FINANCIAL SERVICES COMMISSION

FLORIDA OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

MEDICAL SAVINGS INSURANCE COMPANY

AS OF

April 28, 2006

NAIC COMPANY CODE: 74217

TABLE OF CONTENTS

PURPOSE AND SCOPE OF EXAMINATION

Under authorization of the Financial Services Commission, Florida Office of Insurance Regulation ("Office"), Market Investigations, pursuant to Section 624.3161, Florida Statutes, a target market conduct examination of Medical Savings Insurance Company ("MSIC") was performed by RSM McGladrey, Inc. The scope period for this examination was January 1, 2001 through December 31, 2005.

The purpose of this examination was to review the Company's practices with respect to:

- Florida hospital paid claims;
- Advertising, marketing and script representations regarding benefit payments;
- Health Insurance Portability and Accountability Act ("HIPAA") guaranteed availability coverage for eligible individuals;
- Florida complaints and Florida grievance log; and
- Compliance with Florida Statutes and the Florida Administrative Code for the above areas.

The Company records were examined at its home office located at 5835 West 74th Street, Indianapolis, IN 46278.

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 HISTORY

The Company is a stock company domiciled in the State of Indiana. The Company was organized on April 12, 1965, and commenced writing life business on April 21, 1965. It is a wholly-owned subsidiary of Medical Savings Investment, Inc., which is solely owned by J. Patrick Rooney. The Company's Certificate of Authority was amended on November 20, 1996, to include accident and health insurance.

The Company currently has contracts with two out-of-state group associations for the purposes of selling insurance to association members, but is actively selling to only one of the associations. The Citizens for a Sound Economy (CSE) Association was formed in 1986, and the contract with the Company was executed in October 2000. The Americans for Tax Reform (ATR) Association was formed in 1984, and the contract with the Company was executed in August 1996. The policy issued to ATR is a closed block of business with no additional certificates being sold after February 28, 2001. Both associations were formed before the Company began selling insurance and are political lobbying groups. Both contracts require that the premium and dues be collected by the Company, then the membership dues are remitted to the appropriate association on a monthly basis.

The Company entered into a contract effective January 1, 1998, with the National Preferred Provider Network (NPPN), which has contracts for reduced fees from various providers and hospitals nationwide. The Company pays NPPN a service fee, which is the difference between

the billing statement and the negotiated rate. The fee in the original contracts was reduced effective June 1, 1999.

COMPLAINTS REVIEW

The examination encompassed a review of complaints received by the Florida Department of Financial Services, Division of Consumer Services (DFS), which were related to Florida out-of-state group health insurance business. DFS received 99 complaints against the Company during the scope of the examination. Of the 99 complaints listed on the DFS Complaint Log, the Company provided 91 of these complaint files for review. Subsequent to the examination, it was determined that 2 of the complaints listed on the DFS Complaint Log were simply inquiries made by a consumer and not complaints. The Company's failure to maintain 6 complaint files is a violation of Section 627.318, Florida Statutes. The Company also provided 5 additional complaints for review that were received directly by the Company.

A review of the complaint files revealed complaints were properly handled. In each case, the complaint was acknowledged and resolved in a timely manner. Complaints focused primarily on hospital bill repricing, rescissions, and the Company's claims payment practices. In each case, the Company maintained its claims calculation decision.

Corrective Action: The Company should maintain all records and make those records available to the Office for review upon request.

MARKETING AND SALES REVIEW

Medical Savings Insurance Company sells out-of-state group health insurance to association members who are Florida residents. The certificates are issued pursuant to an out-of-state group policy between MSIC and FreedomWorks (a.k.a. Citizens for a Sound Economy, an association). According to the Company, an applicant must be a member of the association to apply for coverage and the association membership dues are taken from the premium. The application for association membership is included as a loose page insert in the MSIC application package. However, the group membership requirement is not mentioned in any of the other broker or consumer printed information provided by the Company or on the association's website.

During the review of the Company's sales and marketing material, examiners noted references to marketing information which stated, "You pay the deductible...then...the plan pays 100 % of covered expenses! (In some cases co-payments apply, never more than $500)". The definition of "covered expenses" is not clearly disclosed or defined in the advertisement or the policy. This is supported by the complaints which revealed consumers who were caught in a dispute between the providers and the Company over the covered expense determination.

In addition, the Company's advertising information makes references to the assistance it will provide to its insureds if a hospital attempts to charge an "excessive" amount. There is no contractual provision in the Florida certificate that states the Company will protect the insured from being balance billed by the provider or provide any assistance. This was confirmed by the review of the complaint and claim files where it was noted that the insured is being balance billed by the provider and frequently being pursued by collection agencies.

The Company is using marketing and sales material that is in violation of Sections 626.9541(1)(a)1. and 626.9541(1)(b), Florida Statutes, and Rule 69O-150.006(1)(a), Florida Administrative Code.

Corrective Action: The Company should clearly state in its marketing and sales material, and all forms, the methods that will be used to calculate reasonable and customary charges. The insured should also be informed that the reasonable and customary calculation will likely result in the provider declining payment, and in most cases the payment responsibilities will ultimately be the insured's. The marketing and sales material, and all forms, should also specify what protection or assistance the Company will provide the insured in the event of a provider balance billing or if the insured is turned over to a collection agency.

CLAIMS REVIEW

The examiners requested the Company provide a copy of its claims handling manual and any claims training manuals used in training new claims adjusters in order to obtain an understanding of how the Company processes claims. The Company stated in writing that it does not have a claims manual or a training manual to provide to the examiners. Accordingly, the examiners met with the Manager and Assistant Manager of the claims unit to obtain an explanation of the claims handling process and system.

The examiners requested MSIC to provide a data dictionary that illustrates all fields that are captured or populated in its internal claims system and the definition or description of each of those fields. The limited information provided indicated that those fields consist of the claim number, which is assigned when the certificate number is entered, the policy number, the certificate number, the contract number, the check number, date of service, the type field, which indicates the type of transaction, the description and the amount. No other information is captured in MSIC's claim system.

If the claim is under $3,000, MSIC pays the claim based on the billed amount. If the claim is in excess of $3,000, it is routed to the Payment-In-Full (PIF) unit. The PIF unit will determine if claims between $3,000 and $8,000 appear to be billed by the provider within MSIC's reasonable and customary level for the services rendered and, if so, they will authorize the payment as billed. If billed charges are within $3,500 of MSIC's calculated reasonable and customary allowance, MSIC will generally cover the billed amount and not reduce the claim to the Company's calculation of reasonable and customary allowance. If the charges exceed $3,000 and they are deemed to be unreasonable for the services rendered, the Company's reasonable and customary charges will be calculated. This specialized claim unit utilizes three types of procedures and/or resources for calculating what MSIC considers reasonable and customary.

According to Company representations, for outpatient and inpatient surgical services, MSIC uses Medicare reimbursement rates as the starting point to estimate the cost and calculate the reasonable value of medical services provided to its insured. MSIC assigns Medicare Ambulatory Procedure Classification (APC) codes for outpatient surgical services, and Diagnostic Related Group (DRG) codes for inpatient surgical services, based upon the diagnosis and procedure codes provided on the hospital's bill and:

- Calculates the Medicare reimbursement rate, which is approximately 1% above cost and geographically adjusts for the surgical services provided to its insured;

- Increases the hospital's Medicare reimbursement rate by the Medicare Payment Advisory Commission's (MedPAC) reported average private-pay rate versus Medicare - - approximately 12% more than Medicare's reimbursement rate according to the most current and available MedPAC report and Medicare data; and then,

- Increases the median private-pay rate by an additional 1% to reach the 66 2/3rd mathematical percentile of all private payers for the procedure. This methodology results in a hospital payment that is approximately 26% higher than its base Medicare reimbursement rate, nearly 11% more than the average private-pay rate for the medical services, and approximately 27% above cost.

For the non-surgical medical services provided to its insureds, MSIC extracts the Current Procedural Terminology (CPT) codes from the hospital's invoice, inserts that information into an industry-accepted computer software program developed and maintained by ADP Context, and calculates the 70th percentile reimbursement rate of the providers in the facility's postal zip code to calculate "reasonable and customary charges."

MSIC affirms its claim payment calculation by citing statistics gathered from the Healthcare Cost Report Information System (HCRIS). All hospitals participating in the federal Medicare program are required by law to annually submit cost reports to the Center for Medicaid and Medicare Services (CMS). MSIC uses the self-reported cost-to-charge ratio from the HCRIS reports as was submitted by that particular hospital, and utilizes that data to justify its reasonable and customary charges. MSIC uses this data to attempt to show that the provider charges are excessive and to justify the reduction of the billed charges. The table below outlines the statistical findings observed by the examiners in the amount being billed versus the amount being paid from a sample of 151 paid hospital claims:

Amount Billed by Providers	MSIC's Reasonable & Customary Allowance	Original Amt Paid by MSIC	Original Variance Amt (unpaid)	Variance % (unpaid)
$1,943,001.99	$690,090.33	$729,191.95	$1,213,810.04	62.5%

It should be noted that the Company was unable to provide 1 claim file requested by examiners. Failure to maintain records and make those records available to the Office is a violation of Section 627.318, Florida Statutes.

Corrective Action: The Company should maintain all records and make those records available to the Office for review upon request.

The method MSIC uses to calculate claims is reportedly based on Medicare reimbursement rates. The significant difference for providers appears to be that Medicare has contracts in place to allow the provider to calculate in advance what the fee schedule will be based upon the provider's contract with Medicare. The provider then either chooses to participate in the Medicare program or not. Medicare also has provisions in its contracts that protect the insured from being balanced billed by the provider once they have met any deductible or co-payment.

The provider does not know until after the fact that MSIC is going to calculate the reasonable and customary amounts based on Medicare's rates, even though they do not have a Medicare contract and the individuals insured with MSIC are not Medicare eligible. There is also no language at all in MSIC's contracts that protect the consumer from being balanced billed by the provider. This may place the insured in a dispute between the provider and the Company during the determination of the reasonable and customary charges and it may leave the insured faced with collection and litigation charges as a result. The Company's failure to include language in the contract as to what specific method(s) it will use to calculate reasonable and customary charges is a violation of Sections 626.9541(1)(i)2., and 626.9541(1)(i)3.b., Florida Statutes.

Corrective Action: The Company should disclose in all forms what method it will use to calculate reasonable and customary charges prior to treatment of the insured as opposed to after-the-fact. The Company should also incorporate language in all forms that it will protect the insured from being balanced billed by the provider should they not accept MSIC's calculated charges.

GUARANTEED ISSUE

A review of the Company's current out-of-state group insurance application form used in Florida was conducted to determine if it allowed an applicant to apply for coverage under Florida's guaranteed availability law in accordance with Section 627.6487, Florida Statutes, and Rule 69O-154.112(6), Florida Administrative Code.

Effective January 1, 2004, the Company included a disclosure form in its application package that describes the guaranteed issue coverage availability and the process the applicant is required to undertake in order to apply for such coverage. There is, however, no evidence of the Company taking any action during the application process that would constitute "reasonable diligence" in making the determination of guaranteed availability as required by Rule 69O-154.112(6)(a), Florida Administrative Code. The application form does not have a question addressing whether the applicant is applying for guaranteed issue coverage. The application only asks if the applicant has had health insurance coverage in the last 6 months. It also states that if MSIC provides coverage, it will not take effect until the previous health insurance is no longer in force.

The Company confirmed that it relies completely on its brokers to inform any applicants about their guaranteed issue rights under HIPAA. The Company stated that if the applicant wishes to apply for guaranteed issue coverage, they indicate that on their application form. Also, the producer will indicate on the application that the applicant is applying for the guaranteed issue coverage. The Company relies on its brokers to qualify the applicants for guaranteed issue coverage; however, there is no formal training for brokers.

Prior to the January 1, 2004 date the Company began using the revised application package with the guarantee availability disclosure form, there was no indication that the guarantee availability law was either discussed with or offered to a potential insured as required by Section 627.6487, Florida Statutes, and Rule 69O-154.112(6), Florida Administrative Code.

Corrective Action: The Company should develop a formal documented process that allows it to determine whether an applicant is eligible for guaranteed issue coverage. The Company should disclose, in writing, to all applicants at the time of the application, the availability of guaranteed

issue coverage for eligible individuals. The Company should inform the applicant at the time of application of the information necessary to determine whether the applicant for coverage is an eligible individual.

EXAMINATION FINAL REPORT

The Office hereby issues this report as the Final Report, which is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company in response to the draft report.