



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

**MARKET CONDUCT
EXAMINATION REPORT**

OF

**HMO of Northeastern Pennsylvania
Wilkes-Barre, PA**

**As of: JUNE 26, 2013
Issued: AUGUST 16, 2013**

**BUREAU OF MARKET ACTIONS
LIFE AND HEALTH DIVISION**

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.




Michael F. Consedine
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
HMO OF NORTHEASTERN	:	Section 2166 of Act 68 of 1998
INSURANCE COMPANY	:	(40 P.S. §§ 991.2166)
19 North Main Street	:	
Wilkes-Barre, PA 18711-0302	:	Title 31, Pennsylvania Code, Sections
	:	146.5 and 146.7
	:	
Respondent.	:	Docket No. MC13-08-007

CONSENT ORDER

AND NOW, this 16th day of August, 2013, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is HMO of Northeastern Pennsylvania, and maintains its address at 19 North Main Street, Wilkes-Barre, PA 18711-0302.
- (b) From February 8, 2010 through May 13, 2010, a market conduct examination of Respondent was conducted by the Pennsylvania Insurance Department.
- (c) The market conduct examination was resolved through an Examination Report and Consent Order dated February 1, 2011.
- (d) The Examination Report included 2 separate Recommendations which identified corrective measures the Department found necessary as a result of the number of some violations, or the nature and severity of others noted in the Report.
- (e) The Consent Order required after a period of 18 months that Respondent was to be re-examined to verify corrective measures had been implemented.

- (f) In accordance with the terms in the Consent Order, a market conduct re-examination of Respondent was conducted by the Insurance Department covering the period from August 1, 2011 to July 31, 2012.
- (g) On June 26, 2013, the Insurance Department issued a Market Conduct Re-Examination Report to Respondent.
- (h) A response to the Re-Examination Report was provided by Respondent on July 19, 2013.
- (i) The Re-Examination Report notes violations of the following:
 - (i) Section 2166(A) of Act 68 (40 P.S. § 991.2166), which requires a licensed insurer or managed care plan to pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim;
 - (ii) Title 31, Pennsylvania Code, Section 146.5, which states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;

- (iii) Title 31, Pennsylvania Code, Section 146.7, which requires within 15 working days after receipt by the insurer of properly executed proof of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent's violations of Section 2166(A) of Act 68 of 1998 (40 P.S. § 991.2166) are punishable under Section 2182 of Act 68 of 1998 (40 P.S. § 991.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.
- (c) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5 and 146.7 are punishable under Section 9 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9):

- (i) cease and desist from engaging in the prohibited activity;
 - (ii) suspension or revocation of the license(s) of Respondent.
- (d) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:
 - (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
 - (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall pay Fifty Thousand Dollars (\$50,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.
- (d) Payment of this matter shall be made by check payable to the Pennsylvania Insurance Department. Payment should be directed to Cherie L. Leese, Bureau of Market Actions, 1311 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this

Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegate is authorized to bind the

Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: HMO OF NORTHEASTERN PENNSYLVANIA,
Respondent



President / Vice President



Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA

By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

HMO OF NORTHEASTERN PENNSYLVANIA

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I. INTRODUCTION

The Market Conduct Examination was conducted on HMO of Northeastern Pennsylvania; hereafter referred to as “Company,” at the Company’s office located in Wilkes-Barre, Pennsylvania, January 28, 2013, through June 20, 2013. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Yonise Roberts Paige
Market Conduct Division Chief

Gary L. Boose, LUTC, MCM
Market Conduct Examiner

Wanda M. LaPrath, CFE, CIE, MCM, FLMI, ARC
President, The Huff Group

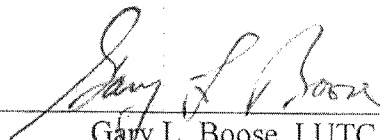
Jenny Jeffers, CISA, AES
IT Specialist

Joseph S. Krug, CPA, AFE
Market Conduct Examiner

Thomas Jones, AIE, AIRC, CCP, CLCR, MCM
Market Conduct Examiner

VERIFICATION

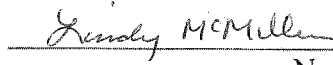
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



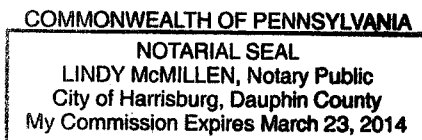
Gary L. Boose, LUTC, MCM

Sworn to and Subscribed Before me

This 21st Day of June, 2013



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §323.3 and §323.4) of the Insurance Department Act and covered the experience period of August 1, 2011, through July 31, 2012. The purpose of the re-examination was to ensure compliance with Pennsylvania insurance laws and regulations including recommendations communicated to the Company in the Market Conduct Examination Report dated February 1, 2011.

The scope of the examination includes, but is not limited to, the Company's activities relating to the implementation of a corrective action plan. The examination also included an informational technology review of the Company's claims systems and related processes.

Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

HMO of Northeastern Pennsylvania, Inc. was incorporated in the Commonwealth of Pennsylvania on May 5, 1986, as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania dba Blue Cross of Northeastern Pennsylvania. Effective October 31, 1986, the Company was issued a Pennsylvania Certificate of Authority as a non-profit health maintenance organization under the provisions of the Health Maintenance Organization Act, Act of December 29, 1972, P.L. 1701, No. 364 (40 P.S. §§1551 et seq.). The Company commenced business on January 1, 1987, and was federally qualified on June 30, 1987.

The Company filed for and received approval of the fictitious name First Priority Health, effective August 22, 1995. At that time, the Company began doing business as First Priority Health.

On April 29, 2005, Blue Cross of Northeastern Pennsylvania sold a 40% minority interest of the Company to Highmark Inc.

Regarding its physician network, the Company is based on a mixed model since it contracts with both individual physicians and physician groups. The Company is authorized to do business in the following counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

The Company provides a basic managed care product, BlueCare HMO, an open access HMO plan, BlueCare HMO Plus, and an HMO Individual Conversion product.

The Company's total Pennsylvania earned premium, as reported in their 2011 Annual Statement, was \$116,614,742. The total annual member months was reported as 398,159.

IV. CLAIMS MANUAL & CLAIMS

A. Claims Manual

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memoranda, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following information:

A. Facets Claims Processing User Guide and Supplement

1. Claims Processing Overview
2. How to Process a Claim
 - Processing a Medical Claim
 - Processing a Hospital Claim
3. Pre-Pricing Claims
4. Logging Claims
5. Claims Adjudication Routine
6. Claims Status
7. Pre-Payment Audit
8. Claims Payment
 - a. Remittance Review
 - b. EOB
 - c. Claims Interest Calculation
 - d. Risk Withhold
 - e. Prompt Payment
9. Coordination of Benefits
10. Processing Control Agent
11. Adjustments
12. Pended Claims
13. External Claims (Electronically Submitted Claims)
14. External Claims Adjudication
15. External Claims Submission
16. Electronic Adjudication
17. Claims Inquiry
18. Claims Security
19. Archiving Claims

- B. Claims User Guide Supplement – Facets 1450 Hospital Claims Training Manual
- C. Claims User Guide Supplement - Facets 1500 Medical Claims Training Manual
- D. Claims User Guide Supplement – Facets Adjustment Claims Processing Manual
- E. Claims Administration – Quality Assurance Program

The information was reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

B. Information Technology Review

The Company was requested to provide a list of all data systems information methodologies used as well as third party administrators (TPA) methods and usage utilized during the experience period. The Company provided all methods as well as their third party administrators methodologies. All data section systems information was requested, received and reviewed. The information was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices and Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. No violations were noted.

C. Subscriber Submitted Medical Claims

The Company was requested to provide a list of subscriber submitted medical claims received during the experience period. The Company identified a universe of 31 subscriber submitted medical claims. All 31 subscribers submitted medical claim files were requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. The following violations were noted:

4 Violations – Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the claim within 10 working days for the 4 noted claim files.

2 Violations – Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. The Company failed to provide notice of acceptance or denial within 15 working days in the 2 noted claim files.

D. Provider Submitted Medical Claims Paid

The Company was requested to provide a list of all provider submitted medical claims paid during the experience period. The Company identified a universe of 208,026 provider submitted medical claims. A random sample of 150 claim files was requested, received and reviewed. The files were reviewed for compliance with the Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. No violations were noted.

E. Provider Submitted Clean Claims Paid Over 45 Days

The Company was requested to provide a list of all provider submitted clean claims paid over 45 days during the experience period. The Company identified a universe

of 110 provider submitted clean claims paid over 45 days. All 110 claim files were requested, received and reviewed. The files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. The following violations were noted:

42 Violations - Quality Health Care Accountability and Protection Act, No. 68, 2166 (40 PS § 991.2166), Prompt Payment of Provider Claims.

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The noted 42 clean claims were not paid within 45 days of receipt.

Department Concern: During the review of Provider Submitted Clean Claims Over 45 Days, it was noted that 11 of the above noted 42 violations resulted in interest having to be paid that exceeded \$2.00 required under **Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.** The Department is very concerned that the adjudication of the claims was lengthy.

F. Provider Submitted Mammography Denied Claims

The Company was requested to provide a list of provider submitted mammography denied claims during the experience period. The Company identified a universe of 452 provider submitted mammography denied all claims. A random sample of 50 provider submitted mammography denied claim files was requested, received and reviewed. The files were reviewed for compliance with the Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. No violations were noted.

The following table shows a brief synopsis for the 50 denied files:

Number	Reasons for Denial	%
12	Coverage Not in Effect	24%
11	Provider Documentation Missing	22%
9	Duplicate Claim	18%
8	Member not Eligible	16%
5	Provider Billing Error	10%
1	Charges Exceed Contract Amount	2%
1	Out of Area Facility	2%
1	Out of Network	2%
1	Patient Not a Covered Member	2%
1	Prior Authorization Required	2%
50	TOTAL	100%

G. Mammography Claims Denied Under Age 40

The Company was requested to provide a list of all mammography claims denied under age 40 during the experience period. The Company identified a universe of 6 mammography claims denied under age 40. All claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices and the provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. No violations were noted.

The following table shows a brief synopsis for the 6 denied files:

Number	Reasons for Denial	%
4	Coverage Not in Effect on Date of Service	67%
2	Member Not Eligible for Benefit	33%
6	TOTAL	100%

H. Provider Submitted Emergency Room Claims Denied

The Company was requested to provide a list of all provider submitted emergency room claims denied during the experience period. The Company identified a universe of 3,767 provider submitted emergency room claims denied. A random sample of 100 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. No violations were noted.

The following table shows a brief synopsis for the 100 denied files:

Number	Reasons for Denial	%
37	Duplicate Claim	37%
23	Coverage Was Not in Effect	23%
10	Service is Not Covered	10%
12	Incomplete Information	12%
9	Billing Error	9%
3	Out of Network	3%
3	Exceeded Time Limit for Filing Claim	3%
3	Automobile Insurance Claim	3%
100	Total	100%

V. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must implement procedures to ensure compliance with the prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

VI. COMPANY RESPONSE



BlueCross of Northeastern Pennsylvania

19 North Main Street, Wilkes-Barre, Pennsylvania 18711-0302
www.bcnepa.com

July 19, 2013

Ms. Yonise Roberts Paige, Chief
Life, Accident and Health Division
Pennsylvania Insurance Department
Market Action Bureau
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 12-M25-046
HMO of Northeastern Pennsylvania (d/b/a, First Priority Health)

Dear Ms. Paige:

This letter is in response to your Report of Examination received on June 26, 2013 regarding the Pennsylvania Insurance Department's ("Department's") Market Conduct Examination of HMO of Northeastern Pennsylvania (d/b/a, First Priority Health ("FPH")) covering the period of August 1, 2011 through July 31, 2012 as of the close of business on June 20, 2013.

Thank you for the opportunity to review the Department's Report of Examination. We have reviewed the report and find the information noted within to be helpful in improving our processes. Listed below are First Priority Health's responses to the concerns and recommendations made by the Department:

1. Section IV.E – Provider Submitted Clean Claims Paid Over 45 Days:

Department Concern

During the review of Provider Submitted Clean Claims Over 45 Days, it was noted that 11 of the above noted 42 violations resulted in interest having to be paid that exceeded \$2.00 required under the Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. The Department is very concerned that the adjudication of the claims was lengthy.

Ms. Yonise Roberts Paige
Page 2. - Examination Warrant Number: 12-M25-046
July 19, 2013

First Priority Health Response

First Priority Health acknowledges the Department's concern regarding the violations that were noted during the Exam and will seek to make process improvements to ensure that all claims are processed timely.

We take pride in our claims processing performance, as evidenced by data indicating that 99.88% of claims were processed within 45 days in 2012.

2. Section V – Recommendations:

Department Recommendation

The Company must implement procedures to ensure compliance with the prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

First Priority Health Response

First Priority Health acknowledges the Department's recommendation and will take it into consideration when reviewing our procedures and claims processing guidelines to ensure that all claims are processed in accordance with the Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

We would like to thank you and your staff for the courtesy and cooperation extended to us during this exam. If you have any questions or require additional information, please contact me at (570) 200-4421 or Kerry.Turner@bcnepa.com. Thank you.

Sincerely,



Kerry M. Turner
Vice President, Corporate Assurance & Compliance

cc: Denise S. Cesare, President & Chief Executive Officer
Brian J. Rinker, Sr. Vice President - Chief Administrative Officer