 146.7, which requires that within 15 working days after receipt by the insurer of properly executed proofs of loss,

the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

- (f) Respondent asserts that many of violations cited above are attributed to Respondent on the basis of vicarious liability relative to the actions of representatives of the Respondent. For violations arising from the Respondent's own direct activity, Respondent asserts that such violations resulted from isolated incidences of inadvertent oversight.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Deputy Insurance Commissioner makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent's violations of The Health Care Insurance Portability Act, No. 29, (40 P.S. § 1302.4), are punishable under 40 P.S. § 1302.5:
 - (i) Upon satisfactory evidence of a violation of this act by any insurer or other person, the commissioner may pursue any one of the following courses of action:

1. Suspend, revoke or refuse to renew the license of the offending person.
2. Enter a cease and desist order.
3. Impose a civil penalty of not more than \$5,000 for each action in violation of this act.
4. Impose a civil penalty of not more than \$10,000 for each action in willful violation of this act.

(ii) Penalties imposed against a person under this act shall not exceed \$500,000 in the aggregate during a single calendar year.

(c) Respondent's violations of Sections 2136, 2166(A) and 2166(B) of Act 68 of 1998 (40 P.S. § 991.2166) are punishable under Section 2182 of Act 68 of 1998 (40 P.S. § 991.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.

(d) Respondent's violations of Section 405-A of the Insurance Company Law, No. 284 (40 P.S. §§ 625-5) are punishable by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation. The enforcement remedies imposed under this section are in addition to any other remedies or penalties imposed by any other applicable statute.

(e) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.3, 146.5(a), 146.6 and 146.7 are punishable under Section 9 of the Unfair Insurance Practices Act (40 P.S. § 1171.9) by the following:

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(f) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 - 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
- (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Deputy Insurance Commissioner orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Fifty-Five Thousand Dollars (\$55,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in this Report.
- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Harbert, Administrative Assistant, Bureau of Enforcement, 1311 Strawberry Square,

Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Deputy Insurance Commissioner finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Deputy Insurance Commissioner may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Deputy Insurance Commissioner may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Deputy Commissioner finds that there has been a breach of any of the provisions of this Order, the Deputy Commissioner may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

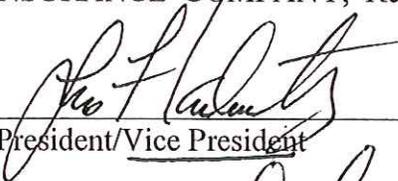
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Consent Order is intended to, and shall, resolve all issues prior to the date of this Consent Order relating to Respondent that were the subject of any aspect of the market conduct examination and report referenced herein.

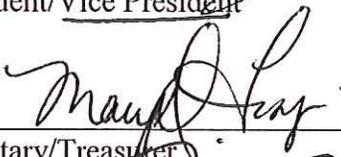
12. This Order shall be final upon execution by the Deputy Insurance Commissioner. Only the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent

Order is not effective until executed by the Insurance Commissioner or a duly authorized Deputy Insurance Commissioner.

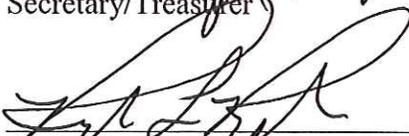
BY: PHILADELPHIA AMERICAN LIFE
INSURANCE COMPANY, Respondent



President/Vice President



Secretary/Treasurer



RANDOLPH L. KOHRBAUGH
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

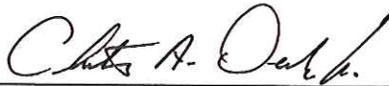
The Market Conduct Examination was conducted on Philadelphia American Life Insurance Company, hereinafter referred to as "Company," at their Administrative Office located at 450 Parkway Boulevard, Suite 200, Broomall, Pennsylvania from August 13, 2002, through November 1, 2002. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in this Report may result in the imposition of penalties. Generally, practices, procedures, or files that were reviewed by the Department examiners during the course of an examination many not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine potential impact upon Company operations or future compliance issues.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review the written summaries provided on the violations found.

The courtesy and cooperation extended by the Company officers and employees during the course of the examination is hereby acknowledged.

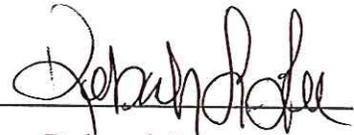
The undersigned participated in this Examination and in preparation of this Report.



Chester A. Derk, Jr., AIE, HIA
Market Conduct Division Chief



Lonnie L. Suggs
Market Conduct Examiner



Deborah Lee
Market Conduct Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2001, through December 31, 2001, unless otherwise noted. The purpose of the examination was to determine the Company's compliance with Pennsylvania Insurance Laws and Regulations.

The examination focused on the Company's operation in areas such as Advertising, Forms, Agent Licensing, Complaints, Underwriting Practices and Procedures, Internal Audits and Compliance Procedures and Claims Handling Procedures.

The Company was requested to identify the universe of files for each area of review during the experience period identified. Based on the universe sizes identified, a random sampling was utilized to select the files to be reviewed for this examination.

III. COMPANY HISTORY AND LICENSING

Philadelphia American Life Insurance Company's Certificate of Authority to write business in the Commonwealth was issued on March 6, 1978. Philadelphia American Life Insurance is a life and health insurance company domiciled in Texas and licensed to do business in 47 jurisdictions, the District of Columbia and the Virgin Islands. Philadelphia American is a wholly-owned subsidiary of New Era Life Insurance Company.

The Company was acquired by New Era Life Insurance Company in 1996. In addition to its existing group business, Philadelphia American's core products include individual major medical preferred provider organization, commercial lines and Medicare Supplement.

Philadelphia American Life assumed an entire block of Accident and Health business from Conestoga Life Assurance Company (a Pennsylvania domiciled company) effective January 1, 2000. This business primarily consisted of small group major medical with a total annualized premium of approximately \$40 million. In addition, four third-party administrators were contractually assigned to Philadelphia American for the continued marketing and administration of this product line along with approximately 20 preferred provider organization network access agreements in Pennsylvania.

A distribution system consisting of an estimated 500 agents and brokers were appointed with Philadelphia American for the sale and promotion of the entire line of individual and group accident and health products.

The Company's 2002 annual statement reflects direct premium of \$414,657.00.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that “Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of these Regulations, may be reviewed at any time at the discretion of the Department.” The Department, in exercising its discretionary authority, requested the Company to provide copies of all advertising materials used for solicitation and sales during the experience period.

Other areas of authority used for advertising review included requirements of Title 31 PA Code, Section 89.785, Filing Requirements for Advertising, and compliance with the requirements of Act 205, Section 5 (40 P.S. §1171.5), Unfair Methods of Competition and Unfair or Deceptive Acts or Practices including anything which could be considered discriminatory, or unusual in nature.

The Company identified and produced a total of 9 brochures for Medicare Supplemental related pieces of direct mail advertising material, and direct mail advertising for Hospital Indemnity Plan coverages, Accidental Death and Dismemberment, as well as marketing material for Long-Term Care products. The Company’s website located at www.neweralife.com was included in the advertising review.

No violations were noted.

V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the administrative agreements, riders, amendments, endorsements, enrollment applications and subscriber contract forms used in order to verify compliance with requirements of the Health and Accident Reform Act No. 159 (40 P.S. §3803). Review was also made to determine compliance with Title 18, Pennsylvania C.S., Section 4117(k), Fraud Warning Notice.

The following violations were noted:

Title 18, Pa. C. S., § 4117(k)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice:

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

1 Violation The fraud statement was not included or attached thereto Form Number (A-3117), Conversion Application.

50 Violations – The Enrollment forms utilized by Philadelphia American Life Insurance Company did not contain the required fraud notice. The forms used were H-005P-GAPP Rev. 4/99 and H-0070P-GAPP Rev. 8/00.

10 Violations – Ten enrollment application forms (Group App F3017), utilized by Preferred Care, Inc. did not contain the required fraud notice or have attached thereto.

2 Violations – Two claim forms used by Gettysburg Insurance Services Inc., Health Claim Form and GISI Health Claim Form CF 5/90 did not contain the required fraud notice or have it attached thereto as required.

1 Violation – The Membership Application brochure for the Senior Savers Association, form number SSA-APP DOC-0717 did not contain the required fraud notice.

2 Violations – A review of the Company's web-site located at www.ega-inc.com, included 2 claim forms; (1) Medical Claim Form and (2) Health Insurance Claim Form, which did not contain the required fraud notice.

11 Violations – Eleven individual conversion application forms ST 3036 and A-3117 were utilized by the Erin Group Administrators, Inc. which did not contain the required fraud notice or have attached thereto.

Required mandated coverages were not included in the following forms:

Group Health Policy Form Number G-3024 (2/00)

1 Violation - Medical Foods Insurance Coverage Act, Act No. 1996 – 191, (40 P.S. §3901)

Group Health Certificate B-3025 (2/00)

1 Violation -Medical Foods Insurance Coverage Act, Act No. 1996 – 191, (40 P.S. §3901)

Major Medical Expense Certificate (H-0055P)

1 Violation – Pennsylvania Insurance Law Chapter 2, §631 (40 P.S. §764e) Reimbursement for Diabetic Supplies and Education/Hearing Aid Coverage, Act. (a) Except to the extent already covered under another policy, any individual or group health, sickness and accident insurance policy, group health insurance plans/policies, and all other forms of managed/capitated care plans/policies or subscriber contract or certificate issued by any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations) or the Act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act," the Act of December 14, 1992 (P.L. 835, No. 134), known as the "Fraternal Benefit Societies Code," or this act providing hospital or medical/surgical coverage shall provide coverage of the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. The benefits specified in this section may be provided through a combination of policies, contracts, certificates or riders, including major medical contracts.

1 Violation - Medical Foods Insurance Coverage Act, Act No. 1996 – 191, (40 P.S. §3901)

Hospital Medical-Surgical Certificate (H-0070P)

1 Violation – Pennsylvania Insurance Law Chapter 2, §631 (40 P.S. §764e)
Reimbursement for Diabetic Supplies and Education/Hearing Aid Coverage, Act
98 of 1998

1 Violation - Medical Foods Insurance Coverage Act, Act No. 1996 – 191, (40
P.S. §3901)

VI. AGENT LICENSING

A review was done to verify that all individuals and agencies were properly licensed and appointed as required by the Insurance Department Act, Section 605 (40 P.S. §235) and Section 623 (40 P.S. §253). The Company identified a total of 889 licensed agents and 76 agent agreements terminated during the period. A comparison was made between the Department licensing records and those agents and brokers identified by the Company, as well as agents and brokers identified during the course of the examination from the various underwriting files reviewed.

The following violation was noted:

1 Violation - Insurance Department Act, Section 605 (40 P.S. §235)

Appointment.

No agent shall do business on behalf of any entity without a written appointment from that entity.

All appointments shall be obtained by procedures established by the Insurance Department's regulations.

Insurance entities authorized by law to transact business in this Commonwealth shall, from time to time as determined by the Insurance Department, certify to the Insurance Department the names of all agents appointed by them.

Each appointment fee, both new and renewal, shall be paid in full by the entity appointing the agent. The Company failed to certify and submit appointment fees to the Insurance Department for the following agent.

AGENT NAME	ID NUMBER	CITY	DATE LICENSED
D'Agosta, Robert	150-46-6153	Bethlehem	03/07/1990

VII. CONSUMER COMPLAINTS

The Company was requested to provide a listing of all complaints received during the experience period. A total of 25 complaint files were identified, requested and received during the experience period. Copies of Pennsylvania complaint logs for calendar years 1997, 1998, 1999 and 2000 were requested, received and reviewed.

The primary purpose of the review was to verify compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires a Company to maintain a complete record of all complaints received during the preceding four years. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

No violations were noted.

The following is a brief synopsis of the 25 consumer complaints reviewed.

NUM	REASON	%
11	Claims Related	44
8	Underwriting	32
2	Refund	8
2	Provider Related	8
1	Eligibility Problem	4
1	Benefit Issue	4
25	TOTAL	100%

VIII. UNDERWRITING/ RATING METHODOLOGY

The Company was requested to provide copies of all established written underwriting guidelines, manuals, bulletins, directives, management correspondence and rating methodology in use during the experience period. The purpose of this review was to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature or specifically prohibited by statute or regulation.

No violations were noted in the underwriting guidelines.

The Underwriting/Rating review was sorted and conducted in 12 general segments.

	SMALL BUSINESS ASSOCIATION
A.	Certificates Issued
B.	Certificates Declined
	GROUP COVERAGES
C.	Group Accounts Issued
D.	Certificates Issued
E.	Group Accounts Declined
F.	Group Accounts Terminated
G.	Group Accounts Not Taken
	INDIVIDUAL COVERAGES
H.	Medicare Supplemental Policies Issued
I.	Medicare Supplemental Policies Declined
J.	Medicare Supplemental Policies Terminated
K.	Medicare Supplemental Policies Not Taken
L.	Conversion Policies

Each segment was reviewed for compliance with underwriting practices and verification of forms identification, consumer complaints, claims handling and agent identification. Issues relating to forms and agent licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

SMALL BUSINESS ASSOCIATION

A. CERTIFICATES ISSUED

The Company identified a universe of 1,100 certificates issued to Pennsylvania residents by the Small Business Association during the experience period. Enrollment files for 50 newly issued certificateholders were randomly selected, received and reviewed for compliance with Title 31 Pennsylvania Code, Chapter 89; Title 18 PA. C.S., Section 4117(k); Health and Accident Reform Act (40P.S. §3806)(Act of Dec 18, 1996, P.L. 1066 No. 159); and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Forms violations noted are included in Section V. Forms of this Report.

No violations were noted.

SMALL BUSINESS ASSOCIATION

B. CERTIFICATES OF COVERAGE DECLINED

The Company identified a total of 242 certificates of coverage declined by the Small Business Association during experience period. A random sample of 50 declined applications was selected, received, and reviewed. The primary purpose of the review was to verify compliance with the requirement of Act 205 Unfair Insurance Practices (40 P.S. §1171) and to determine accuracy and completeness of record management. Forms violations noted are included in Section V. Forms of this Report.

No violations were noted.

GROUP COVERAGES

C. GROUP ACCOUNTS ISSUED

The Company was requested to identify all commercial group account lines of business issued during the experience period. Philadelphia American Life Insurance Company Inc., markets their commercial group account lines of business in Pennsylvania through contract agreements with four third-party administrators. A total of 429 group policies were issued during the period by three third-party administrators; Erin Group Administrators, Inc. issued 155 group policies, Gettysburg Health Administrators, Inc. issued 254 group policies, Preferred Care Inc., issued 20 group policies and Managed Care of America, Inc. did not issue any new group business during the period.

A sample selection of 66 group policies issued was requested, received and reviewed to verify underwriting and forms compliance as required by the Accident and Health Filing Reform Act, No.159 (40 P.S.§3803) Section 3(e)(5) and Title XXVII, Section 2791(d)(6), as Adopted by the Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4, which states a group shall include only employers of two or more employees. Forms violations noted are included in Section V. Forms of this Report.

No violations were noted.

GROUP COVERAGES
D. CERTIFICATES ISSUED

The Company, through its third-party administrators, identified a total of 7,555 certificates issued for group life and accident coverage during the experience period to Pennsylvania residents. Enrollment files for 125 newly issued certificateholders were selected, received and reviewed for compliance with Pennsylvania statute and regulatory requirements. Forms violations noted are included in Section V. Forms of this Report.

No violations were noted.

GROUP COVERAGES

E. GROUP ACCOUNTS DECLINED

The Company identified a total of 7 group applications declined coverage during experience period. All 7 declined group applications were selected, received, and reviewed for compliance with Title 31 Pennsylvania Code, Chapter 88; Title 18 PA. C.S., Section 4117(k); and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171).

No violations were noted.

GROUP COVERAGES

F. GROUP ACCOUNTS TERMINATED

The Company identified 573 commercial group accounts terminated during the experience period. A sample selection of 101 terminated group account files was requested, received and reviewed. A review of the group files was conducted to verify compliance with Title XXVII, Sec. 2701 (e)(1)(A) (i) of the Federal Act, as adopted by the Health Care Insurance Portability Act of June, 1997, P.L. 295, No.29 (40 §1302.4), which requires a group health plan, and a health insurer offering group health insurance coverage, provide certificates of creditable coverage. This provision of the act was to ensure individuals enrolled in a group policy, and for reasons of termination, will not be denied coverage upon enrollment into another group, because of pre-existing conditions.

The following violations were noted:

24 Violations - Title XXVII Section 7201(e), (40 §1302.4) Adopted by the Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4.

- (1) Requirement for certification of period of creditable coverage. A group health plan, and a health insurance insurer offering group health insurance coverage, shall provide the certification.
- (ii) in the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

The Company failed to provide the Department with appropriate evidence of certificates of creditable coverage for 6 terminated group accounts insuring 24 members as required. Company records failed to identify these groups as enrolling with another insurer. In those cases where a group policy is terminated and replacement coverage is not secured, a certificate of creditable shall be issued.

GROUP COVERAGES

G. GROUP ACCOUNTS NOT TAKEN

The Company was requested to identify all group account policies not taken during the experience period. A total of 13 group account policies not taken were identified. A "Not Taken" is a policy, which was underwritten and issued by the insurer, however, for some reason, was not placed with the insured was returned by the insured.

No violations were noted.

INDIVIDUAL COVERAGES

H. MEDICARE SUPPLEMENTAL POLICIES ISSUED

The Company identified a universe of 1,222 Medicare Supplemental policies issued to Pennsylvania residents during the experience period. Medicare supplemental policies were provided through Erin Group Administrators, Inc. of Lancaster, Pennsylvania. Application files for 100 newly issued policies were randomly selected, received and reviewed for compliance with Title 31 Pennsylvania Code, Chapter 89; Title 18 PA. C.S., Section 4117(k); Health and Accident Reform Act (40P.S. §3806)(Act of Dec 18, 1996, P.L. 1066 No. 159); and the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171).

The following violations were noted:

2 Violations - Title 31, Pennsylvania Code, Section (89.784) Requirements for application forms and replacement coverage

Application forms shall include the following questions designed to elicit information as to whether, as of the date of application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing these questions and statements may be used. No replacement forms were included with 2 application file packets.

2 Violations – Ins. Dept. Act. Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such

manner and for such time periods as the department, at its discretion, may require in order that its authorized representatives may readily verify the financial condition of the Company or person and ascertain whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide requested file records for 2 policyholders.

INDIVIDUAL COVERAGES

I. MEDICARE SUPPLEMENTAL POLICIES DECLINED

The Company identified a total of 76 Medicare Supplemental applications declined coverage during experience period. All 76 declined application files were selected, received, and reviewed. The primary purpose of the review was to verify compliance with the requirement of Title 31, Pennsylvania Code, Section 89.790, Guaranteed issue for eligible persons and Act 205 Unfair Insurance Practices (40 P.S. §1171).

No violations were noted.

INDIVIDUAL COVERAGES

J. MEDICARE SUPPLEMENTAL POLICIES TERMINATED

The Company was requested to identify all individual Medicare supplemental policies terminated during the experience period. A total of 189 individual Medicare supplemental policies were terminated during the period. A sample selection of 25 terminated Medicare supplemental files was requested, received, and reviewed.

The following violations were noted:

3 Violations - Ins. Dept. Act, Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for time periods as the Department, at its discretion, may require in order that its authorized representatives may readily verify whether the Company or person has complied with the laws of this Commonwealth. A review of the 25 individual policies terminated, indicates the Company failed to provide all file documentation, including correspondence from the policyholders requesting coverage be terminated and other pertinent information necessary to verify compliance for three policies

INDIVIDUAL COVERAGES

K. MEDICARE SUPPLEMENTAL POLICIES NOT TAKEN

The Company was requested to identify all individual policies not taken during the experience period. A total of 20 individual policies were identified as not taken during the period. All 20 files were requested, with 19 files received and reviewed.

The following violation was noted:

1 Violation - Ins. Dept. Act, Section 903 (40 P.S. §323.3)

Every Company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for time periods as the Department, at its discretion, may require in order that its authorized representatives may readily verify whether the Company or person has complied with the laws of this Commonwealth. The Company failed to provide one file for review.

INDIVIDUAL COVERAGES

L. CONVERSION POLICIES

The Company identified a total universe of 25 group members who converted their group coverage to an individual policy. All 25 files were requested, received, and reviewed. The purpose of this review was to ensure compliance with underwriting, forms and rating statutes and regulations.

No violations were noted.

IX. INTERNAL AUDITS AND COMPLIANCE PROCEDURES

The Company was requested to provide copies all internal audits and compliance procedures utilized during the experience period. Internal audits and compliance procedures were reviewed to verify compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides that every insurer shall institute and maintain internal audit and compliance procedures which provide for the evaluation of compliance with all statutes and regulation dealing with sales methods, advertising and filing and approval requirements for life insurance and annuities. These procedures shall also provide for the following:

- (1) Periodic reviews of consumer complaints to identify patterns of improper practices.
- (2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.
- (3) The establishment of lines of communication, control and responsibility over the dissemination advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company whose employees compensation, other than applicable Company bonus or incentive plans, is not directly linked to marketing or sales

The following violation was noted:

Ins Co. Law, Section 405-A (40 P.S. §625-5)

- (a) Every insurer shall institute and maintain internal audit and compliance procedures which provide for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising and filing and approval requirements for life and annuities. The Company failed to demonstrate they have complied with this requirement.

X. CLAIMS

The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used while processing claims during the experience period. The Company provided a master claim manual and a training manual used for fully insured groups.

Claim guidelines and claim files for the commercial lines of business were reviewed at the Company's Broomall, Pennsylvania location. Further claims review was conducted on site at Erin Group Administrators, Inc., located in Lancaster, Pennsylvania and in the Pittsburgh office of Managed Care of America Inc. Claim files for Gettysburg Administrators, Inc. and Preferred Care Inc. were reviewed in the Broomall office.

No violations were noted.

CONCERNS:

The Company's claims processing guide failed to address the Prompt Payment requirement of Act 68, Section 2166, (40 P.S. §991.2166) "Prompt Payment of Claims"; effective January 1, 1999, which requires managed care plans to remit payment within 45 days of receiving a clean claim. In addition, any claims paid over 45 days; result in an interest penalty of 10% per annum which shall be paid in addition to the amount owed on the clean claim, if interest owed is \$2.00 or greater. Title 31, PA Code, Section 154.18(c) Prompt Payment requires interest payment within 30-days of the payment of the claim. A clean claim is defined as "A claim for payment for a health care service, which has no defect or impropriety".

Another concern noted, during the claims review was the lack of Company manuals addressing the requirements of Title 31, PA Code, Chapter 146, of the Unfair Claims Settlement Practices

The claims review consisted of 4 general segments.

A.	PROVIDER CLAIMS PAID OVER 45 DAYS
B.	LIFE CLAIMS
C.	DIRECT INDIVIDUAL MEDICAL CLAIMS
D.	MANDATED GYN CLAIMS

A. PROVIDER CLAIMS PAID OVER 45 DAYS

The Company and their third-party administrators identified a total universe of 1,730 clean provider submitted claims paid over 45 days during the experience period. A sample of 510 clean claims paid over 45 days from the Company and the four third-party administrators records from date of receipt was reviewed on Company's computer system and paper copies. During the period of the examination, the Company and the Department interacted several times in reviewing claims that were delayed payment due to various claim adjustments.

A concern noted was the large number of claims reported as a medical reimbursement plan. Under this plan the employer maintains a fully insured major medical health plan which contains a very high deductible (usually \$1,000 and higher). Claim payments were delayed due to the employer funding a separate account established and funded by the employer to cover the deductible.

The purpose of the review was to verify compliance with Act 68, Section 2166, Prompt Payment of Claims, which requires managed care plans to remit payment within 45 days of receiving a clean claim, and validate the claims report provided by the Company. Forms violations noted are included in Section V. Forms of this Report.

The following is a brief synopsis of the provider submitted clean claims paid over 45 days from the different entities:

Name	Clean Claims Paid Over 45 Days
Philadelphia American Life Insurance Company	5
Managed Care of America, Inc	55
Preferred Care, Inc.	274
Gettysburg Health Administrators, Inc	353
Erin Group Administrators, Inc.	1,043
Total	1,730

The following violations were noted:

1,730 Violations - Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 PS § 991.2166), Prompt Payment of Provider Claims (A)

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

Claim files for the 510 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. All 510 claims reviewed were found to be clean claims paid over 45 days from date of receipt.

30 Violations - Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 PS § 991.2166), Prompt Payment of Provider Claims (B)

If a licensed insurer or a Managed Care Plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two (\$2) dollars. The Company failed to pay interest due on 30 claims.

and,

Title 31 Pennsylvania Code, Section §154.18(c) Prompt Payment

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The Company failed to pay the interest within the required 30 days of claim payment on 30 claims.

B. LIFE CLAIMS

The Company identified a total 19 life claims during the experience period. Erin Group Administrator, Inc. was the only entity reporting life claims during the period. All 19 claim files were requested, received and reviewed.

The purpose of the review was to determine compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by appointed designees. The files shall contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. The Company failed to provide documentation necessary to verify receipt date.

15 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge receipt of claims within 10 working days.

6 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be

completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely status letters for six life claims.

7 Violations- Title 31, Pa. Code, Chapter 146, Unfair Insurance Practices, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first- party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within the required time frame for seven life claims.

6 Violations - Insurance Company Law, Section 411B, Payment of Benefits (40 P.S. §511b)

(a) Life insurance death benefits not paid within thirty days after satisfactory proof of death was submitted to the insurer shall bear interest at the rate of interest payable on death benefits left on deposit by the beneficiary with the insurer. This interest shall accrue from the date of death of the insured to the date benefits are paid to the beneficiary. In cases where satisfactory proof of death is submitted more than one hundred eighty days after the death of the insured, and the death benefits are not paid within thirty days after the satisfactory proof of death was submitted to the insurer, interest shall accrue from the date on which satisfactory proof was submitted to the date on which the benefits of the policy are paid.

(b) Notwithstanding section 6 of the act of May 11, 1949 (P.L. 1210, No. 367), referred to as the Group Life Insurance Policy Law, this section shall apply to all life insurance policies except variable insurance policies.

(c) The term "left on deposit" shall mean a specific settlement option provided within the life insurance policy under which the death benefit proceeds are retained by the insurer for the beneficiary and are credited with a specific rate of interest. There was no evidence the Company complied with these requirements.

C. DIRECT INDIVIDUAL MEDICAL CLAIMS

The Company identified a total of 33,441 direct individual medical claims during the experience period. Erin Group Administrator, Inc. was the only entity reporting direct individual medical claims during the period. Review of the claim detail was conducted in the office of Erin Group Administrators, located in Lancaster, Pennsylvania. A sample selection of 100 claim files were requested, received and reviewed.

The purpose of the review was to determine compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

The following violations were noted:

9 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge nine member submitted claims within the required time frame.

7 Violations- Title 31, Pennsylvania Code, Chapter 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first- party claimant shall be advised of the acceptance or denial of the claim by the insurer.

The Company failed to provide notice of acceptance or denial within the required time frame for seven member submitted claims.

D. OB/GYN CLAIMS DENIED

The Company and third-party administrators identified a total universe of 217 OB/GYN Annual Examination claims denied during the experience period. Claim files for the entire 217 denied OB/GYN claims were requested, received and reviewed.

The primary purpose of the review was to verify compliance with Act 20 of 1994, OB/GYN Annual Examinations, Act 20 of 1994, PA Insurance Company Law, Chapter 2, §633 (40 P.S. §1571-1575) Known as the “Women’s Preventative Health Services Act.

It was noted during the claims review at Erin Group Administrators, Inc. the Company has been pending payments to providers for OB-GYN services awaiting submission of lab services before processing claims. Act 20 of 1994, OB/GYN Annual Examinations, Act 20 of 1994, PA Insurance Law, Chapter 2, §633 (40 P.S. §1571-1575) Known as the “Women’s Preventative Health Services Act requires coverage for these services. The 33 improperly pended OB-GYN claims are included in Section (A. Provider Claims Paid Over 45 Days) of this report.

The following is a brief synopsis of the provider clean claims paid over 45 days from the different entities:

NAME	NUM OB/GYN CLAIMS DENIED
Philadelphia American Life Insurance Company	26
Managed Care of America, Inc	13
Preferred Care, Inc.	22
Gettysburg Health Administrators, Inc	146

Erin Group Administrators, Inc.	10
Total	217

The following violation was noted:

1 Violation - OB/GYN Annual Examinations, Act 20 of 1994, PA Insurance Company Law, Chapter 2, §633 (40 P.S. §1571-1575) Known as the “Women’s Preventative Health Services Act” requires coverage for annual gynecological examinations and routine Pap smear testing. Deductibles and dollar limits may not be applied. The Act also contains a provision allowing self-referral for these services within the network. One OB/GYN claim was improperly denied as a Non Covered Routine Service.

XI. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise internal control procedures to ensure compliance with Act 68 of 1998, Section 2166, Prompt Payment of Provider Claims, (40 P.S. § 991.2166), which became effective January 1, 1999.
2. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices, for claims submitted by members.
3. The Company must review and revise procedures to ensure all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company are maintained in such a manner and for such period of time to ensure compliance with Section 903(a) (40 P.S. §323.3) of the Insurance Department Act.
4. The Company must ensure all applications, enrollment and claim forms contain the fraud notice required by Title 18, Pennsylvania Consolidated Statutes, Section 4117(k).
5. Company must pay interest due on the 30 late claim payments noted in Section A. Provider Claims Paid Over 45 days, of this report. Proof of such payments must be provided to the Department within 30 days of the Report issue date.

6. The Company must implement procedures to ensure compliance with the requirements of Title XXVII Section 7201(e), (40 §1302.4) Adopted by the Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4.

XII. COMPANY RESPONSE



April 26, 2004

VIA EMAIL AND OVERNIGHT DELIVERY

Chester A. Derk, Jr., AIL, HIA
Market Conduct Division Chief
Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

Re: Company Response to Report of Examination
Examination Warrant Number: 02-M11-012

Dear Mr. Derk:

This letter constitutes the response of Philadelphia American Life Insurance Company (the "Company") to the Report of Examination for the period January 1, 2001 through December 31, 2001 ("Report"). For ease of reference, the headings herein reference the cited laws referenced in the Report, with the Company's response thereto, even though the alleged violation may be referenced in more than one section in the Report.

Fraud Warning 18 Pa.C.S. §4117(k)

The statute requires that applications and claims forms contain a prescribed fraud warning. The Company agrees that the applications and claims forms referenced in the Report did not contain the prescribed warning. The Company has amended the applications and claims forms to include the prescribed fraud language.

Medical Foods Coverage 40 P.S. §3901

The statute requires that coverage be afforded for food needs that arise from certain medical conditions. The Company agrees that the group health policies and certificates referenced in the Report did not contain this coverage. The Company has amended these policies and certificates include this coverage.

Diabetes Coverage 40 P.S. §764e

The statute requires that coverage be afforded for equipment, supplies and self-management for persons with diabetes. The Company agrees that the certificates referenced in the Report did not contain this coverage. The Company has amended the certificates to include this coverage.

Agent Appointment 40 P.S. §235

The statute (now repealed) required that insurers appointment the insurance agents who conducted business on its behalf. The Company agrees that no appointment fee was paid to the Department for the one producer cited in the Report. The Company notes that this producer became associated with the Company during a roll-over of a book of business from another insurer, leading to this inadvertent oversight. The Company appointed the producer when this error was first discovered.

Certificates of Creditable Coverage 40 P.S. §1302.4

The law requires that a group health insurer provide a certificate of creditable coverage to individuals at the time the individual ceases to be covered by the group policy if group replacement coverage is not secured. The Company agrees that certificates of creditable coverage did not appear in its files at the time of the examination for the individuals referenced in the Report, and the Company's records did not contain documentation identifying the group as enrolling with another insurer. The Company has reviewed its procedures with its employees and

representatives to help ensure that documentation of replacement group coverage is obtained or a certificate of creditable coverage is issued to the individual when required.

Medicare Supp Replacement Questions 31 Pa. Code §89.784

The regulation requires that Medicare Supplemental Coverage application forms contain questions inquiring whether the applicant has a Medicare Supp or other health insurance in force on the date of application. The Company agrees that the applications referenced in the Report did not make inquiry into the applicant's existing Medicare Supp or other health insurance coverage. In the two instances cited in the Report, the applicants were moving from group coverage to individual coverage. The Company believed that the replacement coverage questions were not required under these circumstances. The Company has amended the applications to include the Medicare Supp replacement questions, regardless of whether the applicant is moving from a group or individual policy.

Books and Records 40 P.S. §323.3

The statute requires that an insurer keep its books and records in a manner sufficient for the Department's review of such materials. The Company agrees that the documents referenced in the Report were unavailable at the time of the Department's request during the examination. The Company has reviewed its procedures and will endeavor to assure that policyholder file records can be retrieved in a timely manner. Additionally, the Company agrees that the one file noted in the Report failed to contain documentation of the date of receipt. The Company will endeavor to ensure that its existing procedures regarding date stamping for correspondence are followed consistently.

Internal Audit Procedures 40 P.S. §625-5

The statute requires that insurers maintain internal audit procedures to evaluate compliance with laws dealing with life insurance sales methods and regulatory filing and approval requirements. The Company agrees that its written internal audit procedures did not specifically address these issues. However, the Company believes that its procedures were adequate with respect to such matters for the type of life insurance product offered (accidental death and dismemberment), and notes that the Report does not contain any alleged violations relating to its advertising materials. Nevertheless, the Company has amended its written internal audit and compliance procedures to address compliance in this area, including periodic reviews of consumer complaints to identify patterns of improper practices; regular reporting to senior management or the Board of Directors with respect to significant findings; and establishment of lines of communications, control and responsibility regarding the dissemination of advertising materials.

Prompt Payment of Provider Claims 40 P.S. §991.2166(a)

The statute requires that "clean claims" from providers be paid within 45 days of receipt. As noted in the Report, at the time of the examination, the Company utilized the services of four third party administrators ("TPAs") to administer claims payments, in addition to its own internal claims staff personnel. While the Company's performance in the timely payment of claims was exceptional (only 5 claims paid more than 45 days from receipt), the TPAs had varying levels of performance, with one TPA accounting for a significant number of the alleged violations cited in the Report. The Company notes that its relationship with these TPAs was initiated at the time it assumed the book of business from Conestoga Life Assurance Company in 2000. Shortly following the Department's examination, the Company terminated its relationship with all TPAs except EGA. The EGA Administrative Service Agreement was not terminated until 12/31/2003 due to the contractual limitation on the termination of the Service Agreement. The Administrative Service Agreement with all TPAs contains the following clause: "The administrator shall be responsible for complying with all federal, state and local laws regarding its activities, duties and responsibilities,..." Additionally, the Company has now specifically addressed the payment of "clean claims" in its claims processing guide, and improved its internal audit control procedures in this area.

Interest Payments on Provider Claims 40 P.S. §991.2166(b)

The statute requires that 10% interest be paid to providers within 30 days on "clean claims" that are not paid within 45 days of receipt. The Company agrees that interest was not paid on 30 of the provider claims that were paid more than 45 days after receipt. Inasmuch as interest was not paid on these 30 claims, the Company agrees that such interest was not paid within 30 days following payment of the claim. Interest on the provider claims cited in the Report will be paid.

Claims Acknowledgement 31 Pa. Code §146.5

The regulation requires that claims must be acknowledged within 10 working days, unless paid earlier. The Company agrees that the files for the claims cited in the Report did not contain documentation of acknowledgement within 10 working days. The Company has reemphasized the need for timely claims acknowledgements with its claims personnel.

Claims Status Letters 31 Pa. Code §146.6

The regulation requires that status letter be provided to claimants if the initial claims investigation is not completed within 30 days, and every 45 days thereafter until the claim is decided. The Company agrees that the files for the claims cited in the Report did not contain documentation that status letters were provided to claimants. The Company has reemphasized the need for timely status letters with its claims personnel.

First Party Claims Acceptance or Denial 31 Pa. Code §146.7

The regulation requires that an insurer advise a first party claimant of the acceptance or denial of the claim within 15 working days following receipt of a properly executed proof of loss. The Company agrees that the files for the claims cited in the Report did not contain documentation that the claim was accepted or denied within 15 working days. The Company has reemphasized the need for prompt acceptance or denial of first party claims following receipt of a properly executed proof of loss with its claims personnel.

"Left on Deposit" Settlements 40 P.S. §511b

The statute requires that the interest rate specified in the policy shall be applied to death benefits that are "left on deposit" with the insurer. The Company agrees that interest was not credited to death benefits during the time that the Company held the benefit. The Company has reviewed its procedures to ensue that interest is applied when appropriate to death benefit proceeds.

OB/GYN Claims 40 P.S. §1572

The statute requires coverage for annual gynecological examinations and routine PAP smear testing. The Company agrees that coverage for the one claim cited in the Report was erroneously denied. The claim has been readjusted and paid.

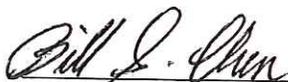
Conclusion

The Company appreciates the Department's courtesies during the examination, and regarding the communications related to the Report. In particular, the Company appreciates the Department's acknowledgment that certificates of creditable coverage do not need to be provided when a group policy is terminated and replaced by another group policy. Additionally, we appreciate the Department's acknowledgment that provider claims are not considered to be "clean" under Act 68 requirements (40 P.S. §991.2166) if (1) the provider ignores the Company's instruction to submit all claims to the network for repricing, (2) particularized circumstances requiring additional investigation and special treatment of the claim, (3) the provider disputes some portion of the payment and the claim must be re-adjudicated, or (4) when the payment check must be reissued because the provider denies receipt of the initially issued check. Additionally, the Department acknowledged that employed funded (self funded) programs are not subject to Act 68's.

Finally, the Company feels by the elimination of the TPAs, the Company retains significantly higher control in ensuring full compliance with all applicable regulations and statutes regarding administration of the cited businesses.

The Company appreciates the opportunity to provide this response, which we understand will be attached to the final version of the Report.

Sincerely,



Bill S. Chen, F.S.A., Ph.D.
President & C.E.O.
281-368-7283