THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

AvMed, Incorporated

AS OF

October 25, 2012

NAIC COMPANY CODE: 95263
NAIC GROUP CODE: 0

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EXECUTIVE SUMMARY

A sample of 368 claims, and policies and procedures as they apply to the adjudication of out of network medical provider claims, were reviewed. The following table represents 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
641.3155(3)(a) & (4)(a)	The Company did not provide timely acknowledgement of the receipt of the out of network claim.	368	36
641.3155(3)(b) & (4)(b)	The Company did not pay, deny, or contest out of network claims within the required timeframe.	368	34
641.3903(5)(b)	The Company paid an out of network claim on less favorable terms than those provided in the subscriber's Schedule of Benefits.	368	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of AvMed Inc. (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC**.** The scope period of this examination was January 1, 2009, through December 31, 2011. The onsite examination began October 8, 2012, and end October 25, 2012.

The purpose of the examination was to review the Company's policies and procedures as they apply to the adjudication of out of network medical provider claims and to determine the Company's compliance with Florida Statutes and the Florida Administrative Code.

The examination included the following procedures:

- Review of the Company's claims handling procedures to ensure adoption and implementation of standards for proper investigation and settlement of claims;
- Review the Company's internal policies and procedures to determine the methodology for payment of out of network claims;
- Determine how the Company defines usual and customary for out of network claims; and
- Review sample of paid and denied out of network claims to determine timely acknowledgements, reasonable and proper investigation, resolution, timely payment and review for consistency with internal policies and procedures and Florida Statutes.

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.

The NAIC Market Conduct Handbook allows the utilization of Audit Command Language (ACL) software for determining sample sizes and sampling. Sample sizes were calculated by entering a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2%. ACL returned a sample size of 184 for each review area.

COMPANY OPERATIONS

AvMed, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on May 17, 1973. The Company provides Group Health coverage in the State of Florida.

Total Direct Health Premiums Written in Florida were as follows:

Year	Total Written Premium In Florida (Per Schedule T of Annual Statement)
2009	1,068,016,915
2010	1,247,526,101
2011	1,289,143,445

OUT OF NETWORK CLAIMS HANDLING

I. COMPANY POLICIES AND PROCEDURES REVIEW

The Company defines the usual and customary reimbursement rates for out of network claims as the amounts that providers are accepting as payment for similar services in the community where the services are provided. The amounts that providers in the community are accepting as payment for similar services include the amounts that the providers are receiving from different sources, including but not limited to, contracts with insurers, contracts with health maintenance organizations, contracts with other third party payers and private pay.

During the scope period, the Company used three methods to determine the rates to be paid to out-of-network providers.

Method One (January 1, 2009, to November 15, 2009):

Claims were paid at a rate equal to the 80th percentile of the Ingenix database of Usual, Customary, and Reasonable (UCR) charges. Ingenix is a third party database used for medical statistics and coding. If no Ingenix rate was established, the claim defaulted to a rate equal to 100% of the billed charges. Regardless of the rate used, the claims were sent to Private Health Care Services Network (PHCS) for re-pricing. PHCS is a re-pricing vendor under contract with the Company that utilized rates from contractual arrangements with their network of providers.

Method Two (November 16, 2009 to December 31, 2009):

The claim payment rates initially defaulted to the Maximum Allowable Payment (MAP). MAP is a reimbursement schedule for services that was developed by the Company and an outside consultant. MAP relied upon resources such as The MedStat MarketScan Claims Database (MedStat), which is an annual medical database. If there was no MAP rate, the claim defaulted to a rate of 100% of the billed charges. Claims from providers outside the Company service area were sent to PHCS for re-pricing.

Method Three (January 1, 2010, to Present):

The claim payment rates initially default to the Maximum Allowable Payment (MAP). If there is no MAP rate, the claim defaults to a rate of 100% of the billed charges. Claims that defaulted to

a payment rate of 100% of submitted billed charges are sent to MultiPlan for re-pricing. MultiPlan is a re-pricing vendor under contract with the Company that utilizes pricing from contractual arrangements with their network of providers and handles the negotiation of rates with providers.

II. CLAIMS REVIEW

The Company was requested to provide a list of all out of network claims paid or denied during the scope period. The Company identified a universe of 1,345,907 paid or denied out of network claims. A random sample of 184 paid out of network claim files and a random sample of 184 denied out of network claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) **In 36 instances, the Company did not provide timely acknowledgement of the receipt of out of network claims, in violation of Sections 641.3155 (3)(a), and (4)(a), Florida Statutes**.

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure timely acknowledgement of the receipt of out of network claims.

1b.) COMPANY RESPONSE: The Company agreed with this violation and indicated they will develop a manual process to provide timely acknowledgement to non-participating providers. The Company's out of network claim acknowledgement timeframe was negatively impacted on non-electronically filed claims because unknown non-participating provider information had to be updated in the electronic claim system prior to processing.

2) **In 34 instances, the Company did not pay, deny, or contest out of network claims within the required timeframe, in violation of Sections 641.3155 (3)(b), and (4)(b) Florida Statutes**.

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that out of network claims are paid, denied, or contested within the required timeframe.

2b.) COMPANY RESPONSE: The Company agreed with this violation.

3) **In one (1) instance, the Company paid an out of network claim on less favorable terms than those provided in the subscriber's Schedule of Benefits, in violation of Section 641.3903(5)(b), Florida Statutes**.

3a.) CORRECTIVE ACTION: The Company should implement procedures that ensure claims are properly investigated, verify that out of network claims are paid in accordance with a subscriber's Schedule of Benefits, and issue the appropriate refund, with interest, to the subscriber.

3b.) COMPANY RESPONSE: The Company agreed with this violation.

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 Company.