



THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

HEALTH OPTIONS, INC.

AS OF

March 5, 2010

NAIC COMPANY CODE: 95089

NAIC GROUP CODE: 00536

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EXECUTIVE SUMMARY

A market conduct examination of Health Options, 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.

<u>TABLE OF TOTAL VIOLATIONS</u>			
Statute/Rule	Description	Files Reviewed	Number of Violations
624.418 F.S.	Company failed to ensure contracted entities held appropriate Certificates of Authority (Operations/Management)	11	8
690-191.074, F.A.C.	Company failed to maintain records (Records Retention/Underwriting)	2,586	23
626.371(1), F.S.	Company failed to notify DFS within 45 days following date of appointment (Producer Licensing)	58	14
626.471(1), F.S.	Company failed to provide at least 60 days advance written notice of its intent to terminate appointment to the appointee (Producer Licensing)	58	52
626.471(2 & 3) & 626.511, F.S.	Company failed to notify DFS within 30 days of appointment termination and provide the reason for the termination. (Producer Licensing)	58	53
641.31(3)(b), F.S.	Company failed to notify insured about changes in premium rates (Policyholder Services)	232	4
641.3108, F.S.	Company failed to provide proof of notification of cancellation/non-renewal (Policyholder Services)	230	2
627.6487(1)(a), F.S.	Company failed to provide documentation that they notified applicants of medically underwritten products, who may have qualified as eligible individuals, of the availability of guaranteed issue coverage (Underwriting and Rating)	202	18
627.6699(6), F.S.	Company incorrectly calculated the premium for a small group policy (Underwriting and Rating)	231	1
641.3155(3)(a) & 641.3155(4)(a), F.S.	Company failed to acknowledge claim timely (Claims Handling – Paid and Denied)	368	4
641.3155(3)(b) & 641.3155(4)(b), F.S.	Company failed to respond to claims (pay or deny) on a timely basis (20 days for electronic claims).	368	3
641.3903(5)(c)4, F.S.	Company denied claim without conducting a reasonable investigation (Claims Review)	368	3

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a comprehensive market conduct examination of Health Options, 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 June 22, 2009 and ended January 28, 2010. The examination continued offsite and ended March 5, 2010.

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 policies; policy forms and filings; claim handling; grievance procedures; network adequacy; utilization review practices; provider credentialing; quality assurance and improvement.

The examination included verification of compliance with the following Florida Statutes and Rules:

- **Operations and Management** - (Operations, 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 624.3905, 626.9651, 626.9891, 624.33, 626.112, 626.88, 626.8805, 626.8817, 626.882, 626.8814, 626.883, 626.884, 626.886, 641.21, 641.27, 641.54, Florida Statutes and Chapter 690-128 and Rule 690 -191.074, Florida Administrative Code.
- **Complaints** – Section 641.3903, Florida Statutes.
- **Marketing and Sales** - Section 641.3903, Florida Statutes, and Rules 690-191.059 through 690-191.063, Florida Administrative Code.
- **Producer Licensing** – (Appointments and Terminations) Sections 641.386, 626.112, 626.461, 626.471, and 626.511, Florida Statutes.
- **Policyholder Services** – (Premium and Billing, and Cancellations) Sections 641.31074, 641.309, and 641.3108, Florida Statutes, and Rule 690-191.042, Florida Administrative Code.
- **Underwriting and Rating** – (Rating Practices, Mandated Disclosures, Forms Filings, Cancellations, Declinations, Rescissions, Rx Changes in Tier) Sections 641.31, 641.31074, 641.3901, 641.3903, 641.3007, 641.3102, 641.31073, 641.185, 641.21, 641.31, 627.6487, 627.6699, 627.674, 641.3108, Florida Statutes, and Rule 690-149.207, 690-191.078, Florida Administrative Code.
- **Claims Handling** – (Claim Acknowledgments, Timely Investigations, Paid, Denied and Overdue Claims) Sections 641.3903, 641.315, 641.3155, 641.3156, and 627.419, Florida Statutes.
- **Grievances** – Sections 641.31, 641.3155, and 641.3903, Florida Statutes and Rule 690-191.078, Florida Administrative Code.
- **Network Adequacy** – Section 641 Part III, Florida Statutes
- **Provider Credentialing** - Section 641 Part III, Florida Statutes
- **Quality Assessment and Improvement Program** - Section 641 Part III, Florida Statutes
- **Utilization Review** - Section 641 Part III, Florida Statutes
- **Reporting Requirements** – (Reports of information on accident and health insurance) Section 627.9175, Florida Statutes

In reviewing materials for this report, the examiner relied on records 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 (NAIC).

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 of less than 50,000 the Acceptance Samples Table was used and for populations of over 50,000 ACL was used. In utilizing ACL to determine the sample sizes, the parameters consisted of a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% in accordance with the handbook.

COMPANY OPERATIONS

Health Options, Inc. is a domestic Health Maintenance Organization (HMO) authorized to conduct business in the State of Florida on September 25, 1984. The Company provides health insurance in the State of Florida.

Total Direct Premiums Written in Florida for Health insurance was as follows:

Year	Total Written Premium In Florida (Per Schedule T of the Annual Statement)
2006	1,241,164,236
2007	992,133,443
2008	877,338,838

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 is a wholly-owned subsidiary of Blue Cross Blue Shield of Florida, Inc. (BCBSFL).

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. OPERATIONS

BCBSFL employees perform the Company's activities under a written agreement to provide certain services, including but not limited to administrative, managerial, professional and technical.

II. CONTROLS OF COMPUTER INFORMATION

BCBSFL is responsible for the Company's Information Security Policy required by Rule 69O-128.032, Florida Administrative Code. The Information Security Policy includes both internal and external procedures to ensure security of electronic data transference. 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.

III. ANTI FRAUD PLAN

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

The Company's anti-fraud plan is handled by BCBSFL's Special Investigation Unit (SIU). Its written policies and procedures comply with statutory requirements. The SIU has set up a fraud hot-line number, (800) 678-8355, and an internet webpage for reporting fraudulent insurance activity.

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 plans are current, specific, and include detailed information for implementation of emergency procedures. The plans reference moving important records off-site, computer back-ups and use of generators to facilitate continuity of business.

V. OUTSOURCING OF MANAGEMENT SERVICES

The Company has contracted external management services with several vendors. The Company provided a list of 95 marketing agreements in effect during the scope of the examination. A sample of 20 contracts was selected for review. In addition, the Company provided a list with 9 service organizations and 15 delivery systems agreements. All 24 agreements were reviewed to determine if the Company has adequate procedures to monitor its contracted external management services, if these contracts contain a provision to allow the Company to conduct audits and, when required, contracted entities have a certificate of authority issued by the Office.

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 and contain provisions for allowing the Company to conduct audits.

The Company has established procedures regarding processes that must be followed prior to entering into an external service agreement. The Company's quality management program includes the oversight of all relevant delegated entities' quality compliance programs.

Annual oversight reviews are conducted. In addition, monthly monitoring is also conducted, depending on the type of service. Targeted audits of claims, enrollment and contact transactions processed by vendors are also conducted.

There were 11 agreements identified in which it appears the contracted entity required a Certificate of Authority.

1) **In 8 instances the Company failed to ensure that contracted entities held appropriate Certificates of Authority in violation of Section 624.418, Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company will ensure that third party administrators hold a Certificate of Authority as required.

1b.) **COMPANY RESPONSE:** Although the Company does not believe there was a violation of Section 624.418, Florida Statutes, it stated that it is in the process of performing a detailed review of these 8 contracted entities. Following this review the Company will ensure that each contracted entity has a Certificate of Authority if required for compliance with Florida Statutes.

The Company also stated that it will revise its procedures to ensure that contracted entities hold a Certificate of Authority when required.

VI. RECORD RETENTION PROCEDURES

The Company's Records Retention Policy categorizes records, including e-mails and electronic documents, by retention length. The records are saved nightly. Each functional area has a record coordinator that ensures the Standard Operation Procedures (SOP) are followed and trains employees. Employees are given precise information on how to decide what constitutes a record and how to establish the record's retention length. The Corporate Compliance Committee reviews the records retention schedule and policy for appropriateness at least every two years. Several databases were used during the scope of the exam. There were 2,586 records requested from the Company during the scope of the examination.

- 1) **In 23 instances the Company failed to maintain and provide requested records in violation of Rule 690-191.074, Florida Administrative Code.**
- 1a.) **CORRECTIVE ACTION:** The Company should review its procedures for maintaining records and make corrections to ensure records can be retrieved upon request.
- 1b.) **COMPANY RESPONSE:** The Company agreed with these findings.

VII. POLICYHOLDER PRIVACY PROCEDURES

The Company's website provides links to the information required by Section 641.54 Florida Statutes.

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.

The Company's Corporate Privacy Procedures, which is administered by its parent, BCBSFL, includes compliance policies and standards of conduct that detail the safeguarding of personal information. The Privacy Notices provided to members also address disclosure of personal information.

A walk through of the mail center confirmed that the member is sent an information package upon enrollment which contains a 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 Notice of Privacy Practices is sent to all new members and is also available for viewing on the Company's website. Members are notified annually as to how they may access or obtain a copy of the Notice of Privacy Practices.

The Company's Notice of Privacy Practices advises customers of the Company's permitted uses and disclosures of their protected health information. The Notice also advises that, where applicable, protected health information will only be disclosed with proper authorization and to third-party business associates who have entered into confidentiality contracts. The Company does not share member information with unaffiliated third parties.

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 237 Department of Financial Services (DFS) complaints and a total of 12,040 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 addressed the issue raised.

DFS COMPLAINTS:

A sample of 23 DFS complaints was selected for review. No exceptions were found.

DIRECT COMPLAINTS AND/OR GRIEVANCES:

A sample of 93 direct complaints and/or grievances was selected for review. No exceptions were found.

MARKETING AND SALES

I. ADVERTISING MATERIALS:

The Company provided a list of all advertising materials that were used during the scope of the examination.

A sample of 86 of 751 advertising materials and the total population of 131 phone scripts was reviewed for compliance. No exceptions were found.

PRODUCER LICENSING

I. APPOINTMENTS AND TERMINATIONS

Agent/broker appointment procedures do not address the requirements of Florida Statutes. The Company agent termination procedures do not address the agent/broker notification requirements of Section 626.471(1), Florida Statutes, which requires the Company 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 the Department of Financial Services (DFS) be notified within 30 days of termination.

CORRECTIVE ACTION: The Company should modify its agent/broker appointment and termination procedures to facilitate compliance with Florida Statutes.

APPOINTMENTS SAMPLE REVIEW:

A random sample of 58 active producers out of a total population of 7,416 was reviewed.

- 1) **In 14 instances the Company failed to provide written notification to DFS within 45 days of appointment in violation of Section 626.371(1), Florida Statutes.**
- 1a.) **CORRECTIVE ACTION:** The Company should record the actual date that the DFS is properly notified, so that verification is possible.
- 1b.) **COMPANY RESPONSE:** The Company agreed with this finding and stated it has revised its procedures to ensure proper notice is given.

TERMINATIONS SAMPLE REVIEW:

A random sample of 58 terminated producers out of a total population of 2,130 was reviewed.

- 1) **In 52 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 ensure proper notice is given to terminated producers.
- 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 53 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 ensure DFS is notified of agent terminations within 30 days and provide 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 they were sent timely. A sample of 232 policies was reviewed.

- 1) **In 4 instances the Company failed to properly notify insureds about changes in premium rates in violation of Section 641.31(3)(b), Florida Statutes.**
- 1a.) **CORRECTIVE ACTION:** The Company should review its procedures for timely notification of rate increases and maintain those records to ensure compliance with Florida Statutes.

1b.) **COMPANY RESPONSE:** The Company agreed with this finding.

II. **CANCELLATIONS AND RESCISSIONS**

CANCELLATIONS:

Cancellations were reviewed to verify 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 5,830 group policies and 7,096 individual policies cancelled during the scope of the examination. A sample of 115 group and 115 individual cancellations was reviewed.

1) **In 2 instances group cancellation notification was not provided in violation of Section 641.3108, Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should review its procedures for timely notification of cancellation and maintain records to document compliance with Florida Statutes.

1b.) **COMPANY RESPONSE:** The Company agreed with this finding but notes these were isolated exceptions.

RESCISSIONS:

The Company stated that it does not do post-claim underwriting and rescinding of policies. Review of paid and denied claims verified there were no rescissions.

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. A total of 26,186 individual and 28,648 group policies were issued during the scope of the examination. A total of 116 individual and 116 group in-force policies, 115 individual and 115 group cancelled policies, and 86 individual declined policies were selected for review.

A total of 116 in-force and 86 declined individual policies was reviewed relative to the Company's compliance with guaranteed issue and pre-existing exclusion requirements.

1) **In 18 of 86 declined individual applications reviewed the Company failed to provide documentation that it notified applicants of medically underwritten products, who may have qualified as eligible individuals as defined by Section 627.6487(3)(a) and (b), Florida Statutes, of the availability of guaranteed issue coverage in violation of Section 627.6487(1)(a), Florida Statutes.**

- 1a.) **CORRECTIVE ACTION:** The Company should inform applicants at the agent/agency level about guaranteed issue policies and ensure they understand the differences between a standard policy and a guaranteed issue policy.
- 1b.) **COMPANY RESPONSE:** The Company agreed with this finding, and stated that it will implement procedures to ensure the applicant is informed and that documentation is retained.
- 2) **In 1 instance the Company incorrectly calculated the premium for one small group policy in violation of Section 627.6699(6), Florida Statutes.**
- 2a.) **CORRECTIVE ACTION:** The Company should review premium rate calculations to ensure that correct rates and rate tables are being utilized. Additionally, the Company should refund the premium overcharged on this policy.
- 2b.) **COMPANY RESPONSE:** The Company agreed with this finding.

II. FORM FILINGS:

The forms filing review included verification that all forms used were properly filed and approved by OIR and verification that the fraud warning was displayed when applicable. No exceptions were found.

III. PRESCRIPTION DRUGS:

The prescription drug review was limited to a review of the Company's practice of making changes to its formularies. No exceptions were found.

CLAIM HANDLING

The claim handling review included: verification of timely claim acknowledgment, review of claim settlements for timely investigations, prompt payment or denial of claim and payment of interest on overdue claims. A total of 11,579,491 claims were paid or denied during the scope of the examination.

I. CLAIM ACKNOWLEDGMENT:

Electronic claims are acknowledged within 24 hours automatically by the Company's system. Paper claims are acknowledged automatically once they are entered into the Company's system. A sample of 368 paid claims and 368 denied claims was reviewed.

- 1) **In 4 instances, the Company failed to acknowledge the claim timely in violation of Sections 641.3155 (3)(a) and 641.3155 (4)(a), Florida Statutes.**
- 1a.) **CORRECTIVE ACTION:** The Company should ensure acknowledgments are provided timely.
- 1b.) **COMPANY RESPONSE:** The Company agreed with the finding.

II. CLAIM SETTLEMENTS:

PAID CLAIMS:

A total of 368 Paid Claims was reviewed. Three violations were found.

- 1) **In 3 instances the Company failed to pay a claim timely in violation of Section 641.3155(3)(b) & 641.3155(4)(b), Florida Statutes.**
- 1a.) **CORRECTIVE ACTION:** The Company should review these claims to confirm that appropriate interest was paid where necessary.
- 1b.) **COMPANY RESPONSE:** The Company agreed with the finding.

DENIED CLAIMS:

A total of 368 Denied Claims was reviewed. Three violations were found.

- 1) **In 3 instances the Company denied a claim without conducting a reasonable investigation in violation of Section 641.3903(5)(c)4, Florida Statutes.**
- 1a.) **CORRECTIVE ACTION:** The Company should conduct a reasonable investigation of these claims and adjudicate as necessary.
- 1b.) **COMPANY RESPONSE:** The Company agreed with the finding but asserts that these were isolated incidents and don't constitute a general business practice.

OVERDUE CLAIMS: A total of 293 Overdue Claims reviewed. Two violations were found.

- 1) **In 2 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 or submit documentation that the claims were paid timely via offsetting. In addition, the Company should ensure interest is paid when applicable.
- 1b.) **COMPANY RESPONSE:** The Company initially agreed with the findings. However, following additional research the Company determined the claims were not actually overdue and had been paid in a timely manner via offsetting in which the provider owed amounts to the Company as a result of overpayments.
- 1c.) **SUBSEQUENT EVENT:** The Company provided documentation after the exam was finalized to support that the "paid" dates in their system, which were reviewed during the audit, and upon which the findings were made, are the dates when the respective provider's previous overpayment(s) were satisfied.

GRIEVANCE PROCEDURES

I. GRIEVANCES

Grievances were reviewed in the Complaints 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, the member 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, the member 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 be reviewed.

NETWORK ADEQUACY

The Agency for Healthcare Administration (AHCA) has the authority to review and regulate network adequacy. As part of this review, AHCA looks at network expansions, 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 indicated they had no concerns at this time. The examiners also reviewed several reports, which showed no areas of concern.

The office also reviewed the Company's National Committee for Quality Assurance Audit (NCQA). Based on information provided to NCQA during the audit, it was deemed that Health Options Inc. satisfied the requirements for accreditation.

UTILIZATION REVIEW PRACTICES

The Agency for Healthcare Administration (AHCA) has the authority over the Company's utilization review program. AHCA's 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 indicated they had no concerns at this time. The examiners also reviewed several reports, which showed no areas of concern. In addition, written procedures were reviewed and appear to be adequate.

The Office also reviewed the Company's National Committee for Quality Assurance Audit (NCQA). Based on information provided to NCQA during the audit, it was deemed that Health Options Inc. satisfied the requirements for accreditation.

PROVIDER CREDENTIALING

The Agency for Healthcare Administration (AHCA) has the authority to review and regulate provider credentialing. The Company provides the credentialing files to AHCA for review. This review includes credentialing, re-credentialing, and 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 indicated they had no concerns at this time. The examiners also reviewed several reports, which showed no areas of concern.

The office also reviewed the Company's National Committee for Quality Assurance Audit (NCQA). Based on information provided to NCQA during the audit, it was deemed that Health Options Inc. satisfied the requirements for accreditation.

QUALITY ASSURANCE AND IMPROVEMENT

The Agency for Healthcare Administration (AHCA) has the authority to review and regulate Quality Improvement and Assessment. AHCA's 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 indicated they had no concerns at this time. The examiners also reviewed several reports, which showed no areas of concern.

The office also reviewed the Company's Policy and Procedures. The following is a summary of the findings:

- Quality Improvement and Care Management/Disease Management Programs have been developed and are maintained by the Company.
- Quality Improvement is a continuous process and a regular part of the Company's activities.
- The stated goals of the plan are to objectively and systematically monitor, evaluate, and improve the quality and safety of clinical and behavioral health care and the quality of service provided to their members through their providers. A Quality Executive Council made up of key corporate personnel is accountable to the Company's Board of Directors for compliance with applicable Federal and State regulatory bodies. They report to the board as appropriate but not less than quarterly.
- The Council reviews and approves the Annual Quality Improvement Programs, Quality Improvement work plans and Evaluations, and the quarterly Incident Report for all lines of business.

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 submitted 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
Guaranteed Issue	\$2,506,776	\$2,169,997	\$50,136	0	275	81	356	16
Self-Employed or Sole Proprietor	\$4,804,279	\$5,534,813	\$38,434	187	187	94	281	16
2 - 5 Member Groups	\$31,154,128	\$24,750,747	\$249,233	1,188	2,692	1,780	4,472	16
6 - 50 Member Groups	\$75,608,652	\$56,990,904	\$604,869	1,654	6,637	3,952	10,589	16
51+ Member Groups	\$441,315,391	\$357,664,033	\$18,535,246	249	59,315	42,730	102,045	16
Conversion	\$43,521,146	\$43,953,188	\$2,654,790	0	4,771	1,403	6,174	16
Totals	\$598,910,372	\$491,063,682	\$22,132,708	3,278	73,877	50,040	123,917	96

The Examiner reviewed work papers and source documentation to verify the accuracy of the 8 reporting areas required on the GAP submission. No exceptions were noted.

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.