THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

MARKET CONDUCT FINAL EXAMINATION REPORT

OF

BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.

AS OF

March 12, 2010

NAIC COMPANY CODE: 98167
NAIC GROUP CODE: 00536

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EXECUTIVE SUMMARY

Target and comprehensive market conduct examinations of Blue Cross Blue Shield of Florida, Inc. were performed to determine compliance with Florida Statutes and the Florida Administrative Code.

The following represent general findings, however, specific details are found in each section of the report. These findings have been separated by examination type (target or comprehensive).

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
69O-128.032-034, F.A.C.	Company failed to document adjustments to its procedures. (Internal Report Review) - Comprehensive Exam	N/A	3
627.6131(7), F.S.	Company failed to pay interest on overdue claims (Internal Report Review) – Comprehensive Exam	25	2
627.6131(5)(e), F.S.	Company failed to pay or deny claim within 140 days (Internal Report Review) – Comprehensive Exam	25	1
624.318, F.S.	Company failed to maintain records (Records Retention/Underwriting) – Comprehensive Exam	4,407	15
20.121(2)(h)2, F.S.	Failure to respond timely to DFS complaints (Complaints Review) – Target Exam	50	3
626.9541(1)(i),3.c, F.S.	Failure to comply with unfair trade practice requirements. The Company failed to acknowledge and act promptly upon communications with respect to claims. (Complaints Review) – Target Exam	134	22
627.6131(8), F.S.	Failure to finalize the appeals process within 60 days. (Complaints Review) – Target Exam	134	8
626.9541(1)(j), F.S.	Failure to maintain complete record of complaints. The Company was unable to locate 2 complaint files. (Complaints Review) – Target Exam	50	2
626.371(1), F.S.	Company failed to notify DFS within 45 days following date of appointment (Producer Licensing) – Comprehensive Exam	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) – Comprehensive Exam	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) – Comprehensive Exam	58	53
627.6043 & 627.6645, F.S.	Company failed to provide proof of notification of cancellation/non-renewal or change in rates (Policyholder Services Review) – Comprehensive Exam	300	5
627.4091(1), F.S.	Company failed to properly notify the applicant of the reason for declination. (Policyholder Services Review) – Comprehensive Exam	201	3
627.6699(5)(c)&(6), F.S., & 627.410(6), F.S.	Failure to follow its filed and approved health benefit plan rate (Underwriting and Rating Review)– Target Exam	116	1
627.6645(1), F.S.	Failure to provide timely notice of premium increase (Underwriting and Rating) – Target Exam	116	2
627.6487(1)(a), F.S.	Company failed to provide documentation that it notified applicants of medically underwritten products, who may have qualified as eligible individuals, of the availability of guaranteed issue coverage (Underwriting and Rating) – Comprehensive Exam	368	35
627.6699(6), F.S.	Company incorrectly calculated the premium for small group policies (Underwriting and Rating) – Comprehensive Exam	184	3
627.6131(4)(b) & 627.6131(5)(b), F.S.	Failure to deny claims timely (Claims Review) – Target Exam	736	17
626.9541(1)(i)3.d, F.S.	Denying claims without conducting reasonable investigations. These claims were improperly denied (Claims Review) – Target Exam	736	7
627.6131(7), F.S.	Failure to accurately pay interest on overdue claims (Claims Review) – Target Exam	368	30
627.6131(7), F.S.	Company failed to pay interest on overdue claims (Claims Handling - Paid) – Comprehensive Exam	293	46
627.9175, F.S.	Company filed an inaccurate 2008 GAP Report. (Accident and Health Premium and Enrollment Reporting) – Comprehensive Exam	1	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination, which was expanded into a comprehensive examination, of Blue Cross and Blue Shield of Florida, Inc. (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC**.** The scope period of the target examination for claims was January 1, 2007 through June 30, 2008 and for complaints and small group renewal rating July 1, 2006 through June 30, 2008. The examination began December 1, 2008 and ended May 5, 2009. The scope period of the expanded comprehensive 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 12, 2010. The findings of both the target and comprehensive examinations are included in this report.

The purpose of the examinations 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 verification of compliance with the following Florida Statute and Administrative Code Sections:

- **Operations and Management** - (Internal Reports, 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, 627.318, 626.9651, 817.5681, 626.9891, 624.33, 626.112, 626.88, 626.8805, 626.8817, 626.882, 626.8814, 626.883, 626.884, 626.886, 624.401, 624.401, 624.402, 624.406, and 624.603, Florida Statutes, and Rules 69O-128.030 through 69O-128.035, Florida Administrative Code.
- **Complaints –** Section 626.9541(1)(j), Florida Statutes.
- **Marketing and Sales** - Rules 69O-150(2) and 69O-191.063, Florida Administrative Code.
- **Producer Licensing** – (Appointments and Terminations) Sections 626.112, 626.461, 626.471, and 626.511, Florida Statutes.
- **Policyholder Services –** (Premium and Billing, and Cancellations) Sections 627.4091, 627.6043, and 627.6645, Florida Statutes.
- **Underwriting and Rating** – (Rating Practices, Mandated Disclosures, Forms Filings, Cancellations, Declinations, Rescissions, Rx Changes in Tier) Sections, 627.410, 627.6699, 627.674, 627.421, 627.4091, Florida Statutes, and Rules 69O-149.207, 69O-191.059, and 690-191.078, Florida Administrative Code.
- **Claims Handling** – (Claim Acknowledgments, Timely Investigations, Paid, Denied and Overdue Claims). Sections 627.419 and 627.6472, Florida Statutes.

- **Grievances** – Section 627.6472, Florida Statutes.
- **Reporting Requirements** – (GAP Report) 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

Blue Cross and Blue Shield of Florida, Inc. is a domestic Accident and Health insurer licensed to conduct business in the State of Florida on July 1, 1980. The Company provides Individual and Group Accident and Health coverage 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	4,950,026,890
2007	5,970,948,057
2008	6,424,314,179

The Company is headquartered in Jacksonville, Florida. Business is produced by Company employees licensed as Health and Life, or Health, Life and Variable Annuity Agents and through independent agents located throughout the state. The Company offers Health, Dental and Life insurance plans on an Individual and Group basis. In addition, the Company provides administration services to self-funded programs. The self-funded programs were not reviewed during the examination.

Claims are processed by the Company except prescription drug claims, which are handled on the Company's behalf by Prime Therapeutics, LLC, a third party pharmacy benefits management company.

OPERATIONS/MANAGEMENT

I. INTERNAL AUDITS AND REPORTS

The internal audit procedures manual indicates the Company has sufficient written procedures in place to identify problematic areas and make recommendations for corrective action. Twenty-eight internal audits and reports were reviewed.

The Company uses internal reports to identify problematic areas and to implement corrective action, however, the review indicated the Company either did not always follow-up on or could not document that report recommendations were implemented to ensure that areas of concern were completely addressed and corrective action taken.

1) **The Company's internal reports indicate it may have failed to protect non-public personal financial and personal health information of its customers.** The Company did not document taking action required by Rule 69O-128.032-034, Florida Administrative Code. The Company's internal reports identified:
   a. 168 system applications where non-public personal information was at risk of improper disclosure and did not provide written documentation that the recommendations in the report were implemented;
   b. files containing protected information had been left unsecured overnight and while a corrective action plan was developed there was no documentation the plan was implemented; and,
   c. 12 of 171 monitored calls in which the caller was not properly authenticated and while an education, testing and mitigation plan was developed there was no documentation the plan was implemented.

1a.) CORRECTIVE ACTION: The Company should document that appropriate corrective actions have been implemented following audit and report recommendations. Additionally, the Company should certify to the Office that they have notified affected individuals of any breaches that occurred, complied with all Florida Statutes relating to the reporting of unauthorized disclosure of such information, and that no unauthorized disclosures of personal information or security breaches have occurred during the scope period of this examination that have not been disclosed to the examiners and/or the Office during this examination.

1b.) COMPANY RESPONSE: The Company disagreed with this finding indicating these were reports, not audits, and representing they had followed up on the reports to ensure that the risks were appropriately mitigated. The Company's internal audit department has established and maintains procedures for follow-up activities.

1c.) SUBSEQUENT EVENT: The Company provided documentation after the exam was finalized to support that their internal reports identified risks related to the protection of non-public personal financial and personal health

information of its customers. The Company has certified that they are unaware of breaches that occurred, and if such breaches are identified in the future, the Company shall comply with all Florida Statutes relating to the reporting of unauthorized disclosures of such information.

2) **In 2 instances the Company failed to pay interest on overdue claims in violation of Section 627.6131(7), Florida Statutes.** Per an internal audit, over 500 claims were found to have been left in queues for more than 120 days. A sample of 25 of these claims showed that in 2 instances interest was not paid

2a.) **CORRECTIVE ACTION:** The Company should pay interest when claims are not paid timely.

2b.) **COMPANY RESPONSE:** The Company agreed with the findings.

3) **In 1 instance the Company failed to pay or deny a claim within 140 days in violation of Section 627.6131(5)(e), Florida Statutes.** Per an internal audit, over 500 claims were found to have been left in queues for more than 120 days. A sample of 25 of these claims showed that in 1 instance a claim was not timely denied creating an uncontestable claim that should have been paid.

3a.) **CORRECTIVE ACTION:** The Company should pay claims that are not denied within 140 days regardless of the reason it could be denied.

3b.) **COMPANY RESPONSE:** The Company agreed with the finding.

II. CONTROLS OF COMPUTER INFORMATION

The Information Security Policy required by Rule 69O-128.032 Florida Administrative Code includes written procedures for the security and confidentiality of customer information. The Company's 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.

All application changes must follow the formally documented Change Management Policy, including the assurance of adequate testing, appropriate management approval, and change management team approval.

The Examiners performed a limited review of the Company's Information Systems. Results of the evaluation were noted in a letter provided to the Company.

III. ANTI- FRAUD PLAN

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

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 address 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. Additionally, 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 and if these contracts contain a provision permitting the Company to conduct audits.

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 agreement with an entity that is providing a service or product. 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 were also conducted.

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 examination. There were 4,407 records requested from the Company during the scope of the examination.

1) **In 15 instances the Company was not able to provide requested records in violation of Section 624.318, Florida Statutes.**

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

The Company uses investigative consumer reports only when it suspects fraudulent enrollment.

The Company's Corporate Privacy Procedures include 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 packet upon enrollment. The packet contains the 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 626.9541(1)(j), Florida Statutes. 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.

Complaints were reviewed in both the target and comprehensive examinations.

Target Examination Findings:

The Company received 2,224 Department of Financial Services (DFS) complaints and 12,824 directly received complaints between July 1, 2006 and June 30, 2008. A sample of 50 DFS complaints and 134 directly received complaints was reviewed for a total of 184.

1) In 3 instances the Company failed to respond timely to DFS complaints in violation of Section 20.121(2)(h)2, Florida Statutes.

1a.) CORRECTIVE ACTION: The Company should respond to DFS requests within 20 days.

1b.) COMPANY RESPONSE: The Company agreed with the findings. The Company also stated that it has implemented a new DFS Tracking Log that should improve the timeliness of responses.

2) In 22 instances the Company failed to acknowledge and act promptly upon communications with respect to claims in violation of Section 626.9541(1)(i)3.c, Florida Statutes. The Company's written procedures state that an acknowledgement is to be sent "upon receipt" of an appeal request. Acknowledgements were sent between 8 and 112 days after receipt of the request for these 22 appeals.

2a.) CORRECTIVE ACTION: The Company should acknowledge appeal requests timely.

2b.) COMPANY RESPONSE: The Company did not agree with the finding, however, stated it will consider modifying the procedures that govern the processing of appeals so that the procedures more clearly define the timeframe for processing appeals. The Member Appeals Department takes appropriate action with respect to any appeals that are not forwarded to them from another BCBSF department within five days.

3) In 8 instances the Company failed to finalize the appeals process within sixty (60) days in violation of Section 627.6131(8), Florida Statutes.

3a.) **CORRECTIVE ACTION:** The Company should process appeals within 60 days after the receipt of the provider's request for review or appeal.

3b.) **COMPANY RESPONSE:** The Company stated that its Member Appeals Department makes every effort to maintain ERISA compliance. In the last 6 months, many processes have been streamlined, and management oversight has been restructured to ensure compliance is met. Procedures are also in place to investigate those instances where an appeal is received within the Member Appeals Department 6 or more days after the appeal was first received by the Company. In addition, efforts have been initiated to ensure that any appeal decisions that warrant review and approval by an ASO (Administrative Services Organization) are returned to Member Appeals in a timely manner. Two of the referenced exceptions involved cases where the ASO did not provide feedback to the Company in a timely manner.

4) **In 2 instances the Company failed to maintain a complete record of complaints in violation of Section 626.9541(1)(j), Florida Statutes.** The Company was unable to locate 2 complaint files.

4a.) **CORRECTIVE ACTION:** The Company should maintain complete complaint records.

4b.) **COMPANY RESPONSE:** The Company agreed with the findings and stated it has initiated efforts to ensure its ability to retain and retrieve documentation to support all complaints.

Comprehensive Examination Findings:

The Company received 1,189 Department of Financial Services (DFS) complaints and a total of 7,218 direct complaints and/or grievances between July 1, 2008 and May 31, 2009.

A sample of 23 DFS complaints and 94 directly received complaints was reviewed. No exceptions were found.

MARKETING AND SALES

I. ADVERTISING MATERIALS:

The Company provided a listing 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 were 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 to facilitate verification.

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 give proper notice 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 notify DFS 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

A total of 983,036 individual and 152,937 group policies were in force during the scope of the examination. Premium and billing notices were reviewed to verify they were sent timely. A sample of 300 policies was reviewed.

1) **In 4 instances the Company failed to properly notify the individual insured about changes in premium rates in violation of Section 627.6043, Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should give timely rate increase notification and maintain those records to ensure compliance with Florida laws.

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

2) **In 1 instance the Company failed to properly notify a group insured about a change in premium rates in violation of Section 627.6645, Florida Statutes.**

2a) **CORRECTIVE ACTION:** The Company should give timely rate increase notification and maintain those records to ensure compliance with Florida laws.

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

II. CANCELLATIONS, DECLINATIONS 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 22,649 group policies and 292,741 individual policies cancelled during the scope of the examination.

A total of 184 group and 184 individual cancellations was reviewed. No exceptions were found.

DECLINATIONS:

A random sample of 201 out of a total population of 53,032 declined applications was reviewed.

1) **In 1 instance an individual insured was not properly notified of the specific reason for declination in violation of Section 627.4091(1), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should give timely notification of adverse underwriting decisions and maintain those records to ensure compliance with Florida laws.

1b.) **COMPANY RESPONSE:** The Company agreed to review and revise, where applicable, its procedures to ensure that records are maintained to support declination notices being provided to applicants who are declined coverage.

2) **In 2 instances a group insured was not properly notified of the specific reason for declination in violation of Section 627.4091(1), Florida Statutes.**

2a.) **CORRECTIVE ACTION:** The Company should give timely notification of adverse underwriting decisions and maintain those records to ensure compliance with Florida laws.

2b.) **COMPANY RESPONSE:** The Company agreed to review and revise, where applicable, its procedures to ensure that records are maintained to support declination notices being provided to groups who are declined coverage.

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:

Target Examination Findings:

The target examination was limited to a review of renewal policies of one-life, and 2 to 50 life groups. The total population for these policies was 46,453. These policies were reviewed to ensure renewal premium rates were priced according to the rating methodology for small group plans in compliance with Section 627.6699, Florida Statutes, and that renewal notices were sent timely.

A total of 116 renewals were reviewed. There were 3 violations found.

1.) In 1 instance the Company failed to follow its filed health benefit plan rate in violation of Sections 627.6699(5)(c)&(6) and 627.410(6), Florida Statutes. In 1 instance, the Company failed to apply a 25% renewal rating cap to one life groups. It was estimated that 122 one life group renewals may be affected by the failure to adhere to this rate cap. This estimate was developed by extracting from the Company's data file, all one life group renewals that received an increase higher than 25%.

1a.) CORRECTIVE ACTION: The Company should re-rate all One-Life Blue Choice renewals prior to March 1, 2008 to ensure they were rated with the 25% cap and refund any difference in premium to the policyholders.

1b.) COMPANY RESPONSE: The Company disagreed with this finding. The Company stated that the purpose of the rating cap was to transition existing business to the new rating methodology which was effective July 1, 2006. Based on OIR's acknowledgement of an informational filing to formally remove all rating caps initially implemented during the transition to its new rating methodology, the Company maintains it proceeded correctly in removing the cap effective March 1, 2008.

1c.) SUBSEQUENT EVENT: The Company provided documentation after the exam was finalized to support that, while this group was a one life group, upon renewal when the rate cap would have been applicable, this group moved to a new policy form. The rate cap only applied to the BlueChoice PPO product and, in 2006, the group moved to a BlueOptions PPO plan at renewal.

2.) In 2 instances the Company failed to provide timely notice of premium increase in violation of Section 627.6645(1), Florida Statutes.

2a.) CORRECTIVE ACTION: The Company should send notices of renewal premium increases timely.

2b.) **COMPANY RESPONSE:** The Company agreed with the findings and stated that appropriate action has been taken to correct the conditions that caused each violation.

Comprehensive Examination Findings:

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 983,036 individual and 152,937 group policies were in force during the scope of the examination. A total of 184 individual and 184 group in-force policies, 184 individual and 184 group cancelled policies, and 184 individual declined policies and 17 group declined policies were selected for review.

A total of 184 in-force and 184 declined individual policies was reviewed relative to the Company's compliance with guaranteed issue and pre-existing exclusion requirements.

1) **In 35 instances the Company failed to provide documentation that they 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.** The Company denied 31 applications from individuals who were eligible for a guaranteed issue policy. In addition, 4 policies issued with exclusionary riders were eligible for a guaranteed issued policy.

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 properly informed and that documentation is retained.

2) **In 3 instances the Company incorrectly calculated the premium for small group policies 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 premium overcharges on these policies.

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

3) **In 1 instance the Company failed to follow its filed health benefit plan rate in violation of Sections 627.6699(5)(c)&(6) and 627.410(6), Florida Statutes.**

3a.) **CORRECTIVE ACTION:** The Company should re-rate all One-Life Blue Choice renewals prior to March 1, 2008 to ensure they were rated considering the 25% cap and refund any difference in premium to affected policyholders.

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

II. FORM FILINGS:

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

CLAIM HANDLING

I. Target Examination Findings:

The examination was divided into four product lines: Individual, Group, Medicare Supplement and Prescription Drug claims.

PAID CLAIMS:

Paid claims were reviewed to ensure timely and proper payment of claims.

Individual Claims: There were a total of 7,213,802 individual claims paid during the scope period. A random sample of 184 claims was reviewed. No exceptions were found.

Group Claims: There were a total of 24,578,766 group claims paid during the scope period. A random sample of 184 claims was reviewed. No exceptions were found.

Medicare Supplement: There were a total of 7,722,635 Medicare supplement claims paid during the scope period. A random sample of 184 claims was reviewed. No exceptions were found.

Prescription Drug: There were a total of 20,552,024 prescription drug claims paid during the scope period. A random sample of 184 claims was reviewed. No exceptions were found.

DENIED CLAIMS:

Denied claims were reviewed to ensure timely and proper denial of claims.

Individual Claims: There were a total of 1,395,417 individual claims denied during the scope period. A random sample of 184 claims was reviewed. Fifteen violations were found.

1) **In 13 instances the Company failed to deny claims timely in violation of Sections 627.6131(4)(b) and 627.6131(5)(b), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should deny claims timely.

1b.) **COMPANY RESPONSE:** The Company agreed with the findings.

2) **In 2 instances the Company denied claims without conducting reasonable investigations in violation of Section 626.9541(1)(i)3.d, Florida Statutes.** These claims were improperly denied.

2a.) **CORRECTIVE ACTION:** The Company should conduct a reasonable investigation prior to denying a claim. Additionally, these claims should be reprocessed.

2b.) **COMPANY RESPONSE:** The Company agreed with the findings but asserts these were isolated incidents and not a general business practice.

Group Claims: There were a total of 6,408,109 group claims denied during the scope period. A random sample of 184 claims was reviewed. Four violations were found.

1) **In 3 instances the Company failed to deny claims timely in violation of Sections 627.6131(4)(b) and 627.6131(5)(b), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should deny claims timely.

1b.) **COMPANY RESPONSE:** The Company agreed with the findings.

2) **In 1 instance the Company denied a claim without conducting a reasonable investigation in violation of Section 626.9541(1)(i)3.d, Florida Statutes.** The claim was improperly denied.

2a.) **CORRECTIVE ACTION:** The Company should conduct a reasonable investigation prior to denying a claim. Additionally, this claim should be reprocessed.

2b.) **COMPANY RESPONSE:** The Company agreed with this finding but asserts it was an isolated incident and not a general business practice.

Medicare Supplement: There were a total of 2,052,281 Medicare Supplement claims denied or paid during the scope period. A random sample of 184 claims was reviewed. Two violations were found.

1) **In 1 instance the Company failed to deny claims timely in violation of Sections 627.6131(4)(b) and 627.6131(5)(b), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should deny claims timely.

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

2) **In 1 instance the Company denied a claim without conducting a reasonable investigation in violation of Section 626.9541(3)(d), Florida Statutes.** The claim was improperly denied.

2a.) **CORRECTIVE ACTION:** The Company should conduct a reasonable investigation prior to denying a claim. Additionally, this claim should be reprocessed.

2b.) **COMPANY RESPONSE:** The Company agreed with this finding but asserts it was an isolated incident and not a general business practice.

Prescription Drug: There were a total of 3,752,000 prescription drug claims denied during the scope period. A random sample of 184 claims was reviewed. Three violations were found.

1) **In 3 instances the Company denied claims without conducting reasonable investigations in violation of Section 626.9541(1)(i)3.d, Florida Statutes.** These claims were improperly denied.

1a.) **CORRECTIVE ACTION:** The Company should conduct a reasonable investigation prior to denying a claim. Additionally, these claims should be reprocessed.

1b.) **COMPANY RESPONSE:** The Company agreed with the findings but asserts these were isolated incidents and not a general business practice.

OVERDUE CLAIMS:

Overdue claims were reviewed to ensure proper payment of interest due.

Individual Claims: There were a total of 48,897 individual overdue claims during the scope period. A random sample of 184 claims was reviewed. Twenty-four violations were found.

1) **In 24 instances the Company failed to pay interest on overdue claims in violation of Section 627.6131(7), Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should pay interest on claims when appropriate and reprocess claims to pay the interest owed.

1b.) COMPANY RESPONSE: The Company agreed with these findings.

Group Claims: There were a total of 529,804 group overdue claims during the scope period. A random sample of 184 claims was reviewed. Six violations were found.

1) In 6 instances the Company failed to pay interest on overdue claims in violation of Section 627.6131(7), Florida Statutes.

1a.) CORRECTIVE ACTION: The Company should reprocess the claims to pay the interest owed. The Company should ensure that interest is paid when applicable.

1b.) COMPANY'S RESPONSE: The Company agreed with these findings.

Medicare Supplement: There were no overdue claims for review.

Prescription Drug: There were no overdue claims for review.

I. Comprehensive Examination Findings:

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 161,903,707 claims were paid or denied during the scope of the examination. The comprehensive examination claims review was limited to claims submitted by specialty providers.

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 random sample of 736 claims was reviewed, of which 368 were paid claims and 368 were denied claims.

CLAIM SETTLEMENTS:

PAID CLAIMS:

A random sample of 368 Paid Claims was reviewed. No exceptions were found.

DENIED CLAIMS:

A random sample of 368 Denied Claims was reviewed. No exceptions were found.

OVERDUE CLAIMS:

A total of 293 Overdue Claims was reviewed. A total of 46 violations was found.

1) **In 46 instances the Company failed to pay interest on overdue claims in violation of Section 627.6131(7), Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should reprocess the claims to pay the interest owed.

OIR REFERRAL – SPECIALTY CLAIMS REVIEW:

The denied claims review included 38 group and 54 individual chiropractic claims. No exceptions were found.

APPEALS AND GRIEVANCES

I. APPEALS AND GRIEVANCES

Appeals and grievances were reviewed in the Complaints Review. The Company has sufficient written procedures in place for receiving and resolving grievances and appeals of adverse benefit determinations. Grievances relating to Exclusive Provider benefit provisions are eligible for appeal to the State of Florida Subscriber Assistance Program.

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	$112,695,206	$106,937,700	$14,424,986	0	29,331	16,078	45,409	7
Individually Underwritten	$662,489,852	$408,257,217	$114,610,744	0	172,425	94,513	266,938	7
Self-Employed or Sole Proprietor	$13,447,561	$13,271,289	$874,091	1,023	1,023	560	1,583	7

2 - 5 Member Groups	$262,954,716	$221,641,989	$31,817,521	14,708	39,551	26,054	65,605	7
6 - 50 Member Groups	$1,182,994,429	$966,365,405	$149,057,298	35,495	185,547	115,497	301,044	7
51+ Member Groups	$1,833,926,121	$1,431,175,062	$82,526,675	4,927	296,110	195,117	491,227	7
Short Term Major Medical	$21,017,111	$14,789,551	$21,017,111	0	5,470	2,998	8,468	7
Conversion	$74,945,196	$95,895,326	$18,361,573	0	19,506	10,692	30,198	7
Administrative Services Only (ASO)	$2,228,228,650	$2,096,989,182	$138,150,176	167	265,237	235,015	500,252	0
Excess/Stop Loss	$3,629,571	$5,614,088	$0	0	17,228	11,861	29,089	0
Long Term Care	$11,601,347	$7,405,855	$0	0	9,884	374	10,258	0
Medicare Supplement	$358,624,299	$293,029,045	$17,931,215	0	179,420	0	179,420	0
TOTALS	**$6,766,554,059**	**$5,661,371,709**	**$588,771,390**	**56,320**	**1,220,732**	**708,759**	**1,929,491**	**56**

The examiner reviewed work papers and source documentation to verify the accuracy of the 8 reporting areas required on the GAP submission. One violation was found.

1) **The Company filed an inaccurate 2008 GAP Report in violation of Section 627.9175, Florida Statutes.** The Company filed incorrect amounts in the ASO section of the Company's GAP filing. Claim payments should not have been included as earned premium. In addition, the direct losses incurred on the ASO business should not have been included as this would not be a direct loss incurred by the Company.

1a.) **CORRECTIVE ACTION:** The Company should correctly report amounts as required.

1b.) **COMPANY RESPONSE:** The Company agreed with the findings.

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.