THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

HEALTH OPTIONS, INC.

AS OF

December 21, 2012

NAIC COMPANY CODE: 95089
NAIC GROUP CODE: 00536

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EXECUTIVE SUMMARY

A sample of 184 paid and 184 denied claims, and policies and procedures as they apply to the adjudication of out of network medical provider claims were reviewed. The following table represents general violation(s) found during the review. The specific violation(s) and additional findings are detailed in the remainder of this report.

TABLE OF TOTAL VIOLATIONS			
Statute/Rule	**Description**	**Files Reviewed**	**Number of Violations**
641.3155(3)(b)	The Company did not pay, deny, or contest out of network claims within the required timeframe.	184	2

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of Health Options, Inc. (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC**.** The scope period of this examination was January 1, 2009, through December 31, 2011. The onsite examination began September 24, 2012, and ended October 25, 2012. The examination continued offsite until December 21, 2012.

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

The examination included reviewing:

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

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and

conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

COMPANY OPERATIONS

Health Options, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on September 25, 1984. The Company provides individual and group health coverage in the State of Florida.

Total Direct Health Premiums Written in Florida were as follows:

Year	Total Written Premiums In Florida (Per Schedule T of Annual Statement)
2009	399,515,908
2010	486,741,696
2011	419,394,145

OUT OF NETWORK CLAIMS HANDLING

I. COMPANY POLICIES AND PROCEDURES

For those out of network covered services that are not provided in an emergency room, before the Company's out of network rates are applied, the underlying rates may be based on pre-existing arrangements between the provider and the Company or they may be based on rates negotiated at the time of authorization or prior approval for such services.

Effective September 23, 2010, for institutional and professional covered services provided in the emergency department of the hospital, the payment rate as required by the federal Affordable Care Act is used for the allowed amount. The allowed amount is the greatest of three amounts: 1) median negotiated rate for in-network providers, 2) the plan's out of network rate, or 3) the amount allowed under Medicare. However, any pre-existing rates between the provider and the Company or rates negotiated at the time of authorization or prior approval for such services would take precedence over those rates required by the Affordable Care Act.

The Company issues a new claim number each time a claim is reprocessed or if changes occur during the processing of a claim. For review purposes, the examiners treated all claim numbers submitted by the same provider for the same date of service as if they were related to the sampled claim under review. As a result, all related claims were viewed as a single claim regardless of the Company's process of assigning different claim numbers.

II. CLAIMS REVIEW

The Company was requested to provide a list of all out of network claims paid or denied during the scope period. The Company identified a universe of 237,039 paid or denied out of network claims. A random sample of 184 paid out of network claim files and a random sample of 184

denied out of network claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

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

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that out of network claims are paid, denied, or contested within the required timeframe.

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

The following findings were also noted during the examination:

1) **During the paid claims review in three (3) instances, the Company did not properly follow its standards for the proper investigation of out of network claims as follows**:

- The Company improperly denied a participating provider's claim for no authorization.
- The Company improperly paid the same provider $50.00 for a procedure code on one date of service and paid $25.00 for the same procedure code on a different date of service.
- The Company improperly applied multiple co-pays to the same claim.

1a.) CORRECTIVE ACTION: The Company should implement procedures to ensure it follows its standards for the proper investigation and payment of out of network claims, pay any interest due on identified, overdue claims, and provide proof of payment.

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

2) **During the denied claims review in 10 instances, the Company did not properly follow its standards for the proper investigation of out of network claims as follows:**

- The Company improperly denied a non-participating provider's claim for no authorization when authorization was on file.
- The Company improperly paid seven claims to a single provider that were mistakenly submitted by the provider under that provider's non-participating provider number. The provider then submitted seven duplicate claims which the Company properly denied. The Company reversed the payments that were made in error and then denied such claims because the provider was already receiving monthly capitation payments under the provider's participating agreement with the Company.

- The Company improperly classified two participating providers as non-participating providers causing two claim denials for no authorization.

2a.) <u>CORRECTIVE ACTION</u>: The Company should implement procedures to ensure it follows its standards for the proper investigation and payment of out of network claims, pay any interest due on identified, overdue claims, and provide proof of payment.

2b.) <u>COMPANY RESPONSE</u>: The Company disagreed with the seven findings that pertain to claims that were originally paid to the non-participating providers under the second bullet because the improper claim payments in question occurred on claims that were not sampled within the underlying random sample of claims. However, the Company stated it will agree to the fact that such improper claim activity occurred on "out-of-sample" claims and noted that appropriate corrective actions have already been taken on such claims. The Company agreed with the remaining findings listed under bullets one and three.

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.