

**FLORIDA DEPARTMENT
OF
INSURANCE**

TARGET MARKET CONDUCT REPORT

OF

FOUNDATION HEALTH, A FLORIDA HEALTH PLAN, INC.

AS OF

DECEMBER 7, 1999

**DIVISION OF INSURER SERVICES
BUREAU OF MARKET CONDUCT**

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I. **OVERVIEW AND SUMMARY OF FINDINGS**

General

Foundation Health, a Florida Health Plan, Inc., (Company), is a health maintenance organization domiciled in the State of Florida, and licensed to conduct business in this State during the period (scope) of this examination,

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The Florida Department of Insurance (Department) performed a target Claims and Procedures Examination of the Company pursuant to Section 641.27, Florida Statutes, at the Company's office in Sunrise, Florida, from December 7, 1999, to December 21, 1999.

The purpose of the examination was to determine if the Company's practices and procedures relating to claims processing, and related procedure manual, comport with Florida Statutes and the Florida Administrative Code.

The scope period for the examination covered claims with dates of service from October 1, 1998, through December 7, 1999.

Findings

The examination identified multiple violations of statutes relating to claims processing. The violations included: failure to timely process claims; failure to accurately and timely pay interest; failure to adopt and implement standards for the proper investigation of claims; failure to act promptly relative to communications on claims; and failure to conduct reasonable investigations before denying claims. In numerous instances, the Company failed to comply with Sections 641.3155, 641.3901, and 641.3903(5)(c)(1)(3) and (4), Florida Statutes.

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Moreover, the examination found violations relating to the improper denial of private passenger automobile accident health insurance (PIP) claims. These actions violate Sections 641.3901, and 641.3903(5)(c)(1) and (4), Florida Statutes.

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Recommendations

Based on the findings detailed in this examination, the Department will issue a Consent Order in which certain corrective measures will be established. The Consent Order will require that the Company establish other corrective measures. A penalty in the amount of fifty five thousand five hundred dollars (\$55,500), plus appropriate Administrative Legal costs, will also be levied in response to the violations of law determined during this examination. In response to these findings, and in addition to the aforementioned administrative fines, the Company is directed to take the following corrective actions:

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CLAIMS

- Process paid, denied and contested claims pursuant to Sections 641.3155(1), Florida Statutes, Ed. 00.
- Calculate and process interest payments pursuant to Section 641.3155(2), Florida Statutes, Ed. 00.
- Process paid and denied claims pursuant to Section 641.3155(3), Florida Statutes, Ed. 00.
- Establish procedures that will facilitate compliance with Section 641.3903(5)(c), Florida Statutes.

PROCEDURE MANUALS

Amend the relevant manual(s):

- To ensure that automobile accident health insurance claims (PIP) are processed pursuant to Sections 641.3901, and 641.3903(5)(c)(1) and (4), Florida Statutes.

II. CLAIMS REVIEW

Overview

The Company processes claims directly and also utilized a Management Service Organization (MSO).

The Company processes approximately seventy percent of its claims.

Magellan Behavioral Health, an MSO, was processing approximately thirty percent of the Company's claims. Its contract with the Company was terminated effective November 30, 1999.

Operating Systems

A. **Foundation Health, A Florida Health Plan, Inc.**

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Seventy-one claims processed by the Company's system were examined. See Exhibit I for details. The findings are summarized below:

1. Thirteen (13) claims were not paid, denied or contested within thirty-five (35) days of receipt. No documentation was provided to justify these delays.
2. Foundation Health failed to pay interest on one (1) of these claims.

A review of the Company's pending claim age report indicated that there were four hundred twenty-two claims (422) pending in excess of 120 days. See Exhibit II for details.

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A review of thirty (30) of these claims confirmed that all thirty (30) claims were pending in excess of 120 days. See Exhibit III for details.

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B. **Magellan Behavioral Health**

Thirty (30) claims processed by Magellan Behavioral Health were examined. See Exhibit IV for details. The findings are summarized below:

1. Nineteen (19) claims were not paid, denied or contested within thirty-five (35) days of receipt. No documentation was provided to justify these delays.
2. Magellan Behavioral Health failed to pay interest on nine (9) of these claims.

III. PROCEDURE MANUALS REVIEW

Policy and procedure manuals relating to the processing of claims were examined. The findings are:

1. Coordination of Benefits (COB)

It is the practice of Foundation to ultimately deny Personal Injury Protection (PIP) claims that are submitted without the attendant PIP worksheet typically prepared by the PIP carrier. If a PIP claim is submitted without the worksheet, Foundation writes the member and asks for documentation confirming the existence of PIP coverage. If such documentation is not forthcoming, Foundation contacts the member or the carrier, if known, by telephone and orally makes the request for documentation. If no documentation is remitted, Foundation denies the claim. The denial of these claims violates Sections 641.3901 and 641.3903(5)(c)(1) and (4), Florida Statutes. See Exhibit V for details.

2. Interest Calculation

The Company's current procedure is to calculate interest up to the date the claims examiner approves payment, not the date the payment is received or otherwise delivered to the claimant. This procedure violates Section 641.3155(2), Florida Statutes, Ed. 99. See Exhibit VI for details.

IV. FINDINGS/CORRECTIVE ACTIONS

CLAIMS

Foundation Health, A Florida Health Plan, Inc. & Magellan Behavioral Health

Each claim system had claims that were not being processed as required by Section 641.3155 (1), (2) and (3), Florida Statutes, Ed. 99.

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CORRECTIVE ACTION

The Company is directed to prepare an action plan within thirty (30) days from the date of the Consent Order that outlines the steps taken to bring any system currently utilized into compliance with the requirements of Sections 641.3155 (1), (2), and (3), Florida Statutes, Ed. 00. This plan shall be submitted to the Department for review and approval prior to implementation.

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PROCEDURE MANUALS

The current Company procedure is to calculate interest up to the date the claims examiner approves payment, not the date the payment is received or otherwise delivered to the claimant pursuant to Section 641.3155 (2), Florida Statutes, Ed. 99.

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A review of the claims manual found that it is the policy of the Company to ultimately deny Personal Injury Protection (PIP) claims received without the automobile carrier's PIP worksheets. This practice violates Sections 641.3901, and 641.3903(5)(c)(1) and (4), Florida Statutes. See Exhibit V for details.

CORRECTIVE ACTION

The Company is directed to revise its procedure manuals within thirty (30) days of the date of the Consent Order to insure future compliance with the requirements of Sections 641.3901, 641.3903(5)(c)(1) and (4), and 641.3155 (2) Florida Statutes, Ed. 00. Revisions to the procedure manuals shall be submitted to the Department for review and approval prior to implementation.

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1999 TARGET CLAIMS AND PROCEDURES EXAMINATION
OF
FOUNDATION HEALTH, A FLORIDA HEALTH PLAN, INC.

EXHIBITS

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