THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

COVENTRY HEALTH PLAN OF FLORIDA, INC.

AS OF

September 13, 2012

NAIC COMPANY CODE: 95266
NAIC GROUP CODE: 1137

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EXECUTIVE SUMMARY

A target market conduct examination of Coventry Health Plan of Florida, Inc. was performed to determine compliance with Florida Statutes and Florida Administrative Code.

The following represent general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS

Statute/Rule	Description	Files Reviewed	Number of Violations
641.3903(6)	The Company did not maintain any record of the direct consumer complaints received from January 1, 2009, through May 31, 2010. (Direct Consumer Complaints Review)	No Records	1
641.3903(6)	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)	40	3
641.3903(6)	The Company did not maintain a complete record of verbal complaints and failed to follow its internal complaint handling policy. (Direct Consumer Complaints Review)	40	29
641.3903(6)	The Company did not maintain a complete record of all DFS complaints received from January 1, 2009, to December 31, 2011. (DFS Complaint Files Review, sample)	63	30
641.3903(6)	The Company did not maintain a complete record of all DFS complaints from January 1, 2009, to December 31, 2009. (DFS Complaint Files Review, universe)	35	28
69O-191.074(1)(e)	The Company's archive vendor destroyed 2009 member grievance and appeals files. (Grievance/Appeals Review, universe)	519	309
69O-191.074(1)(e)	The company did not maintain a complete record of all grievance files for the period of January 1, 2010, through June 30, 2010. (Grievance/Appeals Review, sample)	154	14
641.511	The Company did not resolve the grievance within 60 days after receipt. (Grievance/Appeals Review)	154	1
69O-191.078(11)	The Company did not maintain accurate records of grievance files as they did not contain determination letters, or were missing altogether. (Grievance/Appeals Review)	154	18

69O-191.074(1)(e)	The Company did not maintain complete member records as they did not contain policy cancellation notices. (Cancellations Policy Review)	109	17
69O-191.074(1)(e)	The Company did not maintain complete member records as they did not contain proof of the premium refund. (Declinations Policy Review)	108	4
69O-191.074(1)(e)	The Company did not maintain complete member records as they did not contain copies of premium invoices, applications, or electronic funds transfer amounts. (Individual Underwriting and Rating Policy Review)	184	27
641.31(3)(b)	The Company did not mail or deliver 30-days advance written notice of a premium rate change to the subscriber. (Individual Underwriting and Rating Policy Review)	184	21
641.3107	The Company did not mail or deliver the health maintenance contract to the subscriber within 10 working days of the effective date of coverage. (Individual Underwriting and Rating Policy Review)	184	69
690-191.054(1)	The Company charged rates that did not match the rates approved by the Office. (Individual Underwriting and Rating Policy Review)	184	70
641.3107	The Company did not mail or deliver the health maintenance contract to the subscriber within 10 working days of the effective date of coverage. (Small Group Underwriting and Rating Policy Review)	10	1
69O-191.074(1)(e)	The Company did not maintain a complete member record as it did not contain a copy of the Explanation of Benefits. (Claims Handling Review)	184	1
641.3155(3)(b)	The Company did not pay, deny or contest electronically submitted claims within 20 days after receipt. (Claims Handling Review)	184	6
641.3155(3)(e)	The Company did not pay, deny or contest electronically submitted claims within 90 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 Plan of Florida, Inc. (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 offsite 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 record retention; complaint handling; policyholder services; underwriting and rating, including small group and individual; claim handling; grievance/appeal procedures; and network adequacy.

The examination included the following procedures:

- **Operations and Management Review**- (Internal Audits, Subcontractor Oversight, Record Retention). Sections 624.318, 624.603, 626.88, 626.8817, 626.882, 626.883, 626.884, 626.886, 626.9651, 641.234, 641.36, 641.3905, 641.54, and 817.5681, Florida Statutes; and Rules 690-128, and 69O-191.074, Florida Administrative Code.
- **Complaints Review**- Sections 641.3903, 641.31(41), and 627.6562(2), Florida Statutes.
- **Policyholder Services Review** – (Premium, Billing, and Cancellations) Sections 641.31074, and 641.3108, Florida Statutes; and Rule 690-191.042, Florida Administrative Code.
- **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 641.31(2), 641.31(36), 641.31074, 641.3903, 641.3007, 641.3102, 641.3107, 641.31073, 641.185, 641.185, 627.410, 627.674, 627.421, 641.3102, and 641.309, Florida Statutes; and Rules 690-149.207, and 690-191.054, Florida Administrative Code.
- **Claims Handling Review**- (Claim Acknowledgments, Timely Investigations, Paid, Denied and Overdue Claims) Sections 641.3106, 641.315, 641.3155, 641.3156, and 641.3903, Florida Statutes.
- **Grievances/Appeals Review**- Sections 641.31, 641.3155, and 641.3903, Florida Statutes; and Rule 690-191.078, Florida Administrative Code.
- **Network Adequacy** – Section 641, Part III, Florida Statutes.

The Company records were examined at its office located at 1340 Concord Terrace, Sunrise, Florida, 33323. In reviewing materials for this draft 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 Plan of Florida, Inc. is a domestic Health Maintenance Organization (HMO) authorized to conduct business in the State of Florida on September 9, 1993. The Company provides health insurance in the State of Florida.

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

Year	Total Written Premium In Florida (Per Schedule T of the Annual Statement)
2010	277,113,148
2011	267,659,152

Coventry Health Care, Inc. acquired all membership interests of Florida Health Plan Administrators, LLC on September 10, 2007, which includes its subsidiary upon receipt of all required regulatory approvals and satisfaction of closing conditions set forth in the Membership Interest Purchase Agreement dated July 6, 2007.

Vista Healthplan of South Florida, Inc. (VISTA-SFL) is a Florida licensed HMO. On January 1, 2003, Foundation Health, A Florida Health Plan, Inc. (FHP) changed its name to Vista Healthplan of South Florida, Inc.

The current owner of VISTA-SFL is Florida Health Plan Holdings II, LLC (FHPH II). FHPH II acquired all of the outstanding shares of capital stock of VISTA-SFL (f/k/a FHP) from Health Net, Inc. of August 1, 2001. FHP was formed through the merger of CareFlorida Health Plan, Inc., CareFlorida, Inc., Community Medical Plan, Inc., and CMP Health Administrators, Inc., a third party administrator.

FHP was the direct successor to CareFlorida Health Plan, Inc. (CFHP). CFHP was incorporated on September 9, 1993. On June 27, 1996, the organization's name was changed to Foundation Health, a Florida Health Plan, Inc.

CareFlorida was originally incorporated as Heritage Health Plan of South Florida, Inc. on November 13, 1984. Heritage Health Plan of South Florida, Inc. changed its name to CareFlorida in March, 1990. CareFlorida merged into FHP on February 28, 1997.

CMP, incorporated on December 18, 1990, was acquired by the original Foundation Health Plan on November 15, 1994, and it merged with CFHP in February, 1995. CMP Health Administrators was incorporated in October, 1992, and it merged with FHP on January 2, 1998. The original Foundation Health, incorporated in January, 1994, merged with CFHP on June 27, 1996, and ceased existence as Foundation Health. At the time of the merger, CFHP changed its name to Foundation Health, a Florida Health Plan, Inc.

In October 2010, Vista Healthplan of South Florida, Inc. changed its name to Coventry Heath Plan of Florida, Inc.

COMPANY OPERATIONS AND MANAGEMENT

I. INTERNAL AUDITS

The Company indicated that the Health Plan does not have an Internal Audit Department. 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. 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 received. They 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, Subscriber may request review by the State of Florida Subscriber Assistance Program (SAP).

A Subscriber, or their Authorized Representative, may orally or in writing request 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 104 direct consumer complaints received from June 1, 2010, through December 31, 2011. A random sample of 40 complaint files was requested and received. The files were reviewed for compliance with Section 641.3903, Florida Statutes. The following exceptions were noted:

1) **In one (1) instance, the Company did not maintain any record of direct consumer complaints received from January 1, 2009, through May 31, 2010, in violation of Section 641.3903, 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 three (3) 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 641.3903, Florida Statutes**.

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

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

3) **In 29 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 133 complaints that were forwarded to the Company during the scope period. A random sample of 63 complaint files was requested for review; however, only 33 files were received due to the destruction of archived records. The files were reviewed for compliance with Section 641.3903(6), Florida Statutes. The following exceptions were noted:

4) **In 30 instances, the Company did not did not maintain a complete record of all DFS complaints received from January 1, 2009, to December 31, 2011 (sample), in violation of Section 641.3903 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 number of 2009 DFS complaints that were destroyed amounted to 50 files, 22 of which were accounted for under subsection 4) above as they were contained in the sample. The 28 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 28 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 641.3903, 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 519 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 309 of the 519 grievance files contained in the universe were destroyed.

6) In 309 instances, the Company's archive vendor destroyed 2009 member grievance and appeals files (universe), in violation of 69O-191.074, Florida Administrative Code.

6a.) CORRECTIVE ACTION: The Company should implement procedures to ensure a complete record of grievance files are maintained.

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

The Company identified a universe of 511 grievances received from January 1, 2010, through December 31, 2011. A random sample of 154 grievances was requested, 139 were received. The grievance files were reviewed for compliance with Sections 641.3155, 641.3903, and 641.511(6), Florida Statutes; and Rules 690-191.074, and 690-191.078, Florida Administrative Code. The following exceptions were noted:

7) In 14 instances, the Company did not maintain a complete record of all grievance files for the period of January 1, 2010, through June 30, 2010, in violation of Rule 69O-191.074, Florida Administrative Code.

7a.) CORRECTIVE ACTION: The Company should implement procedures to ensure a complete record of member grievances is maintained.

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

8) In one (1) instance, the Company did not resolve the grievance within 60 days after receipt, in violation of Section 641.511, Florida Statutes.

8a.) CORRECTIVE ACTION: The Company should implement procedures to ensure grievances are resolved within 60 days after receipt.

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

9) In 18 instances, the Company did not maintain accurate record of grievance files as they did not contain determination letters, or were missing altogether, in violation of Rule 69O-191.078, Florida Administrative Code .

9a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that accurate records of all grievance files are maintained.

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

POLICYHOLDER SERVICES

I. PREMIUM AND BILLING NOTICES

The Company was requested to provide a list of all Small Group Policies renewed to any Florida group during the scope period. The Company identified a universe of 101 renewed policies. A random sample of 38 policy files was requested and received. Upon review, it was determined that 36 of the 38 files were conversions to individual HMO policies, and not small group policies. The Company provided an additional sample of 8 small group policy files. The small group policies were reviewed for compliance with Section 641.31, Florida Statutes.

No exceptions were noted.

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 20,824 policies. A random sample of 109 files was requested and received. The files were reviewed to ensure nonrenewal, cancellation and rescission notices were sent timely and the reason for nonrenewal, cancellation or rescission was in compliance with contract provisions, cancellation laws and regulations. The following exceptions were noted:

1) **In 17 instances, the Company did not maintain complete member records as they did not contain policy cancellation notices, in violation of Rule 69O-191.074 Florida Administrative Code.**

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

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

III. DECLINATIONS

The Company was requested to provide a list of all Florida applicants whose coverage was declined or issued other than applied for during the scope period. The Company identified a universe of 2,563 applicants. A random sample of 108 files was requested and received. The files were reviewed to ensure declinations were in compliance with Sections 641.3102, 641.3903(8), Florida Statutes; and Rules 69O-154.112 (6) & (7), and 69O-191.074, Florida Administrative Code. The following exceptions were noted:

1) **In four (4) instances, the Company did not maintain complete member records as they did not contain proof of the premium refund, in violation of Rule 69O-191.074, Florida Administrative Code.**

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

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

UNDERWRITING AND RATING

I. INDIVIDUAL UNDERWRITING AND RATING PRACTICES

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 68,744 policies issued and renewed. A random sample of 184 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 27 instances, the Company did not maintain complete member records as they did not contain copies of premium invoices, applications, or electronic funds transfer amounts, in violation of Rule 69O-191.074, Florida Administrative Code.**

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

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

2) **In 21 instances, the Company did not mail or deliver 30-days advance written notice of a premium rate change to the subscriber, in violation of Section 641.31, Florida Statutes.**

2a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure that 30-day advance written notice of premium rate changes are mailed to subscribers.

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

3) **In 69 instances, the Company did not mail or deliver the health maintenance contract to the subscriber within 10 working days of the effective date of coverage, in violation of Section 641.3107, Florida Statutes.**

3a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure that health maintenance contracts are mailed or delivered to the subscriber within 10 working day of the coverage effective date.

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

4) **In 70 instances, the Company charged rates that did not match the rates approved by the Office, in violation of Rule 69O-191.054, Florida Administrative Code.**

4a.) 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.

4b.) 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 renewed to any Florida group during the scope period. The Company identified a universe of 101 renewed policies. A random sample of 38 policy files was requested and received. Upon review, it was determined that 36 policies were group conversions to individual HMO policies, and not small group policies. The remaining 2 small group policies were reviewed. The Company provided an additional sample of 8 small group policy files. The 10 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 one (1) instance, the Company did not mail or deliver the health maintenance contract to the subscriber within 10 working days of the effective date of coverage, in violation of Section 641.3107, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that health maintenance contracts are mailed or delivered to the subscriber within 10 working day of the coverage effective date.

1b.) 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 191,169 medical claims paid or denied. A random sample of 184 claim files was requested and received. Of the 184 claim files reviewed, 150 were submitted electronically and 34 were submitted nonelectronically. The claim files were reviewed for compliance with Sections 641.3155; 641.3156; and 641.3903 Florida Statutes and Rule 69O-191.074, Florida Administrative Code. The following exceptions were noted:

1) **In one (1) instance, the Company did not maintain a complete member record as it did not contain a copy of the Explanation of Benefits, in violation of Rule 69O-191.074, Florida Administrative Code.**

1a.) CORRECTIVE ACTION: The Company should implement procedures to maintain complete claim records.

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

2) **In six (6) instances, the Company did not pay, deny or contest, electronically submitted claims within 20 days after receipt, in violation of Section 641.3155, Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure 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.

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

3) **In two (2) instances, the Company did not pay or deny the electronically submitted claims within 90 days after receipt of the claim, in violation of Section 641.3155, Florida Statutes.**

3a.) CORRECTIVE ACTION: The Company should ensure all electronically submitted claims are either paid or denied within 90 days after receipt and pay the appropriate interest on all overdue claims, if due.

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

NETWORK ADEQUACY

The Agency for Healthcare Administration (AHCA) has the authority to review and regulate network adequacy. As part of this review, AHCA looks at network expansions, directories, provider standards and responsibilities, proximity of providers, and access to emergency services.

During the examination, the Office contacted AHCA to inquire if they had any concerns with the Company's Network Adequacy. AHCA indicated they had no concerns at this time. The Office also reviewed the Company's National Committee for Quality Assurance Audit (NCQA). Based on information provided to NCQA during the audit, it was deemed that Coventry Health Plan of Florida, Inc. satisfied the requirements for accreditation.

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.