THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

CAPITAL HEALTH PLAN, INC.

AS OF

October 9, 2009

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EXECUTIVE SUMMARY

A market conduct examination of Capital Health Plan, Inc. was performed to determine compliance with Florida Statutes and Florida Administrative Code.

The following represent general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
641.3903(10)(b)	Company failed to charge the correct premium (Complaints Review)	34	1
641.3903(5)(c)4	Company denied claim without conducting a reasonable investigation (Complaints Review)	34	1
69O-191.063	Advertising materials failed to display the form number (Marketing & Sales Review)	20	5
626.471(1)	Company failed to provide appointee at least 60 days advance written notice of its intent to terminate appointment (Producer Licensing Review)	10	10
626.471(2 & 3) and 626.511	Company failed to notify DFS within 30 days of appointment termination and provide the reason for the termination (Producer Licensing Review)	10	5
641.31(36)	Company amended coverage, reducing benefits, in advance of coverage renewal (Underwriting & Rating Review – Prescription Drugs)	115	1,313
641.3155(3)(a) & 641.3155(4)(a)	Company failed to acknowledge claim timely (Paid and Denied Claims Review)	384	36
641.3155(6)	Company failed to pay interest on overdue claims (Paid Claims Review)	192	3
641.3155(3)(b) & (4)(b)	Company failed to pay claim timely (Paid Claims Review)	192	1
641.3903(5)(c)4	Company denied claim without conducting a reasonable investigation (Paid Claims Review)	192	1
641.315(4)(d)1	Company failed to pay claim in accordance with provider contract (Paid Claims Review)	192	1
641.3106	Company failed to send written explanation of claim decision to the member as set forth in the policy (Paid and Denied Claims Review)	384	316
641.3903(5)(c)4	Company denied claim without conducting a reasonable investigation (Denied Claims Review)	192	1
641.3155(3)(b) & (4)(b)	Company failed to pay claim timely (Denied Claims Review)	192	7

641.3155(6)	Company failed to pay interest on overdue claims (Overdue Paid Claims Review)	192	40
641.31(36)	Company increased co-payment prior to the time of coverage renewal (Claims Review - Rx Paid Claims)	192	3
627.9175	Company filed an inaccurate report of information on health and accident insurance	1	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a comprehensive market conduct examination of Capital Health Plan, Inc. (Company) pursuant to Section 641.3905, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of this examination was January 1, 2006 through May 31, 2009. The onsite examination began July 6, 2009 and ended August 20, 2009. The examination continued offsite and ended October 9, 2009.

The purpose of this examination was to review the Company's business practices, including those in each of the following categories: operations/management, including but not limited to: management and organizational controls; physical and logical security, application management, record retention, and disaster recovery; complaint handling; marketing and sales, including products, advertising and advertising materials, and licensing and distribution; policyholder services; underwriting and rating, including large group, small group and individual; policy forms and filings; claim handling; grievance procedures; network adequacy; utilization review practices; provider credentialing; quality assurance and improvement.

The examination included the following procedures:

- **Operations and Management Review** - (Internal audits, Controls of Computer Information, Anti-fraud Initiatives, Disaster Recovery, Outsource of Management Services, Record Retention, Certificate of Authority, Privacy Requirements, Board of Directors Minutes). Sections 624.318; 626.9651; 817.5681; 641.3915; 626.989; 626.9891; 624.33; 626.88; 626.8805; 626.8817; 626.882; 626.8814; 626.883; 626.884; 626.886; 641.22; 641.221; 641.3905; 641.36; 641.234; and, 641.54 Florida Statutes, and Rules 69O-128; 69O-128.032; 69O-128.033; 69O-128.034; 69O-128.035; and, 69O-191.074 Florida Administrative Code.
- **Complaints Review** – Sections 641.3903; 641.31(41); and, 627.6562(2), Florida Statutes.
- **Marketing and Sales Review** - Sections 641.305; 641.3903; and, 641.309, Florida Statutes, and Chapter 69O-191, Florida Administrative Code.
- **Producer Licensing Review** – (Appointments and Terminations) Sections 641.386; 626.461; 626.471; 626.112; and, 626.511, Florida Statutes.
- **Policyholder Services Review** – (Premium, Billing, and Cancellations) Sections 641.31074 and 641.3108, Florida Statutes, and Rule 69O-191.042, Florida Administrative Code.
- **Underwriting and Rating Review** – (Rating Practices, Mandated Disclosures, Forms Filings, Cancellations, Declinations, Rescissions, Rx Changes in Tier) Sections 641.31; 641.31(2); 641.31(36); 641.31074; 641.3903; 641.3007; 641.3102; 641.3107; 641.31073; 641.185; 641.185; 627.410; 627.674; 627.421; 641.3102; and, 641.309, Florida Statutes, and Rules 69O-149.207 and 69O-191.054, Florida Administrative Code.
- **Claims Handling Review** – (Claim Acknowledgments, timely investigations, paid, denied and overdue claims) Sections 641.3903; 641.315; 641.3155; 641.3156; and, 641.3106, Florida Statutes.
- **Grievances Review** – Sections 641.31; 641.3155; and, 641.3903, Florida Statutes and 690-191.078, Florida Administrative Code.
- **Network Adequacy Review** – Section 641 Part III, Florida Statutes

- **Provider Credentialing Review** - Section 641 Part III, Florida Statutes
- **Quality Assessment and Improvement Program Review** - Section 641 Part III, Florida Statutes
- **Utilization Review** - Section 641 Part III, Florida Statutes
- **Reporting Requirement Review** – (GAP Report) Section 627.9175, Florida Statutes

The Company records were examined at its office located at 1545 Raymond Deihl Rd, Tallahassee, FL 32317. This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

Sample sizes were determined using the Acceptance Samples Table of the NAIC Market Regulation Handbook or by the Audit Command Language (ACL) software. The handbook allows several methods for determining sample sizes. Two methods were used during the examination. For populations less than 50,000 the Acceptance Samples Table was used and for populations 50,000 and over ACL was used. Utilizing ACL to determine the sample sizes, a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% was used in accordance with the handbook.

COMPANY OPERATIONS

Capital Health Plan, Inc. is a domestic Health Maintenance Organization (HMO) authorized to conduct business in the State of Florida on May 25, 1982. The Company provides health insurance in the State of Florida.

Total Direct Premiums Written in Florida for Health insurance were:

Year	Total Written Premium In Florida (Per Schedule T of the Annual Statement)
2006	433,551,746
2007	468,205,514
2008	501,686,968

The Company writes business through licensed independent agents, brokers and Company captive licensed agents. The Company contracts with various health care providers for the provision of certain medical services to its members. The Company compensates these providers on a capitated or non-capitated basis.

The Company has an affiliation agreement with Blue Cross Blue Shield of Florida, Inc. (BCBSFL) giving BCBSFL majority control of the corporate membership of the Company. The agreement provides that BCBSFL may supply certain administrative services and products to the Company and also commits BCBSFL to loan the Company operating funds.

The Company maintains an agreement with BCBSFL whereby the companies combine to offer several group purchasers a multiple option health care program, which includes consolidated billing and administrative services.

OPERATIONS/MANAGEMENT

I. INTERNAL AUDITS

Review of the internal audit procedures manual indicates that the Company has sufficient written procedures in place to identify problematic areas and make recommendations for corrective action.

The Company provided internal audit reports issued during the scope of the examination. The Company is using the reports to identify problematic areas and implement corrective action. The Company monitors some of its contracted entities on a limited basis; however, there is no consistent procedure or practice in place. The Company should consider including a provision in all agreements that permits the Company to audit the functions being performed by a third party.

No exceptions were found.

II. CONTROLS OF COMPUTER INFORMATION

The Information Security Policy required by Rule 69O-128.032 Florida Administrative Code includes written procedures to ensure the security and confidentiality of customer information, which was the emphasis of our review. The Company's Information Security Policy includes both internal and external procedures to ensure security of electronic data transference. All computer systems are password protected and the Company has strict procedures for password use, sharing, protection, constraints, and storage. Employees are instructed to follow appropriate security precautions at all times.

Review of the Information Security Policy indicates that before any application system can be changed, the Information Systems Department must give written approval. All procedure changes must go through the Compliance Committee for authorization.

No exceptions were found.

III. ANTI FRAUD PLAN

The Company has filed its Anti Fraud Plan with the Office as required by Sections 626.9891 and 641.3915, Florida Statutes.

The Company's anti-fraud plan is handled by the Company's affiliate, Blue Cross Blue Shield of Florida Special Investigation Unit (SIU). Its written policies and procedures comply with statutory requirements. The SIU has set up a fraud hot-line number, 1 (800) 678-8355, and an internet webpage, http://siu.bcbsfl.com/, for reporting of fraudulent insurance activity.

No exceptions were found.

IV. DISASTER RECOVERY PLAN

The Company has established a Disaster Recovery Plan with procedures to ensure business continuity during natural disasters and other adverse events. The recovery plan is current, specific, and includes detailed information for implementation of emergency procedures. The plan includes moving important records off-site, computer back-ups and the use of generators to facilitate continuity of business.

No exceptions were found.

V. OUTSOURCING OF MANAGEMENT SERVICES

The Company has contracted external management services with several vendors. The Company provided a list of 32 contracts in effect during the scope of the examination. A sample of 10 contracts was selected for review. The purpose of the review was to determine if the Company has adequate procedures to monitor its contracted external management services and if these contracts contain a provision to allow the Company to conduct audits.

The review showed that the contracts stipulate privacy requirements of the information obtained in connection with the agreement. The contracts specify the responsibilities of the subcontractor in regard to record keeping; however most contracts did not contain provisions for allowing the Company to conduct audits.

The Company did not conduct audits of any contracted entities during the scope period. Review of the information provided indicates the Company monitors some of its contracted entities on a limited basis; however, there is no consistent procedure or practice in place. The Company should consider including a provision in all contracts that permits the Company to audit the third party.

No exceptions were found.

VI. RECORD RETENTION PROCEDURES

The Company has established record retention procedures and was able to produce all records requested. The Company does not maintain paper files. Information is captured and maintained electronically. Several databases were used during the scope of the exam. During review of the written procedures it was noted that the retention schedule for certain records subject to regulatory review may not be sufficient. The Company should consider revising its record retention timeframes in order to reduce the likelihood of the Company being unable to produce documents subject to examination or investigation pursuant to Section 641.36 Florida Statutes and Rule 69O-191.074 Florida Administrative Code.

No exceptions were found.

VII. POLICYHOLDER PRIVACY PROCEDURES

The Company's website, http://capitalhealth.com, provides links to the information required by Section 641.54 Florida Statutes.

The Company provided its written procedures, titled *How to Complete a Communication Directive*, which explains how to complete the Communicative Directive forms. The procedures also explain how the member can limit, revoke, or place restrictions on how their information is disclosed.

Procedures included safeguarding confidential and proprietary information, protected health information, computer data, fax communications, direct requests for information, and use of inside information.

The Company does not use investigative consumer reports unless it suspects fraudulent enrollment. In such instances, the enrollment manager runs a report through the Lexis Nexis system to determine enrollment issue errors or potential fraud.

The Company's Beacon Program includes compliance policies and standards of conduct which details the safeguarding of personal information. The Privacy Notices provided to members also address disclosure of personal information.

A walk through the mail center confirmed that the member is sent an information package upon enrollment including a CD disk which contains handbook, endorsements, privacy procedures and grievance procedures. Members may also request this information in writing.

Notice of Privacy Practices and the Privacy Notice were reviewed. The Company stated that the Privacy notice is sent to members annually. The Notice of Privacy Practices is sent to all new members. This notice is also mailed to members every three years or at each change. The Notice of Privacy Practices is required for any member who is seen by a network doctor. A note is added to the member's record indicating the privacy notice was provided to the member.

The Company's Notice of Privacy Practices advises members that no personal health or financial information will be disclosed without proper authorization, except to third-party business associates who have entered confidentiality contracts. The Company utilizes privacy notices and authorization forms to permit members to exercise their rights regarding sharing of their health information.

Communication Directive Forms completed by members were reviewed to verify the Company obtained valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information.

No exceptions were found.

COMPLAINT HANDLING

I. COMPLAINT HANDLING PROCEDURES

The Company has established complaint handling procedures as required by Section 641.3903(6), Florida Statutes. The Company received 34 Department of Financial Services (DFS) complaints and a total of 3,523 direct complaints and/or grievances during the scope period. A sample of complaints was reviewed to determine that responses to complaints were timely, file documentation was adequately maintained, and that the Company's response fully addresses the issue raised. The Company's complaint register contains limited information. The Company should consider adding the DFS service request number (if applicable), issue and resolution to its register, as well as noting whether the issue is a grievance or a direct complaint.

DFS COMPLAINTS:

All 34 DFS complaints were reviewed with the following noted:

1. **In 1 instance the Company failed to charge the correct premium in violation of Section 641.3903(10)(b), Florida Statutes.**

1a.) CORRECTIVE ACTION: No further action is necessary as the Company resolved this issue with the insured. The insured was overbilled, but reimbursed for the overpayment at the time the complaint was finalized.

1b.) Company Response: The Company agreed with this violation.

2. **In 1 instance the Company denied a claim without conducting a reasonable investigation in violation of Section 641.3903(5)(c)4, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Claim was reprocessed at the time the complaint was filed. The Company should establish procedures to ensure that a reasonable investigation is conducted prior to denying a claim.

2b.) Company Response: The Company agreed with this violation.

DIRECT COMPLAINTS AND/OR GRIEVANCES:

A sample of 81 direct complaints and/or grievances was selected for review.

No exceptions were found.

II. OIR REFERRALS:

The examination included a review to verify compliance with Sections 641.31(41), 641.31(2) and 627.6562, Florida Statutes. Sections 641.31 and 627.6562 Florida Statutes were amended in 2008 requiring that an offer of coverage be extended for eligible dependents until the end of the calendar year in which the child reaches the age of 30.

The review revealed that the Company could not document compliance with this requirement.

RECOMMENDATION: It is recommended that the Company implement procedures to assure that offers of coverage are extended for eligible dependents to age 30 and maintain documentation of compliance.

Company Response: The Company disagrees with this finding, indicating they provided a substantive proxy of specific coverage notification communication methods, used by groups that comprise approximately 63% of their total Commercial membership. Additionally, the Company maintains that overall awareness of this coverage option was further corroborated by the fact that they currently provide this coverage to members in each of its Commercial rating blocks including groups that are not among the 63%.

MARKETING AND SALES

I. ADVERTISING MATERIALS:

The Company was requested to provide a listing of all advertising materials that were used during the scope of the examination.

A sample of 20 advertising materials was selected for review to verify compliance with applicable laws and regulations.

There were 5 violations found.

1. **In 5 instances the advertising materials failed to display the form number in violation of Rule 69O-191.063, Florida Administrative Code.**

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure that all marketing materials contain a unique form number which will readily identify it from all other advertising.

1b.) Company Response: The Company agreed with the findings and has already taken corrective measures to ensure that marketing materials contain a form number.

PRODUCER LICENSING

I. APPOINTMENTS AND TERMINATIONS

Company agent/broker appointments and terminations procedures were reviewed. Pursuant to section 641.386(2), Florida Statutes, appointment procedures by HMOs must comply with the same appointment procedures as insurers. The Company terminations procedures do not address the agent/broker notification requirements of Section 626.471(1), Florida Statutes in which the Company is required to provide at least 60 days advance notice of termination to the appointee. In addition, the procedures do not

address the requirements of Sections 626.471(2) and 626.511, Florida Statutes, which require that DFS be notified within 30 days of termination.

APPOINTMENTS SAMPLE REVIEW: Agents licensing was reviewed as part of the underwriting and rating review. A total of 115 policies were reviewed and all agents were properly licensed and appointed.

TERMINATIONS SAMPLE REVIEW: The Company provided a list of 45 agents that were terminated during the scope of the examination. A sample of 10 terminated agents was selected for review.

A total of 15 violations were found.

1. **In 10 instances the Company failed to provide at least 60 days advance written notice of its intent to terminate the appointment to the appointee in violation of Section 626.471(1), Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure proper notice is given to terminated agents.

1b.) Company Response: The Company agreed with the finding and stated it has revised its procedures to ensure proper notice is given to terminated agents.

2. **In 5 instances the Company failed to notify DFS within 30 days of appointment termination and provide the reason for the termination in violation of Sections 626.471 (2 and 3) and 626.511, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should establish procedures to ensure DFS is notified of agent terminations within 30 days and providing the reason for the termination.

2b.) Company Response: The Company agreed with the finding and stated it has revised its procedures to ensure notice and reasons for termination are provided to DFS timely.

POLICYHOLDER SERVICES

I. PREMIUM AND BILLING NOTICES

Premium and billing notices were reviewed to verify if they were sent timely. This was reviewed as part of the underwriting and rating review. A sample of 115 policies was reviewed.

No exceptions were found.

II. CANCELLATIONS, DECLINATIONS AND RESCISSIONS

CANCELLATIONS: Cancellations were reviewed to verify if proper notice was given and applicable refunds of unearned premium were processed timely and accurately. In addition, the reasons for the cancellations were reviewed to ensure they were valid and that the Company was following its own guidelines. There were 1,098 policies cancelled during the scope of the examination. A total of 114 cancellations were reviewed.

No exceptions were found.

DECLINATIONS: The Company did not have any declinations during the scope of the examination.

RESCISSIONS: The Company provided a list of rescinded policies. There were 4 policies rescinded during the scope of the examination. All 4 rescissions were reviewed.

No exceptions were found.

UNDERWRITING AND RATING

I. UNDERWRITING AND RATING PRACTICES:

Review of the Company's underwriting and rating practices included: verification that rates used were properly filed and approved by the OIR; adherence with underwriting guidelines; accuracy of premiums; verification that disclosures were provided; and, determination of any unfair discriminatory practices. There were a total of 3,999 policies issued during the scope of the examination. A total of 115 policies were selected for review.

No exceptions were found.

II. FORM FILINGS:

The forms filing review included verification that all forms used were properly filed and approved by the OIR and verification that the fraud warning was displayed when applicable.

No exceptions were found.

III. PRESCRIPTION DRUGS:

The Rx Paid Claims Review identified 3 violations that were due to the Company's practice of changing formularies mid-term, resulting in higher co-payments for the members. As a result, the Office expanded the review to include the Company's practice of making mid-term changes to the formularies.

The Company provided copies of the formularies used during the scope of the examination and copies of notices sent to the members. The Company's practice is to send the notices to members that had used the drug at least 60 days before the effective date of the change.

A review of the formularies used during the scope of the examination revealed that the co-payments for 125 drugs were changed mid-term, however, for review purposes, only those changes in the formulary involving drugs that did not have a generic equivalent were considered as violations. The number of drugs not having a generic equivalent totaled 65.

The review revealed that the Company made many of these changes prior to the coverage renewal date. During 2006 and 2007, changes to the formularies were made on an annual basis. Beginning in January, 2008 when the Company contracted with CareMark to manage the formularies, the prescription tier changes were subsequently made on a quarterly basis.

The 115 policies selected for the underwriting and rating review were also used for the Prescription Drugs review. There were 1,313 violations found in 88 of the 115 policies reviewed.

1. **In 1,313 instances the Company increased the co-payment, a reduction in benefits, prior to coverage renewal in violation of Section 641.31(36), Florida Statutes.** Changes in the formularies, reducing benefits, were made mid-term.

1a.) CORRECTIVE ACTION: The Company should only decrease benefits at the renewal date. All prescription claims during the scope of the examination should be reviewed and a refund of the co-pay difference should be issued to members whose co-pay was increased other than at renewal due to formulary changes.

1b.) Company Response: The Company did not agree with the findings; however, the Company pro-actively made a business decision to refund co-payment differences paid by members.

CLAIM HANDLING

The claim handling review included: verification of timely claim acknowledgments; review of claim settlements for timely investigations; prompt payment or denial of claims; and, payment of interest on overdue claims. There were a total of 1,850,132 claims paid or denied during the scope of the examination. In addition, there were 5,255,621 Prescription Drug (Rx) claims paid during the scope of the examination. Rx claims are managed by Caremark and, aside from paid claims, are not captured by the Company's claim system.

I. CLAIM ACKNOWLEDGMENT:

Electronic claims are acknowledged within 24 hours automatically by the Company's system. Paper claims are acknowledged automatically by the system once they are

entered into the Company's system. There were a total of 384 claims reviewed, of which 192 were paid claims and 192 were denied claims. The sample included a total of 212 electronic claims and 172 paper claims. There were 36 violations found. All the violations involved paper claims.

1. **In 36 instances, the Company failed to acknowledge a claim timely in violation of Sections 641.3155 (3)(a) and 641.3155 (4)(a), Florida Statutes.** Paper claims were not entered into the system timely, therefore, missing the required acknowledgment timeframe.

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure acknowledgments are provided timely.

1b.) Company Response: The Company agreed with the findings and stated that it has established procedures to ensure compliance with acknowledgment requirements.

II. CLAIM SETTLEMENTS:

PAID CLAIMS: There were a total of 192 Paid Claims reviewed. A total of 198 violations were found.

1. **In 3 instances the Company failed to pay interest on overdue claims in violation of Section 641.3155 (6), Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure interest is paid when applicable.

1b.) Company Response: The Company agreed with the findings and pro-actively paid the applicable interest.

2. **In 1 instance the Company failed to pay a claim timely in violation of Section 641.3155(3)(b) Florida Statutes.** This case was a clean electronic claim that was paid after 39 days.

2a.) CORRECTIVE ACTION: The violation appears to be an isolated case; therefore, no corrective action is necessary.

2b.) Company Response: The Company agreed with the finding.

3. **In 1 instance the Company denied a claim without conducting reasonable investigation in violation of Section 641.3903(5)(c)4, Florida Statutes.** The claim was initially denied in error and later paid.

3a.) CORRECTIVE ACTION: The violation appears to be an isolated case; therefore, no corrective action is necessary.

3b.) Company Response: The Company agreed with the finding.

4. **In 1 instance the Company failed to pay claim in accordance with provider contract in violation of Section 641.315(4)(d)1, Florida Statutes.** The issue was due to an outdated provider contract in the system.

4a.) CORRECTIVE ACTION: The violation appears to be an isolated case, therefore, no corrective action is necessary.

4b.) Company Response: The Company agreed with the finding.

5. **In 192 instances the Company failed to send a written explanation of claim decision to the member as set forth in the policy in violation of Section 641.3106, Florida Statutes.** The Company failed to comply with policy provisions. Payment explanations are included in the provider remits; however, in all 192 paid claims reviewed, the member was not sent a written explanation of the claim decision. Policy language of the contracts state that "All claims decisions, including denial and claims review decisions, will be communicated to you in writing".

5a.) CORRECTIVE ACTION: The Company should establish procedures to ensure that all claims decisions are communicated to the members.

5b.) Company Response: The Company did not agree with the findings stating that the information is available to the member electronically, through the Company's website, should they wish to review the information. The Company also stated that the wording in the Member Handbook will be reviewed and changed to reflect the changes that technology has allowed since the last revision of the handbook and to reflect the electronic availability of the information in question.

DENIED CLAIMS: There were a total of 192 Denied Claims reviewed. A total of 132 violations were found.

1. **In 124 instances the Company failed to send written explanation of a claim decision to the member as set forth in the policy in violation of Section 641.3106, Florida Statutes.** The Company failed to comply with policy provisions. Payment explanations are included in the provider remits; however, in all 192 paid claims reviewed, the member was not sent a written explanation of the claim decision. Policy language of the contracts state that "All claims decisions, including denial and claims review decisions, will be communicated to you in writing".

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure that all claims decisions are communicated to the members.

1b.) Company Response: The Company did not agree with the findings stating that the information is available to the member electronically, through the Company's website, should they wish to review the information. The Company also stated that the wording in the Member Handbook will be reviewed and changed to reflect the changes that technology has allowed since the last revision of the handbook and to reflect the electronic availability of the information in question.

2. **In 1 instance the Company denied a claim without conducting reasonable investigation in violation of Section 641.3903(5)(c)4, Florida Statutes.** The claim was initially denied in error and later paid.

2a.) CORRECTIVE ACTION: The violation appears to be an isolated case; therefore, no corrective action is necessary.

2b.) Company Response: The Company agreed with the finding.

3. **In 7 instances the Company failed to pay a claim timely in violation of Section 641.3155(3)(b) & (4)(b), Florida Statutes.**

3a.) CORRECTIVE ACTION: The Company should establish procedures to ensure claims are paid timely.

3b). Company Response: The Company agreed with the findings.

OVERDUE CLAIMS: There were a total of 192 Overdue Claims reviewed. A total of 40 violations were found.

1. **In 40 instances the Company failed to pay interest on overdue claims in violation of Section 641.3155 (6), Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should reprocess the claims to pay the interest owed. In addition, the Company should establish procedures to ensure interest is paid when applicable.

1b.) Company Response: The Company agreed with the finding and has made interest payments to affected providers. The Company also stated that it made system upgrades, effective April 20, 2009, allowing for automatic payment of interest at the correct rates for payments occurring outside the timely payment guidelines. All cases in the sample were paid prior to the conversion of the system.

Rx PAID CLAIMS: A total of 192 Rx Claims was reviewed. There were a total of 3 violations found.

1. **In 3 instances the Company increased the co-payment prior to the time of coverage renewal in violation of Section 641.31(36), Florida Statutes.** As a result of these violations, further review of this issue was performed in the underwriting and rating review procedures.

1a.) CORRECTIVE ACTION: The Company should only decrease benefits at the renewal date. All prescription claims during the scope of the examination should be reviewed and a refund of the co-pay difference should be issued to members whose co-pay was increased other than at renewal due to formulary changes.

1b.) **Company Response:** The Company did not agree with the findings, however, it stated that it has made a business decision to refund co-payment differences paid by members.

GRIEVANCE PROCEDURES

I. GRIEVANCES

Grievances were reviewed in the Complaint Review. The review concluded that the Company has sufficient written grievance procedures in place for receiving and resolving grievances.

There are two levels of grievance review. In Level One, if the grievance involves a pre-service claim, the Company's decision regarding the grievance will be made within 15 calendar days of receipt of the grievance. If the grievance involves a post-service claim, the Company's decision regarding the grievance will be made within 30 calendar days. If a member has a grievance that involves an adverse benefit determination that an admission, availability of care, continued stay, or other health care service does not meet the Company's requirements for medical necessity, appropriateness of care, health care setting, level of care, or effectiveness, the grievance will be reviewed by the Clinical Grievance Review Panel. If the member remains dissatisfied with the decision of the Grievance Review Panel, he or she may request a reconsideration of the decision by the State of Florida Subscriber Assistance Program.

In the Level Two Review, if the member remains dissatisfied with the decision of the Level One Committee, he or she may request a reconsideration of the decision by the Executive Review Panel. The Company's Executive Grievance Panel will review the Level One decision as quickly as possible and advise the member of its decision in writing.

Any request for expedited review will be evaluated by a health care professional who was not involved in the initial decision and who is in the same or similar specialty, if any, as typically manages the condition, process, or treatment that the member, the representative, or the provider is asking to be reviewed.

No exceptions were found.

NETWORK ADEQUACY

The Agency for Healthcare Administration (AHCA) has the authority to review and regulate network adequacy. This includes AHCA review of network expansions, provider directories, provider standards and responsibilities, proximity of providers, and access to emergency services.

During the examination, the examiners contacted AHCA to inquire if they had any concerns with the Company's Network Adequacy. AHCA stated they had no concerns at the time. The

examiners also reviewed ACHA reports related to the Company's network adequacy during the scope of the examination. No areas of concern were noted.

No exceptions were found.

UTILIZATION REVIEW PRACTICES

AHCA has authority over the Company's utilization review program. The agency review includes referrals, authorizations, over and under utilization, oversight, effectiveness and efficiency, and compliance with provisions.

During the examination, the examiners contacted AHCA to inquire if they had any concerns with the Company's Utilization Review Program. AHCA stated they had no concerns at the time. The examiners also reviewed ACHA reports related to the Company's Utilization Review Program during the scope of the examination. No areas of concern were noted. Additionally, written utilization review procedures were reviewed and appear to be adequate.

No exceptions were found.

PROVIDER CREDENTIALING

AHCA has authority to review and regulate provider credentialing. The Company provides the credentialing files to AHCA for review. The review includes credentialing, re-credentialing, and the Company's monitoring of providers.

During the examination, the examiners contacted AHCA to inquire if they had any concerns with the Company's Provider Credentialing Program. AHCA stated they had no concerns at the time. The examiners also reviewed ACHA reports related to the Company's Provider Credentialing Program during the scope of the examination. No areas of concern were noted.

No exceptions were found.

QUALITY ASSURANCE AND IMPROVEMENT

AHCA has authority to review and regulate Quality Improvement and Assessment. The agency review includes training, complaints, grievances, incident reports and auditing.

During the examination, the examiners contacted AHCA to inquire if they had any concerns with the Company's Quality Assurance and Improvement Program. AHCA stated they had no concerns at the time. The examiners also reviewed AHCA reports related to the Company's Provider Credentialing Program during the scope of the examination. No areas of concern were noted.

The examiners also reviewed the Company's Policies and Procedures. Following is a summary of the findings:

- Both Quality Improvement & Assessment Programs have been developed and are maintained by the Company.

- Quality Improvement and Assessment Programs are a continuous process and a regular part of the Company's activities.
- The stated goals of the plan are: 1) the timely delivery of evidence based medical care; 2) low administrative costs; and, 3) being proactive and innovative in quality improvement.
- A Quality Improvement Management Team (QIMT) made up of key corporate managers meets 10 times annually to monitor and evaluate the implementation of quality improvement initiatives.
- A Quality Improvement Committee (QIC) meets 4 times annually and reports to the Healthcare Delivery Committee which in turn regularly reports directly to the Board of Directors (BOD) regarding QIC activities.
- A Quality Improvement and Evaluation Report is produced annually to analyze, document and assess the effectiveness of the QIC program. This report must be approved by the BOD and QMIT.
- The evaluations and assessments are used in part by corporate management to prioritize and set quality improvement goals and work plans for the coming year.
- Corporate officers and managers are identified and accountable for their respective parts of these programs.

No exceptions were found.

ACCIDENT AND HEALTH PREMIUM AND ENROLLMENT REPORTING

I. GROSS ANNUAL PREMIUM (GAP) FILING

The Company is required to annually file a Report of Gross Annual Premiums and Enrollment Data for Health Benefit Plans issued to Florida Residents (GAP Report) pursuant to Section 627.9175, Florida Statutes.

The Calendar Year 2008 GAP Report that was due on April 1, 2009 was reviewed. The Company timely submitted its filing on March 13, 2009.

The Company filed the following figures:

Description	Direct Premiums Earned	Direct Losses Incurred	New Direct Premiums Earned	Group Coverage	Primary Insureds	Dependents	Covered Lives	Average Days to Pay Claims
Self-Employed or Sole Prop.	$3,926,353	$4,276,490	$82,742	379	379	340	719	1
2 - 5 Member Groups	$15,610,937	$13,947,359	$591,693	1,003	2,181	1,894	4,075	1
6 - 50 Member Groups	$44,005,516	$38,604,283	$782,574	692	6,573	4,668	11,241	1
51+ Member Groups	$351,938,071	$331,647,777	$214,439	135	41,658	45,558	87,216	1
Conversion	$3,009,861	$3,531,396	$0	0	266	75	341	1
Totals	**$418,490,738**	**$392,007,305**	**$1,671,448**	**2,209**	**51,057**	**52,535**	**103,592**	

Work papers and source documentation were reviewed to verify the accuracy of the reporting areas required on the GAP submission with the following noted.

1. **The Company filed an inaccurate 2008 GAP report.** The report filed indicated an average of 1 day to pay claims, however, the source documentation showed the average days to pay claims for the 1-Life groups was 8 days, the 2-5 member group average was 8 days, the 6-50 member group average was 10 days, the 51+ member group average was 10 days, and Conversions an average of 11 days to pay claims. Additionally, the reported total Direct Premiums Earned for Accident and Health Insurance exceeded the total reported on the Company's Annual Statement. This error resulted from the Company erroneously including Federal Employee Health Benefit Program Premiums in the GAP Report in the amount of $11,040,555.

1a.) CORRECTIVE ACTION: The Company should ensure it accurately files all information required by Section 627.9175, Florida Statutes.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issued this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.