THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT F I N A L EXAMINATION REPORT

OF

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

AS OF

September 13, 2012

NAIC COMPANY CODE: 81973
NAIC GROUP CODE: 1137

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EXECUTIVE SUMMARY

A target market conduct examination of Coventry Health and Life Insurance Company 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.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
626.9541(1)(j)	The Company did not maintain any records of direct consumer complaints received from January 1, 2009, through May 31, 2010. (Direct Consumer Complaints Review)	No Records	1
626.9541(1)(j)	The Company's written complaint files did not contain a response/resolution or a copy of the Subscriber's written communication. (Direct Consumer Complaints Review)	18	2
626.9541(1)(j)	The Company did not maintain a complete record of all verbal complaints and failed to follow its internal complaint handling policy. (Direct Consumer Complaints Review)	18	13
626.9541(1)(j)	The Company did not maintain a complete record of all DFS complaints from January 1, 2009, to December 31, 2011. (DFS Complaints Review, sample)	46	19
626.9541(1)(j)	The Company did not maintain a complete record of all DFS complaints from January 1, 2009, to December 31, 2009. (DFS Complaints Review, universe)	22	9
626.9541(1)(j)	The Company's archive vendor destroyed 2009 member grievance and appeals files. (Grievance/Appeals Review, universe)	56	34
624.318	The Company did not maintain a complete record of all grievance files. (Grievance/Appeals Review)	91	9
627.6131(8)	The Company did not finalize the dispute resolution process within 60 days after the receipt of the grievance. (Grievance/Appeals Review)	91	1
627.6141	The Company did not respond to medically necessary appeals within 15 business days. (Grievance/Appeals Review)	91	2
627.6141	The Company's response to medically necessary appeals was provided by someone other than the insurer's licensed physician. (Grievance/Appeals Review)	91	10

627.6645(1)	The Company did not provide small group policyholders with 45 days' advance notice of a change in rates. (Premium and Billing Notices Review)	107	4
624.318	The Company's records were inadequate as they did not contain cancellation notices/requests, and responses to member requests. (Cancellations Review)	107	5
627.6043(1)	The Company's records did not contain the 10-day written notice of cancellation for nonpayment of premium. (Cancellations Review)	107	5
624.318	The Company's records were inadequate as they did not contain proof of the premium refund. (Declinations Review)	105	2
627.4091(1)	The Company did not provide the specific reasons, including the specific underwriting reasons, for denying the application. (Declinations Review)	105	96
627.6487(1)(a)(b)	The Company denied coverage when the applicant was eligible for guaranteed issue individual health insurance. (Declinations Review)	105	1
624.318	The Company's records were inadequate as they were completely missing, or did not contain copies of renewal notices or electronic fund transfer amounts. (Individual Underwriting and Rating Policy Review)	109	18
627.410(6)(a)	The Company charged rates that did not match the rates as filed and approved by the Office. (Individual Underwriting and Rating Policy Review)	109	69
627.421(1)	The Company did not mail or deliver the policy to the insured or to the person entitled within 60 days of the effective date of coverage. (Individual Underwriting and Rating Policy Review)	109	14
624.318	The Company's records were inadequate as they did not contain premium invoices or applications. (Small Group Underwriting and Rating Policy Review)	107	14
627.410(1)	The Company utilized form # CHL.CHC.CHP.Empr App.LG/SG(4/10) that was not filed with or approved by the Office. (Small Group Underwriting and Rating Policy Review)	107	27
627.421(1)	The Company did not mail or deliver the policy to the insured or to the person entitled within 60 days of the effective date of coverage. (Small Group Underwriting and Rating Policy Review)	107	33
627.6699(6)(b)5	The Company charged small employer renewal premiums in excess of the 10% annual allowable adjustment amount. (Small Group Underwriting and Rating Policy Review)	107	1
627.6131(4)(b)	The Company did not pay, deny or contest electronically submitted claims within 20 days after receipt. (Claims Handling Review)	184	5

627.6131(5)(b)	The Company did not pay, deny or contest nonelectronically submitted claims within 40 days after receipt. (Claims Handling Review)	184	2

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations, conducted a target market conduct examination of Coventry Health and Life Insurance Company (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by INS Regulatory Insurance Services, Inc. The scope period of this examination was January 1, 2009, through December 31, 2011. The scope period for claims handling was January 1, 2011, through December 31, 2011. The on-site examination began May 7, 2012, and ended July 12, 2012, with the examination continuing offsite. The on-site examination resumed September 4, 2012, and ended on September 13, 2012. The examination continued off-site and ended October 4, 2012.

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: internal audit controls, subcontractor oversight, and records retention; complaint handling; policyholder services; small group and individual underwriting and rating; claims handling; and grievance/appeals procedures.

The examination included the following procedures:

- **Operations and Management Review**- (Internal Audits, Subcontractor Oversight, Records Retention). Sections 624.318, 624.33, 624.603, 626.88, 626.8817, 626.882, 626.883, 626.884, 626.886, 626.9651, and 817.5681, Florida Statutes.
- **Complaints Review**- Sections 20.121(2)(h)2, and 626.9541(1)(j), Florida Statutes.
- **Policyholder Services Review** - (Premium, Billing, and Cancellations) Sections 627.6043, 627.6645, and 627.6699, Florida Statutes.
- **Underwriting and Rating Review**- (New and Renewal Rating Practices, Cancellations Rescissions, Declined, Issued Other Than Applied For, HIPAA Eligibility, Conversions, Dependent Coverage and Guaranteed Issue Disclosure.) Sections 627.4091, 627.410, 627.421, 627.607, 627.6487, 627.6515, 627.6562(2), 627.65625, 627.6645, 627.6675, 627.6699, 627.674, 627.6741, Florida Statutes; and Rules 69O-149.005, 69O-149.010, 69O-149.032, 69O-149.037, 69O-149.202, 69O-149.203, and 69O-149.206, Florida Administrative Code.
- **Claims Handling Review** - (Claim Acknowledgments, Timely Investigations, Paid, Denied and Overdue Claims) Sections 626.9541(1)(i), 627.6044, 627.613, 627.6131, and 627.662, Florida Statutes.
- **Grievances/Appeals Review**- Sections 627.6131(8), 627.6141, and 627.6472, Florida Statutes.

The Company records were examined at its office located at 1340 Concord Terrace, Sunrise, Florida, 33323. In reviewing materials for this final report, the examiner relied on records provided by the Company. 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 less than 50,000 the Acceptance Samples Table was used and for populations 50,000 and over ACL was used. Utilizing ACL to determine the sample sizes, a Confidence Level of 95%, an Upper Error Limit of 5% and an Expected Error Rate of 2% was used in accordance with the handbook.

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.

COMPANY OPERATIONS

Coventry Health and Life Insurance Company is a foreign Life, Accident and Health Insurance Company authorized to conduct business in the State of Florida on April 24, 1968. The Company provides health insurance in the State of Florida.

Total Direct Premiums Written in Florida for Health insurance were:

Year	Total Written Premium In Florida (Per Schedule T of the Annual Statement)
2010	$36,800,956
2011	$45,379,068

Originally established on April 6, 1995 as Vista Insurance Plan, Inc., the organization was acquired by Coventry Health Care, Inc., on September 10, 2007.

In August 2008, Vista Insurance Plan, Inc. was merged with Coventry Health and Life Insurance Company and authorized to transact health insurance coverage in Florida, in accordance with Section 624.401, F.S.

All PPO products are offered through Coventry Health and Life Insurance Company.

COMPANY OPERATIONS AND MANAGEMENT

I. INTERNAL AUDITS

The Company indicated that the Health Plan does not have an Internal Audit Department or procedures for performing audits. The Company did not provide lists of internal audits performed.

FINDING: The Company does not have internal audit procedures to identify problematic areas or make recommendations for corrective action until after problems have occurred.

CORRECTIVE ACTION: The Company should develop written procedures for and perform regularly scheduled Internal Audits.

II. SUBCONTRACTOR OVERSIGHT

The Company has contracted external management services with several vendors. The Company provided a list of 14 Third Party Administrators/Vendors utilized by the Company during the scope of the examination. For each Third Party Administrator (TPA) the Company provided accreditation and licensing documentation, annual audits and annual reports. All 14 contracts were selected for review. The purpose of the review was to determine if the Company has adequate procedures to monitor its contracted external management services and if these contracts contain a provision to allow the Company to conduct audits.

The review showed that the Company's Delegation Oversight Committee (DOC) is responsible for monitoring program functions delegated to third parties that fall under the Health Plan's Delegated Agreements. The DOC ensures that the functions delegated to outside entities are performed according to the Health Plan's specifications, accreditation standards, CMS and AHCA monitoring guidelines, and Florida Statutes. The DOC's main responsibilities include: Pre-Assessment Delegation, Annual Delegation Audit, Delegation Oversight Reporting, Corrective Action Plans and Delegation Oversight of Nationally Accredited Organizations.

The review also determined that the Company has a Quality Improvement (QI) Department which is responsible for ensuring that the TPA complies with all governmental regulations for the areas that have been delegated. The Quality Improvement Coordinator ensures compliance by reviewing reports from the TPAs and conducting annual evaluations.

No exceptions were noted.

III. RECORD RETENTION PROCEDURES

The Company was requested to provide a copy of its record retention manual for review. The Company provided a Retention and Resolution Schedule for Official Records Manual. The manual contained a detailed record retention and destruction schedule that

indicated the record description, retention period and retention trigger. The company indicated that the retention periods specified are legal retention periods and that the legal retention period specified for each type of record is designed to comply with existing record retention requirements in all states in which Coventry Health Care (CHC) entities do business.

A number of inconsistencies were noted with the Company's application of these procedures and are described throughout this Report.

COMPLAINT AND GRIEVANCE HANDLING

I. COMPLAINT HANDLING PROCEDURES

The Company provided a copy of the Company's Complaint Handling guidelines/procedures. The Company defines a Complaint as "*any expression of dissatisfaction by a Subscriber, including dissatisfaction with the administration, claims practices or provision of services, which relates to the quality of care provided by a provider pursuant to the Plan's contract and which is submitted to the Plan or to a State agency. A Complaint is part of the informal steps of a Grievance procedure and is not part of the formal steps of a Grievance procedure, unless it is a Grievance as defined.*" It is noted that, during the scope period, the Company did not maintain Complaints received from the Department of Financial Services (DFS) in the same database as Complaints or Grievances received directly to it by Subscribers. The examiners requested and reviewed records in the categories of Direct Consumer Complaints, DFS Complaints, and Grievance/Appeals.

No exceptions were noted.

II. GRIEVANCE/APPEAL PROCEDURES

The Company's Grievance and Appeal procedures were requested and reviewed. The review concluded that the Company has written grievance procedures in place.

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 the member has a Grievance Adverse Benefit Determination, in whole or in part, on medical judgment, it will be reviewed by a Clinical Peer, or by a committee that is appropriately comprised of Clinical Peers. In the event that the first level Grievance decision is to uphold the initial Adverse Benefit Determination, the Subscriber has 31 calendar days from the date of the Plan's first level Grievance decision letter to request, orally or in writing, a second level Grievance review.

In the Level Two Review, if the member remains dissatisfied with the decision of the Level One Committee, he or she may request a reconsideration of the decision by the Grievance and Appeals Committee (Committee). The Committee will render a final

determination on the subscriber's grievance. If the Grievance is resolved in the Subscriber's favor, the second level Grievance decision letter will advise the Subscriber of the favorable determination and further instructions on authorization of services and/or claims payment. If the Grievance is not resolved in the Subscriber's favor, the second level Grievance decision letter will provide all required notice provisions.

After exhausting both levels of the Plan's internal Grievance process, and within 365 days of receiving the second level Grievance decision letter, the Subscriber may request a review by the State of Florida Subscriber Assistance Program (SAP).

A Subscriber, or their Authorized Representative, may request orally or in writing that a Grievance be reviewed on an expedited basis as an Urgent Grievance. If the Subscriber is requesting the Grievance for the first time (similar to a first level Grievance) and the decision is unfavorable to the Subscriber upon review of the Urgent Grievance, the Subscriber's recourse is to request a review by the Subscriber Assistance Program. Second level reviews are not offered by the Plan for Urgent Grievances. If a Subscriber initially requested a first level Grievance related to an Adverse Benefit Determination and the Plan upheld its initial Adverse Benefit Determination, the Subscriber will not be precluded from requesting a second level Grievance as an Urgent Grievance, if relevant. If it is the Plan's decision to uphold the initial Adverse Benefit Determination, the Subscriber will be given further review rights with the SAP. No second level review of Urgent Grievances is available through the Plan's internal Grievance process.

No exceptions were noted.

III. COMPLAINTS AND GRIEVANCE/APPEALS

The Company was requested to provide a list of all complaints, grievances, and appeals received from consumers, claimants, and the Florida Department of Financial Services (DFS) during the scope period. The Company was unable to provide any complaint records received directly from consumers from January 1, 2009, through May 31, 2010. The Company was also unable to provide a complete universe of DFS complaints or grievances because, on or around June 4, 2012, their off-site storage vendor destroyed 20 of 36 archived boxes containing those records.

The Company identified a universe of 46 direct consumer complaints received from June 1, 2010, through December 31, 2011. A random sample of 18 complaint files was requested and received. The files were reviewed for compliance with Section 626.9541(1)(j), Florida Statutes. The following exceptions were noted:

1) **In one (1) instance, the Company did not maintain a complete record of direct consumer complaints received from January 1, 2009, through May 31, 2010, in violation of Section 626.9541, Florida Statutes**.

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure a complete record of all complaints is maintained.

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

2) **In two (2) instances, the Company's written complaint files did not contain a response/resolution or a copy of the Subscriber's written communication in violation of Section 626.9541, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should ensure that response/resolution records are maintained for all complaints.

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

3) **In 13 instances, the Company did not maintain a complete record of all verbal complaints and failed to follow its internal complaint handling policy - Policy Number V.GA.188.05, Standard and Expedited Grievance Review Process: Commercial and Individual Subscribers, in violation of Section 641.3903, Florida Statutes.** The Company's internal complaint handling policy defines a complaint as, "*any expression of dissatisfaction by a Subscriber*" and states, "*If the Plan receives an initial Complaint from a Subscriber, the Plan must respond to the Complaint within a reasonable time after its submission.*" The files contained no proof that a response/resolution was communicated to the Subscriber.

3a.) CORRECTIVE ACTION: The Company should ensure that response/resolution records are maintained for all complaints.

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

The DFS identified a universe of 74 complaints that were forwarded to the Company during the scope period. A random sample of 46 DFS complaint files was requested for review; however, only 27 files were received due the destruction of archived records. The files were reviewed for compliance with Section 626.9541(1)(j), Florida Statutes. The following exceptions were noted:

4) **In 19 instances, the Company did not maintain a complete record of all DFS complaints received from January 1, 2009, to December 31, 2011 (sample), in violation of Section 626.9541, Florida Statutes.**

4a.) CORRECTIVE ACTION: The Company should implement procedures to ensure a complete record of all complaints is maintained.

4b.) COMPANY RESPONSE: The Company agreed with this violation.

The remaining 16 archived boxes were inventoried. The total number of 2009 DFS complaints that were destroyed amounted to 22 files, 13 of which were accounted for previously under subsection 4) as they were contained in the sample. The 9 complaint files noted below represent the remaining 2009 DFS complaint files that were not requested in the sample but were contained in the universe and destroyed by the archive vendor.

5) **In nine (9) instances, the Company did not maintain a complete record of all DFS complaints received from January 1, 2009, to December 31, 2009 (universe), in violation of Section 626.9541, Florida Statutes.**

5a.) CORRECTIVE ACTION: The Company should implement procedures to ensure a complete record of all complaints is maintained.

5b.) COMPANY RESPONSE: The Company agreed with this violation.

The Company identified a universe of 56 grievances received from January 1, 2009, through December 31, 2009; however, no sample was taken due to the destruction of archived records. After the 16 remaining archived boxes were inventoried, it was determined that 34 of the 56 grievance files contained in the universe were destroyed.

6) **In 34 instances, the Company's archive vendor destroyed 2009 member grievance and appeals files (universe), in violation of Section 626.9541, Florida Statutes.**

6a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that a complete record of all grievance/appeals and DFS complaint files is maintained.

6b.) COMPANY RESPONSE: The Company agreed with this violation.

The Company identified a universe of 240 grievances received from January 1, 2010, through December 31, 2011. A random sample of 91 grievances was requested; however, only 87 were received. The grievance files were reviewed for compliance with Sections 624.318, 626.9541, 627.6131(8), and 627.6141, Florida Statutes. The following exceptions were noted:

7) **In nine (9) instances, the Company did not maintain a complete record of all grievance files, in violation of Section 624.318, Florida Statutes.**

7a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that grievance files and a complete record of all grievances are maintained.

7b.) COMPANY RESPONSE: The Company agreed with this violation.

8) **In one (1) instance, the Company did not finalize the dispute resolution process within 60 days after the receipt of the grievance, in violation of Section 627.6131, Florida Statutes.**

8a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that grievance resolutions are finalized within 60 days.

8b.) COMPANY RESPONSE: The Company agreed with this violation.

9) **In two (2) instances, the Company did not respond to medically necessary appeal files within 15 business days, in violation of Section 627.6141, Florida Statutes.**

9a.) **CORRECTIVE ACTION**: The Company should implement procedures to ensure that medical necessity appeal responses are provided within 15 business days.

9b.) **COMPANY RESPONSE**: The Company disagreed with this violation.

10) **In 10 instances, the Company's response to medically necessary appeals was provided by someone other than the insurer's licensed physician, in violation of Section 627.6141, Florida Statutes.**

10a.) **CORRECTIVE ACTION**: The Company should implement procedures to ensure that medical necessity appeal responses are from the company's licensed physician.

10b.) **COMPANY RESPONSE**: The Company disagreed with this violation.

POLICYHOLDER SERVICES

I. PREMIUM AND BILLING NOTICES

The Company was requested to provide a list of all Florida small group policies that were newly issued and renewed during the scope period. The Company identified a universe of 1,205 policies. A random sample of 107 files was requested and received. The files were reviewed to ensure policyholders were given advance notice of a change in rates as required by Section 627.6645, Florida Statutes. The following exceptions were noted:

1) **In four (4) instances, the Company did not provide small group policyholders with 45 days' advance notice of a change in rates, in violation of Section 627.6645, Florida Statutes.**

1a.) **CORRECTIVE ACTION**: The Company should implement procedures to ensure that policyholders are provided with 45 days' advance notice of a change in rates.

1b.) **COMPANY RESPONSE**: The Company disagreed with this violation.

II. CANCELLATIONS, NONRENEWALS AND RESCISSIONS

The Company was requested to provide a list of all individual policyholders cancelled/rescinded/non-renewed during the scope period. The Company identified a universe of 1,629 policies. A random sample of 107 policy files was requested and received. The files were reviewed to ensure cancellation notices were sent timely and the reason for cancellation was in compliance with contract provisions, termination laws, and regulations. The following exceptions were noted:

1) **In five (5) instances, the Company's records were inadequate as they did not contain cancellation notices/requests, and responses to member requests, in violation of Section 624.318, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that complete file records are maintained.

1b.) COMPANY RESPONSE: The Company disagreed with this violation.

2) **In five (5) instances, the Company's records did not contain the 10-day written notice of cancellation for nonpayment of premium, in violation of Section 627.6043, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure records of 10-day written notices of cancellation for non-payment of premium are maintained.

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

III. DECLINATIONS

The Company was requested to provide a list of all applicants whose coverage was declined or issued other than applied for during the scope period. The Company identified a universe of 1,629 applicants. A random sample of 105 applicant files was requested and received. The files were reviewed to ensure declinations were in compliance with Sections 626.9541, 627.4091, and 627.6487, Florida Statutes and Rule 690-154.112, Florida Administrative Code. The following exceptions were noted:

1) **In two (2) instances, the Company's records were inadequate as they did not contain proof of the premium refund, in violation of Section 624.318, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that adequate records are maintained.

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

2) **In 96 instances, the Company did not provide the specific reasons, including the specific underwriting reasons, for denying the application, in violation of Section 627.4091, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that notices include the specific underwriting reasons for denying the application.

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

3) **In one (1) instance, the Company denied coverage when the applicant was eligible for guaranteed issue individual health insurance, in violation of Section 627.6487, Florida Statutes.**

3a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure that eligible applicants are not denied guaranteed issue individual health insurance coverage.

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

UNDERWRITING AND RATING

I. INDIVIDUAL UNDERWRITING AND RATING

The Company was requested to provide a list of all individual policies newly issued and renewed in Florida during the scope period. The Company identified a universe of 8,369 policies issued and renewed. A random sample of 109 files was requested. Of the 109 files requested, 107 files were received. The number of sample files received was sufficient to conduct the necessary review. The files were reviewed to verify that the rates were applied as filed and approved, and the Company was providing health coverage in compliance with the statutory requirements for HIPAA eligibility, conversions and dependent coverage. The following exceptions were noted:

1) **In 18 instances, the Company's records were inadequate as they were completely missing, or did not contain copies of renewal notices or electronic fund transfer amounts, in violation of Section 624.318, Florida Statutes.**

1a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure that adequate records are maintained.

1b.) **COMPANY RESPONSE:** The Company disagreed with this violation.

2) **In 69 instances, the Company charged rates that did not match the rates as filed and approved by the Office, in violation of Section 627.410, Florida Statutes.**

2a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure the rates charged match the rates filed and approved by the Office, review all rates charged for individual plans for accuracy, and refund, with interest, all overpaid premiums.

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

3) **In 14 instances, the Company did not mail or deliver the policy to the insured or to the person entitled within 60 days of the effective date of coverage, in violation of Section 627.421, Florida Statutes.**

3a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that proof of mailing or delivery is provided within 60 days of the effective date of coverage.

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

II. SMALL GROUP UNDERWRITING AND RATING

The Company was requested to provide a list of all small group policies newly issued and renewed to any Florida group during the scope period. The Company identified a universe of 1,205 policies issued and renewed. A random sample of 107 files was requested and received. The files were reviewed to verify that the rates were applied as filed and approved, and the company was providing health coverage in compliance with the statutory requirements for HIPAA eligibility, conversions and dependent coverage. The following exceptions were noted:

1) **In 14 instances, the Company's records were inadequate as they did not contain premium invoices or applications, in violation of Section 624.318, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that complete file records are maintained.

1b.) COMPANY RESPONSE: The Company disagreed with this violation.

2) **In 27 instances, the Company utilized form #CHL.CHC.CHP.EmprApp.LG/SG (4/10) that was not filed with or approved by the Office, in violation of Section 627.410, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure the forms utilized are filed and approved by the Office.

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

3) **In 33 instances, the Company did not mail or deliver the policy to the insured or to the person entitled within 60 days of the effective date of coverage. in violation of Section 627.421, Florida Statutes.**

3a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that policies are mailed or delivered within 60 days of the coverage effective date.

3b.) COMPANY RESPONSE: The Company disagreed with this violation but did not provide sufficient documentation to remove the remaining violations.

4) **In one (1) instance, the Company charged small employer renewal premiums in excess of the 10% annual allowable adjustment amount, in violation of Section 627.6699, Florida Statutes.**

4a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that small employer renewal premiums are not adjusted to exceed 10% annually, review the adjusted small employer renewal rates for accuracy, and refund, with interest, any overpaid premium.

4b.) COMPANY RESPONSE: The Company disagreed with this violation.

CLAIM HANDLING

The Company was requested to provide a list of all medical claims paid or denied during the scope period. The Company identified a universe of 131,351 medical claims paid or denied. A random sample of 184 claim files was requested and received. Of the 184 claims, 141 were submitted electronically and 43 were submitted nonelectronically. The claim files were reviewed for compliance with Sections 626.884, 626.9541(1)(i), 627.613, 627.6131, 627.645, and 627.662, Florida Statutes. The following exceptions were noted:

1) **In five (5) instances, the Company did not pay, deny or contest electronically submitted claims within 20 days after receipt, in violation of Section 627.6131, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that all electronically submitted claims are paid, denied, or contested within 20 days after receipt and pay the appropriate interest on all overdue claims, if due.

1b.) COMPANY RESPONSE: The Company disagreed with the violation.

2) **In two (2) instances, the Company did not pay, deny or contest nonelectronically submitted claims within 40 days after receipt, in violation of Section 627.6131, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that all nonelectronically submitted claims are paid, denied, or contested within 40 days after receipt and pay the appropriate interest on all overdue claims, if due.

2b.) COMPANY RESPONSE: The Company disagreed with the 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.