REPORT OF
MARKET CONDUCT EXAMINATION
OF

KEYSTONE HEALTH PLAN CENTRAL
Harrisburg, Pennsylvania

AS OF
September 17, 2009

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT

Issued: November 4, 2009

KEYSTONE HEALTH PLAN CENTRAL

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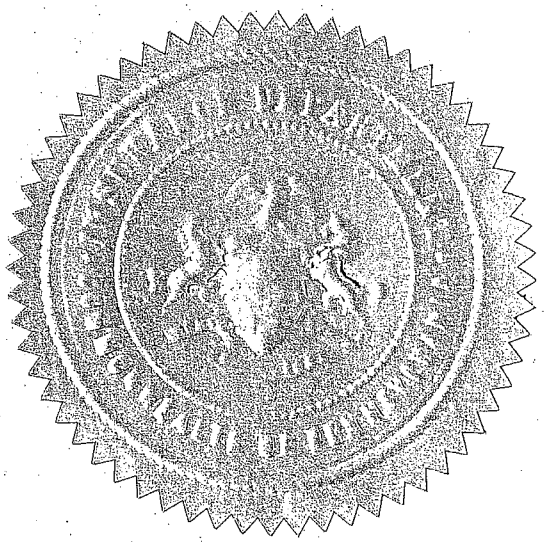
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22nd day of July, 2008, 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.



Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
KEYSTONE HEALTH PLAN CENTRAL 2500 Elmerton Avenue Harrisburg, PA 17110	:	Sections 2166(A) and (B) of the Act of June 17, 1998, P.L. 464, No. 68, (40 P.S. §§ 991.2166)
	:	
	:	Section 602-A of the Insurance Company Law, Act of May 17, 1921, P.L. 682, No. 284 (40 P.S. § 908-2)
	:	
	:	Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§1171.5(a)(10))
	:	
	:	Title 31, Pennsylvania Code, Sections 89.612 and 154.18(c)
	:	
	:	
Respondent.	:	Docket No. MC09-10-023

CONSENT ORDER

AND NOW, this 4th day of NOVEMBER, 2009, 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 Keystone Health Plan Central, and maintains its address at 2500 Elmerton Avenue, Harrisburg, Pennsylania 17110.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering various periods from January 1, 2005 through December 31, 2006.

(c) On September 17, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on October 15, 2009.

(e) The Examination Report notes violations of the following:

(i) Section 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;

(ii) Section 602-A of the Insurance Company Law (40 P.S. § 908-2), which states all group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act shall, in addition to other provisions required by this act, include within the coverage, those benefits for alcohol or other drug abuse and dependency as provided;

(iii) Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§1171.5(a)(10)), which defines unfair methods of competition and unfair or deceptive acts or practices in the business of insurance as:

(10) Any of the following acts, if committed or performed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices:

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

(iv) Title 31, Pennsylvania Code, Section 89.612, which states (a) non-hospital, residential alcohol treatment services which are included as a covered benefit shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services; (b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-

hospital residential alcohol treatment services; (c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital, residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b); and (d) Treatment services provided in subsections (a) through (c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits; and

(v) Title 31, Pennsylvania Code, Sections 154.18(c), states that interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

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 Sections 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), 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 Section 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.5) are punishable by the following, 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 comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Twenty-Five Thousand Dollars ($25,000.00) to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of Market Conduct, PA Insurance Department, 1227 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 delegee 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: KEYSTONE HEALTH PLAN CENTRAL,
Respondent

President / ~~Vice President~~

Secretary / ~~Treasurer~~

COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Keystone Health Plan Central; hereafter referred to as "Company," at the Company's office located in Harrisburg, Pennsylvania, April 11, 2008, through July 23, 2008. 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.

Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Michael A. Jones
Market Conduct Examiner

Gerald P. O'Hara Jr.
Market Conduct Examiner

Verification

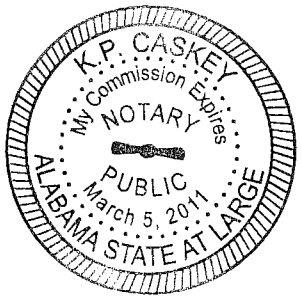
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 10th Day of September, 2009

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 January 1, 2005 through December 31, 2006, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Forms, and Claim Handling Practices and Procedures related to alcohol and substance abuse and mental illness coverage.

The Company was requested to identify the universe of files for each segment of the review. 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

Keystone Health Plan Central (KHPC) was incorporated on December 31, 1985. In 1986, Keystone Health Plan Central became a jointly owned subsidiary of Capital BlueCross and Pennsylvania Blue Shield. On September 30, 1988, the Insurance Commissioner granted a Certificate of Authority for Keystone Health Plan Central to establish, maintain, and operate a Health Maintenance Organization throughout the Commonwealth.

Keystone Health Plan Central commenced operations on November 1, 1988. In December 1996, one of the Keystone Health Plan Central parent companies, Pennsylvania Blue Shield, merged with Blue Cross of Western Pennsylvania to form Highmark Inc.

On November 26, 2003, Capital BlueCross acquired Highmark's shares of common stock in Keystone Health Plan Central, resulting in sole ownership by Capital BlueCross.

Keystone Health Plan Central became a wholly owned subsidiary of Capital Advantage Insurance Company on December 30, 2005. This change in ownership resulted from a capital contribution by Capital BlueCross to Capital Advantage Insurance Company in the form of one hundred percent of the shares of Keystone Health Plan Central stock. The Insurance Department gave prior approval for this transaction in a letter dated December 15, 2005.

Keystone Health Plan Central's total Pennsylvania earned premium, as reported in their 2008 annual statement was $423,206,560. The total annual member months was reported as 1,131,502.

IV. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, certificates of coverage, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354; the Accident and Health Reform Filing Act, No. 159 (40 P.S. §3803); and the Quality Health Care Accountability and Protection Act No. 68, Section 2136 (40 P.S. §991.2136), Required Disclosure. In addition, forms were reviewed to ensure compliance with Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options and Section 5 of the Insurance Company Law, No. 150 (40 P.S. §764g), Coverage for Serious Mental Illnesses. The following concern was noted:

Department Concern:

The Department is concerned with the Alcohol and Drug Abuse Benefits provision as stated in the Company's Small and Large Group Certificates of Coverage. The Alcohol and Drug Abuse provision states that preauthorization is required for certain services, coverage for this benefit is provided only when Keystone Health Plan Central determines the service to be Medically Necessary. The statement is ambiguous and could be easily misconstrued and applied in a manner inconsistent with the intent of the Alcohol and Substance Abuse mandated benefit law. Under the law, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment.

V. CLAIMS

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, memorandums, directives and any correspondence or instructions used for processing claims during the experience period.

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

The claim file review consisted of the following 8 areas:

A. Alcohol and Drug Facility Claims Denied
B. Magellan Alcohol and Drug Claims Denied
C. PacifiCare Alcohol and Drug Claims Denied
D. Alcohol and Drug Facility Services Denied
E. PacifiCare Alcohol and Drug Services Denied
F. Mental Illness Facility Claims Denied
G. Magellan Mental Illness Claims Denied
H. PacifiCare Mental Illness Claims Denied

All claim files were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171); Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options; Title 31, Pennsylvania Code, Section 89.612, Minimum covered services; Section 5 of the Insurance Company Law, No. 150 (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Alcohol and Drug Facility Claims Denied

The Company was requested to provide a list of alcohol and drug facility claims denied during the experience period. The Company initially identified a universe of 3,866 denied claims. From the original universe of 3,866 claims, the Department utilizing an audit program, extracted claims that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied claims was 725 claims. From the new universe, a random sample of 50 claim files was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and Section 602-A of the Insurance Company Law (40 P.S. §908-2). The following violations were noted:

8 Violations – Act 205, Section 5 (40 P.S. §1171.5)

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

- *(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.*
- *(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.*
- *(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.*
- *(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.*

(v) *Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.*

(vi) *Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.*

The denial of the 8 facility claims was not justified. The contract provisions require payment. The appropriate licensed provider certification was present in the files.

10 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §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 10 clean claims noted were not paid within 45 days of receipt.

8 Violations -Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Provider Claims (B)

If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two ($2) dollars.

The interest due on the 8 claims noted was not paid as required.

8 Violations – Title 31, Pennsylvania Code, Section 154.18(c)

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

Interest payment for the 8 claims noted was not paid within 30 days of the claim payment.

B. Magellan Alcohol and Drug Claims Denied

The Company was requested to provide a list of alcohol and drug claims denied during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 341 Magellan alcohol and drug claims denied. A random sample of 50 claim files was requested and received. Upon the initial review, 1 file was found to be covered under the Federal Employee Program and therefore was excluded from this review. The remaining 49 claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and Section 602-A of the Insurance Company Law (40 P.S. §908-2). No violations were noted.

C. PacifiCare Alcohol and Drug Claims Denied

The Company was requested to provide a list of alcohol and drug claims denied during the experience period of January 1, 2005 through December 31, 2005. The Company identified a universe of 1,426 PacifiCare alcohol and drug claims denied. A random sample of 50 claim files was requested and received. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract and Section 602-A of the Insurance Company Law (40 P.S. §908-2). The following violations were noted:

2 Violations - Insurance Company Law, Section 602-A (40 P.S. §908-2)

Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options.

(a) All group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act" or the act of July 29, 1977 (P. L. 105, No. 38), known as the " Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 603-A, 604-A, and 605-A.

and

Title 31, Pennsylvania Code, Section 89.612 Minimum covered services. *(a) Non-hospital, residential alcohol treatment services which are included as a covered benefit under Article VI-A of the act (40 P. S. § § 908-1—908-8) shall be covered for a*

minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.

(b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services.

(c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b).

(d) Treatment services provided in subsections (a)—(c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa.B. 4041 dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment.

The denial of coverage for the 2 claims noted is not in compliance with the laws governing mandated benefits. The appropriate licensed provider identification was present in the claim files.

6 Violations - Insurance Company Law of 1921, Section 2166 (40 P.S. §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 6 clean claims noted were not paid within 45 days of receipt.

1 Violation - Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Provider Claims (B)

If a licensed insurer or a Managed Care Plan Fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two ($2) dollars.

The claim noted had interest due for an amount over two dollars.

D. Alcohol and Drug Facility Services Denied

The Company was requested to provide a list of alcohol and drug facility services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 7 alcohol and drug facility requests for services that were denied. All 7 files were requested, received and reviewed. The files were reviewed to ensure the Company's denial of services for access to alcohol and drug use and dependency coverage services were not in violation of Commonwealth Law. The claim files were reviewed to ensure the Company claims adjudication process was

adhering to the provisions of the policy contract and Section 602-A of the Insurance Company Law (40 P.S. §908-2). The following violations were noted.

2 Violations - Insurance Company Law, Section 602-A (40 P.S. §908-2)

Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.

(a) All group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act" or the act of July 29, 1977 (P. L. 105, No. 38), known as the " Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections 603-A, 604-A, and 605-A.

and

Title 31, Pennsylvania Code, Section 89.612 Minimum covered services.

(a) Non-hospital, residential alcohol treatment services which are included as a covered benefit under Article VI-A of the act (40 P. S. § § 908-1—908-8) shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.

(b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services.

(c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital residential alcohol

treatment days, shall be available in addition to the minimum required in subsections (a) and (b).

(d) Treatment services provided in subsections (a) (c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa .B. 4041, dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment.

The denial or reduction of coverage for the 2 requests for service is not in compliance with this mandated benefit. The appropriate licensed provider certification was present in the files.

E. PacifiCare Alcohol and Drug Services Denied

The Company was requested to provide a list of alcohol and drug facility services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 10 alcohol and drug facility request for services that were denied. All 10 files were requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and Section 602-A of the Insurance Company Law (40 P.S. §908-2). No violations were noted.

F. Mental Illness Facility Claims Denied

The Company was requested to provide a list of mental illness denied claims during the experience period. The Company initially identified a universe of 11,228 denied claims. Based on a subsequent review of the data, the Department requested a more targeted criterion resulting in a new universe of 5,869 claim files. A random sample of 25 claim files was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with mental illness minimum mandated benefits. No violations were noted.

G. Magellan Mental Illness Claims Denied

The Company was requested to provide a list of mental illness denied claims during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 3,426 Magellan mental illness denied claims. A random sample of 25 claim files was requested and received. Upon the initial review, 5 files were found to be covered under the Federal Employee program and therefore all 5 were excluded from this review. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with mental illness minimum mandated benefits. No violations were noted.

H. PacifiCare Mental Illness Claims Denied

The Company was requested to provide a list of mental illness denied claims during the experience period of January 1, 2005 through December 31, 2005. The Company identified a universe of 1,369 PacifiCare Behavioral Health mental illness denied claims. A random sample of 25 claim files was requested and received. Upon the initial review, 1 file was found to be covered under the Federal Employee Program and therefore it was excluded from this review. The remaining 24 claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with mental illness minimum mandated benefits. No violations were noted.

VI. 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 review internal control procedures to ensure compliance with prompt and fair claim settlement practices requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

2. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.

3. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

4. The Company must review and revise internal control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.

5. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Section 154.18, related to timely interest payments on clean claims paid over 45 days.

6. Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of payment on the claims noted in the examination for improper denials.

VII. COMPANY RESPONSE

Capital BlueCross

Glenn P. Heisey
Corporate Secretary and Chief Compliance Officer

(717) 541-7288
(717) 651-8497 Fax
Glenn.Heisey@capbluecross.com

October 15, 2009

Daniel A. Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department
1227 Strawberry Square
Harrisburg, PA 17120

Via Electronic Mail and Overnight Delivery

RE: Examination Warrant Number: 07-M25-053
Response to Report of Examination of Keystone Health Plan Central

Dear Mr. Stemcosky:

On behalf of Keystone Health Plan Central, please allow this letter to serve as our response to the Report of Market Conduct Examination Warrant Number 07-M25-053 (the Report), which was received with your cover letter dated September 17, 2009. We have reviewed the Report and respectfully submit this response.

Our response addresses the Department's six recommendations beginning on page 19 of the Report as follows:

1. **The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement practices requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).**

   Keystone Health Plan Central accepts this recommendation. As we discussed with the Department during our exit conference on July 23, 2009, six out of the eight claims which form the basis for the violation of 40 P.S. §1171.5 were denied as the result of claims processing errors. In each of these six instances, the Company authorized the requested substance abuse treatment services; however, the authorizations were subsequently mismatched during claims processing. The Company has corrected the circumstances that gave rise to these claims processing errors.

2. **The Company must review and revise internal control procedures to ensure compliance with requirements of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.**

   Keystone Health Plan Central accepts this recommendation. The Company has implemented a detailed protocol for Magellan Behavior Health to follow to ensure ongoing compliance with the cited statute and regulation.

3. **The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P. S. §991.2166), relating to prompt payment of provider claims.**

   Keystone Health Plan Central accepts this recommendation. The Company believes that it has a well-earned reputation for prompt and accurate processing and payment of provider claims. Subsequent to the experience period covered by this examination, the Company implemented enhancements to its claims processing procedures. These improvements will help to ensure compliance with the applicable requirements.

4. **The Company must review and revise internal control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.**

   Keystone Health Plan Central accepts this recommendation and has revised its prompt payment interest procedures to ensure compliance with the cited statute. Within sixty days of the Report issue date, Keystone Health Plan Central will provide proof of interest payment on the claims at issue.

5. **The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Section 154.18, related to timely interest payments on clean claims paid over 45 days.**

   Keystone Health Plan Central accepts this recommendation and has revised its interest payment procedures to ensure compliance with the cited regulation.

6. **Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of payment on the claims noted in the examination for improper denial.**

   Within sixty days of the Report issue date, Keystone Health Plan Central will provide proof of payment on any unpaid claims at issue.

* * * * *

Thank you for your consideration of this matter and for providing us with this opportunity to respond to the Report. Thank you, too, for the courtesies extended by Mr. Jones and the other examiners throughout the course of this examination.

Very truly yours,

Glenn P. Heisey