



# **THE STATE OF FLORIDA**

**OFFICE OF INSURANCE REGULATION  
MARKET INVESTIGATIONS**

**TARGET MARKET CONDUCT FINAL EXAMINATION REPORT**

**OF THE**

**FLORIDA COMPREHENSIVE HEALTH ASSOCIATION**

**AS OF**

**APRIL 1, 2013**

**FLORIDA COMPANY CODE: 99024**

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## **EXECUTIVE SUMMARY**

An operational review of The Florida Comprehensive Health Association (FCHA) current systems and controls was performed including the evaluation of processes for corporate records, general operations, accounting, complaint handling, underwriting and rating, premiums, general claims, investments, legislative changes, and pending litigation. The following information represents general findings; specific details are found in each section of the report.

A sample of 25 paid and 25 denied claims were reviewed. The following table represents general findings, however, specific details are found in each section of the report.

<b><u>TABLE OF VIOLATIONS</u></b>			
Statute/Rule	Description	Files Reviewed	Number of Violations
626.9541(1)(i)3.a	Improper denial of claims.	25	6
627.649(3)(d)	Failure to properly monitor third party administrator.	25	1

## **PURPOSE AND SCOPE OF EXAMINATION**

The Florida Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of the Florida Comprehensive Health Association (FCHA or Association) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of the examination was January 1, 2009 through December 31, 2011. Due to a change of claims processor in 2012, the claims scope was expanded to include claims handled during the transition. The onsite examination began March 25, 2013 and ended April 1, 2013.

The purpose of this target market conduct examination was to determine the Association's compliance with Florida Statutes, the Florida Administrative Code, its filed plan of operation, and its internal operational procedures. The operational review of current systems and controls included evaluating FCHA processes for maintaining corporate records, general operations, accounting, complaint handling, underwriting and rating, premiums, general claims, investments, responsiveness to legislative changes, and pending litigation.

Information regarding the internal controls of the Association and its service providers was provided by Thomas Howell Ferguson, P.A., who performs audits of the Association annual financial statements and review of the Association internal controls. The examination incorporated the Thomas Howell & Ferguson, P.A., internal control review.

FCHA records were examined at the Association's home office located at 2928 Wellington Circle, Suite 101, Tallahassee, Florida. Documentation utilized in this report was provided by the Association, its service providers and independent auditors, and other external sources.

The Report is based upon information obtained during the examination, additional research conducted by the Office, and additional information provided by the Association. Each finding by the Office was provided to the FCHA. Procedures and conduct of the examination were in accordance with the *Market Conduct Examiner's Handbook*, and the *Financial Condition Examiners Handbook* produced by the National Association of Insurance Commissioners.

## **OPERATIONS REVIEW**

### **CORPORATE RECORDS**

The State Comprehensive Health Association ("SCHA"), predecessor of the FCHA, was established in 1983 as a non-profit legal entity, pursuant to Florida Laws 1982, c. 82-243, Section 496, in order to provide availability of a comprehensive health care plan to Florida residents not eligible to obtain coverage in the private market. The Florida Legislature dissolved the SCHA, effective October 1, 1990, simultaneously establishing the FCHA, a not-for-profit legal entity. The FCHA continues to pay SCHA claims and levies assessments if existing funds are insufficient to fund operations.

The Association is funded by premiums charged to policyholders and through assessments levied against companies writing health insurance in Florida. Assessments are levied in the event that

premiums are not sufficient to provide for the expenses of the Association. Subject to statutory provisions, operating losses may be recouped through additional assessments.

The FCHA, closed to new enrollees since 1991, continues to serve existing members. There were 208 policyholders participating in the plan as of December 31, 2011 and 182 members as of December 31, 2012. The examination testing procedures included reviewing the Association:

- Plan of Operation;
- Board Meeting Minutes;
- Reports of external audits performed during the scope of the examination; and,
- Organizational Chart.

No prior exams were performed within the last ten years.

**Examination Findings:**

No findings were noted pertaining to corporate records during the examination period.

**GENERAL OPERATIONS**

**Assessments**

The FCHA collects annual assessments from all eligible insurers for operating expenses and incurred or estimated losses, in accordance with Section 627.6492, Florida Statutes. Annual assessments are levied when operating results and earned premiums for the calendar year are known. Excess assessments collected are retained for future losses.

Each insurer writing health coverage in Florida is assessed annually based upon the insurer earned health insurance premium in the state during the calendar year preceding the assessment. The participating insurer assessment cannot exceed 1% of its health insurance premium earned in Florida during the calendar year preceding the year the assessment is levied. The FCHA did not have any uncollected assessments during the examination period.

**Assessments Summary as of the December 31:**

<b>Description</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Assessments	\$0	\$1,252,993	\$2,245,799	\$810,542

**Examination Findings:**

No findings were noted relating to assessments.

**Service Provider**

The FCHA engages CoreSource, Inc., (CoreSource) for administrative services. The administrative servicing agreement, effective October 1, 2012 through June 30, 2015, encompasses case management services including adjudication, processing, payment of medical and institutional claims, and communication and correspondence with policyholders.

The FCHA, closed to new enrollment, provides services to existing policyholders only. The Association determines the continuing eligibility of existing policyholders and advises CoreSource on a monthly basis of any changes in eligibility.

CoreSource adheres to specific claims processing and communication standards as stipulated in the administrative servicing agreement. CoreSource is responsible for maintaining sufficient records in its claims files.

From January 1, 2009 through September 30, 2012, the FCHA contracted with Covenant Administrators (Covenant) for administrative services. In 2012, Covenant surrendered its Third Party Administrator (TPA or Administrators) Certificate of Authority and ceased providing services in Florida.

Administrators are selected every three years through a competitive bid process as specified in the Plan of Operations. Due to the Association's small and declining population of policyholders, the FCHA did not receive sufficient responses to the 2012 Request for Proposal. As a result, the FCHA was allowed to select an alternate administrator outside the required bidding process. The Association reached an agreement with CoreSource. The selection was approved by the Board and the Office. The Association engages the following services from external parties:

- Thomas Howell & Ferguson, P.A., as external auditors performing annual audits of annual financial statements;
- Law, Redd, Crona, & Monroe, P.A., for accounting and reporting services; and,
- Leif Associates, Inc., for actuarial services.

#### **Examination Findings:**

No findings were noted relating to the service providers.

#### **Board and Management**

The Association is directed by a three member Board of Directors (Board) who meet annually to review Association activities. Board Members are selected by the Chief Financial Officer (CFO) of the State of Florida, serve three year terms, and consist of the CFO or designee, one representative of participating insurers, and one representative of policyholders who is not associated with the medical profession, a hospital or an insurer.

The Board is charged with overseeing all responsibilities and functions of the FCHA. The Board appoints an Executive Director to manage the day-to-day operations of the Association. The Executive Director reports directly to the Board. There is an Accounting Manager and a Manager of Member, Policyholders and Administrative Services, who assist the Executive Director in the operational activities of the FCHA. Internally performed operational responsibilities include:

- Overseeing service provider activity;
- Monitoring policyholder eligibility;
- Processing assessments;
- Determining rates; and,
- Performing accounting functions.

**Examination Findings:**

No findings were noted relating to Board and Management Oversight.

**Accounting**

A review of the FCHA accounting processes and procedures was performed for the scope period examined. Testing procedures included verifying:

- Trial balances align with the filed Annual Statement at December 31, 2012; and,
- The Association completed all filings as required by the Office and the Florida Department of Financial Services.

The FCHA had an annual audit performed of its financial statements for the reporting periods ending December 31, 2012, 2011, 2010, and 2009. The CPA issued unqualified opinions for each year audited.

**Examination Findings:**

No findings were noted relating to accounting processes and procedures.

**COMPLAINT HANDLING**

Complaints may originate from various sources including Florida Regulatory Offices, Legislative Offices, Executive Offices, and from providers and consumers. The review found that the FCHA did not have any complaints reported during the examination scope period.

**Examination Findings:**

No findings were noted relating to complaint handling.

**RATING AND UNDERWRITING**

The FCHA is responsible for monitoring the continuing eligibility of existing policyholders. Premium rate setting is established in Section 627.6498, Florida Statutes. The schedule of premiums is established by the FCHA. Standard risk rates are established by the Association, subject to approval by the Office.

Separate premium schedules are established for low-risk, medium-risk, and high-risk individuals. The FCHA is responsible for adjusting premiums annually. Premiums cannot exceed 200 percent of the approved standard risk rate for low-risk individuals, 225 percent for medium-risk individuals, or 250 percent for high-risk individuals. The standard risk premium is determined by using the average rate for all health coverages written in Florida by private insurers writing insurance similar to the FCHA.

In classifying low, medium, or high-risk classifications, the FCHA considers anticipated claims payments based upon the individual's health. Rate adjustments occurring over the exam scope period were:

**Average Rate Change as of the December 31<sup>st</sup> EOY:**

Description	2009	2010	2011	2012
Average Rate Adjustment	+ 10.21%	+ 2.88%	+ 15.00%	+ 6.02%

Rate testing included reviewing:

- CPA audit work papers encompassing the testing of rate adequacy;
- FCHA 2012 rate worksheets; and,
- Confirming rates were prepared in accordance with Section 627.6498, Florida Statutes, and were approved by the Office.

**Examination Findings:**

No findings were noted relating to rating and underwriting processes.

**PREMIUMS**

A review of premiums trends finds policyholder premiums collected declined during the scope period examined while rates continued to rise. Policyholder counts decreased from 322 members at 2009EOY to 203 members at 2012EOY. The FCHA advises the service administrator monthly of any changes in policyholder eligibility. Policyholder eligibility requirements are identified in Section 627.6486, Florida Statutes.

The FCHA annually surveys its policyholders. As a requirement of maintaining coverage, surveys are required to be signed by the policyholder and returned to the Association. All out of state claims filed for payment are scrutinized to verify the policyholder is maintaining required Florida residency.

**Premiums Summary as of the December 31<sup>st</sup> EOY:**

Description	2009	2010	2011	2012
Number of Policyholders	322	262	238	203
Annual Premiums	\$1,609,857	\$1,441,564	\$1,355,391	\$1,252,788

A review of the premium processes was completed for the scope period examined. Testing procedures included reviewing:

- CPA audit work papers encompassing the testing of premium processes; and,
- FCHA monitoring processes for determining continuing policyholder eligibility.

**Examination Findings:**

No findings were noted relating to premiums or the monitoring of policyholder eligibility.

**GENERAL CLAIMS REVIEW**

The FCHA engages CoreSource, Inc., for claims processing services. The current agreement, effective October 1, 2012 through June 30, 2015, encompasses case management services including adjudication, processing, medical, and institutional claims payments, and communication and correspondence with policyholders. Prior to the CoreSource agreement, the Association contracted with Covenant Administrators, Inc., for similar services covering the

period January 1, 2009 through September 30, 2012. Claims processing standards and guidelines are stipulated in the administrative service agreement.

The following represents the claims processed for each period under examination:

**Claims Summary as of the December 31<sup>st</sup> EOY:**

<b>Description</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>
Number of Claims Paid	6,188	5,602	6,192	5,045
Claims Amount Paid	\$1,668,994	\$1,468,339	\$1,916,987	\$1,093,620

A review of the claims processes was completed for the scope period examined. Testing procedures included reviewing:

- CPA audit work papers surrounding testing of the claims process; and,
- A sample of paid claims and denied claims.

During the 2012 and 2011 annual financial audit of the Association, external auditors Thomas Howell & Ferguson, P.A., performed an internal limited assessment of the claims cycle processes as part of the planning of the audit procedures. Based upon the testing performed the auditors concluded, while not expressing an opinion of the internal controls effectiveness, "the controls over the claims cycle appear to be functioning as intended, are consistent with [their] documented understanding of the controls and can be relied upon to reduce substantive testing."

**Sampling Methodology**

Samples consisting of 25 denied and paid claims were randomly selected for review. The former Third Party Administrator (TPA), Covenant, failed to provide a requested claims data file. Consequently, random claims were manually chosen from the Covenant secure website. Because the data file provided by CoreSource did not contain paid and denied indicators, examiners manually chose a random sample of 12 denied and 13 paid claims from the CoreSource files and 13 denied and 12 paid claims from the Covenant files.

**Paid Claims Reviewed**

Paid claims were reviewed to ensure timely and proper payment. One exception of the servicing agreement was found to have occurred in the Covenant sample whereby a claim was paid at 55 days (the servicing agreement requires claims adjudication within 45 days). No concerns were noted in the paid claims records of the current administrator, CoreSource.

**Denied Claims Reviewed**

Denied claims were reviewed to ensure timely and proper denial of claims. Six violations were found to have occurred in the Covenant sample whereby claims were denied as a result of the policyholder's coverages incorrectly appearing as terminated. All denied claims exceptions noted occurred during the transition from the former to the current administrator. No concerns were noted in the denied claims records of the current administrator, CoreSource.

**Examination Findings:**

Seven violations were found during the claims review:

1. In six instances the service administrator improperly denied claims as “no coverage in effect” when the policyholders in fact had coverage. The improperly denied claims are a violation of Section 626.9541(1)(i)3.a, Florida Statutes.

**Association Response:**

The Association disagreed with the findings stating in part, “We acknowledge that the events referenced in the subject advisory occurred. However, they occurred during the transition from Covenant Administrators to CoreSource Administrators as the contracted TPA firm for the FCHA and, consequently, they did not come to our attention in the course of the customary monitoring of claims activity during an active contract period. For reasons unknown to us, Covenant made these statements to FCHA policyholders following the termination of their contract and during a period in which we were no longer actively monitoring their contract activities. We believe some, or all, of these events would have come to our attention during the course of our annual audit activity scheduled to begin on May 1, 2013 and would have been included in our annual audit scheduled to be submitted to OIR on or before June 1, 2013. We have initiated an aggressive effort to identify all claims that may have been improperly denied, follow-up on those claims with both the appropriate providers and policyholders and insure that such claims are properly and fully adjudicated.”

Examiners noted that during the examination, FCHA employees stated that they received a number of calls from policyholders reporting that their claims had been incorrectly denied for no coverage during the TPA transition period.

During the examination process, the FCHA initiated an audit of all denied claims occurring during the transition period and has certified to the Office that all claims inadvertently denied have been paid.

1a.) **Corrective Action:**

FCHA should adopt measures to increase scrutiny and auditing claims during the time of transition to a new administrator to ensure claims are properly adjudicated. Additionally, the FCHA should adopt procedures of performing regular internal audits of service administrator claims processing to ensure accuracy.

1b.) **Additional Response to Section 1:**

“While the report notes our overall adherence to our statutory responsibilities...it should be noted that all of these the instances occurred in a time period that was outside the originally stipulated time frame of the Market Report...Further, all these instances occurred during a very brief time period when we were transitioning from Covenant Administrators to CoreSource Administrators and involved a very small number of claims relative to the total number of claims processed over time...”

1c.) **Office Response to Association Additional Response to Section 1:**

The Association response is noted.

2. The Association failed to adequately monitor the actions of the contracted service administrator. The prior and current service administrator contracts state that semi-annual audits are to be performed, particularly when, as the contract states in part, “certain types of claims that are of concern.”

**Association Response:**

The Association disagreed with the findings stating in part "Our interpretation of this contract provision is that it empowered us to conduct claims audits other than our usual and customary annual audits of claims activity in those circumstances in which we had exceptional concerns about the nature or circumstances of one or more claims payments or activities. In our opinion, the semi-annual audit was to be used in the event of heightened concern about the accuracy or legitimacy of TPA activity, rather than as a mandated audit activity."

2a.) **Corrective Action:**

FCHA should adopt measures to increase scrutiny and auditing of claims during the time of transition to a new service administrator to ensure all claims are properly adjudicated. Additionally, the FCHA should perform regular internal audits of the service administrator claims processing to ensure accuracy.

2b.) **Additional Response to Section 2:**

“The Examiner found no complaints outside this very limited transitional period. Closer examination also indicates that these few instances involved newly hired, inexperienced Covenant personnel not familiar with our prior relationship with Covenant. All of the instances and several others were discovered and corrected prior to the Report, to the satisfaction of our subscribers and their health care providers.”

2c.) **Office Response to Association Additional Response to Section 2:**

The Association response is noted.

**INVESTMENTS**

Excess cash is conservatively invested in demand deposits with financial institutions. The Association does not have a formal investment program. Due to the nature of the operations, the Board has determined it is not feasible to establish an investment program and assume additional risk.

**Examination Findings:**

Assessment of the FCHA investment program was not performed.

**LEGISLATIVE CHANGES**

A review was conducted of the processes and controls the FCHA has in place to monitor and communicate legislative changes impacting Association operations.

Subsequent to the conclusion of the on-site portion of the examination, the 2013 Florida Legislature enacted CS/SB 1842 dissolving the FCHA effective September 1, 2015. Coverage for FCHA policyholders will end on June 30, 2014. In regards to federal legislation, the Association is impacted by Patient Protection and Affordable Care Act of 2010 (PPACA).

Beginning on October 1, 2013, the Guaranteed Issue provision of the PPACA ensures that FCHA policyholders will be able to purchase health insurance coverage through commercial insurers. The FCHA governing statutes stipulate that individuals who are eligible for coverage in the open market are not eligible for coverage through the Association. Accordingly, policyholders must pursue purchasing health insurance coverage through the available commercial market. Further, as a result of the PPACA, the services of the Association are no longer necessary after January 1, 2014. Based upon discussions with the Executive Director, the FCHA will commence a wind down of its operations beginning January 1, 2014.

**Examination Findings:**

The FCHA demonstrated adequate processes and controls to monitor and communicate legislative changes to the Board and Management.

**PENDING LITIGATION**

The Association is not a party in any court proceedings as either a plaintiff or as a defendant.

**EXAMINATION FINAL REPORT SUBMISSION**

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