REPORT OF
MARKET CONDUCT EXAMINATION
OF

KEYSTONE HEALTH PLAN WEST, INC.
Pittsburgh, Pennsylvania

AS OF
February 25, 2009

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT

Issued: March 31, 2009

KEYSTONE HEALTH PLAN WEST, INC.

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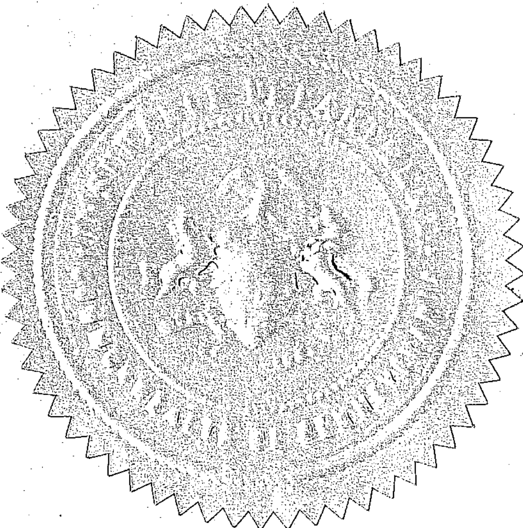
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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

Keystone Health Plan West, Inc.
Market Conduct Examination as of the
close of business on February 25, 2009

Docket No.
MC09-03-023

ORDER

A market conduct examination of Keystone Health Plan West, Inc. (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. §323.1, et seq., for the period January 1, 2006 through December 31, 2006. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices. Based on the documentation and information submitted by Respondent, the Department is satisfied that Respondent has taken corrective measures pursuant to the recommendations of the Examination Report.

It is hereby ordered as follows:

1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.

2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with all recommendations contained in the attached Report.

4. 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.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. §323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: The Pennsylvania Insurance Department

Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Keystone Health Plan West, Inc.; hereafter referred to as "Company," at the Company's office located in Camp Hill, May 19, 2008, through August 22, 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.

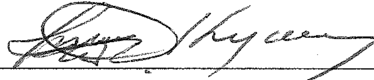
Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Frank Kyazze, AIE, FLMI, ALHC, MCM
Market Conduct Examiner

Michael T. Vogel, MCM
Market Conduct Examiner

Verification

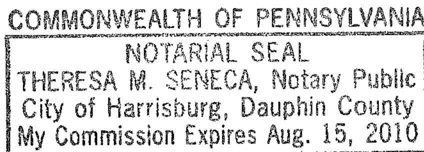
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



Frank W. Kyazze, MCM, AIE, ALHC, FLMI
[Examiner in Charge]

Sworn to and Subscribed Before me

This 23 Day of , 2009



Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
THERESA M. SENECA, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires Aug. 15, 2010

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, 2006, through December 31, 2006, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations concerning the mandated benefits for Alcohol and Substance Abuse and Mental Illness. Additionally, the examination targeted compliance with group termination and conversion statutes and regulations.

The examination focused on the Company's operation in areas such as: Forms, Underwriting Practices and Procedures and Claim Handling Practices and Procedures.

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 West, Inc. (KHPW) was incorporated in 1985, as a for profit corporation for the purpose of operating as a health maintenance organization (HMO). A joint Certificate of Authority was issued by the Pennsylvania Department of Insurance and the Pennsylvania Department of Health, effective December 31, 1986. KHPW was federally qualified as an HMO on August 25, 1987. KHPW is a wholly-owned subsidiary of Highmark Inc., a Pennsylvania non-profit corporation.

The Company's current service area consists of the following 29 counties in Western Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Centre, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland. Current lines of business include HMO group commercial (Keystone Blue), HMO individual (Keystone Blue) and Medicare Advantage (SecurityBlue). The SecurityBlue product is offered in seventeen (17) of the twenty-nine (29) counties.

KHPW received a three-year accreditation from the National Committee for Quality Assurance, effective June, 2006. KHPW is currently preparing for renewal of this accreditation, which is anticipated to occur in May, 2009.

KHPW's total Pennsylvania earned premium, as reported in their 2006 annual statement was $2,409,786,482. The total annual member months was reported as 3,774,967.

IV. FORMS

The Company was requested to provide a list and copies of all individual and group policy/certificate forms and conversion contracts used during the experience period in Pennsylvania. The forms provided were reviewed to ensure compliance with pertinent state insurance laws and regulations including, but not limited to: Insurance Company Law, Section 354; Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Warning Notice; 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, contracts were reviewed for inclusion of the following state mandated coverages:

- Alcohol/Substance Abuse
- Conversion
- Chemotherapy/Cancer Hormone Treatment
- Childhood Immunizations
- Dependent Children
- Diabetic Supplies and Education
- Emergency Reimbursement
- Gynecological Examination/Pap Smear
- Mammography Screenings
- Mastectomy/Reconstructive Surgery
- Maternity
- Medical/Nutritional Foods
- New Born Children
- Physically Handicapped/Mental Retarded Child

No violations were noted.

V. UNDERWRITING

The Underwriting review was sorted and conducted in three (3) general segments.

A. Group Policies Terminated
B. Group Certificates Terminated
C. Group Conversions

Each segment was reviewed for compliance with underwriting practices and procedures and applicable issuance, conversion and underwriting statutes and regulations.

A. Group Policies Terminated

The Company was requested to provide a list of all group policies terminated during the experience period of January 1, 2007, through December 31, 2007. The Company identified a universe of 212 group policies terminated. A random sample of 25 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

B. Group Certificates Terminated

The Company was requested to provide a list of all Pennsylvania residents holding a certificate of coverage terminated during the experience period of January 1, 2007, through December 31, 2007. The Company identified a universe of 74,646 group certificates terminated. A random sample of 50 certificate files was requested, received and reviewed. The files were reviewed to ensure that terminations were not the result of any discriminatory underwriting practice and that the certificate holders were provided the required notice of conversion to an individual plan of coverage. No violations were noted.

C. Group Conversions

The Company was requested to provide a list of all applications for conversion of group coverage to individual coverage for the experience period of January 1, 2007, through December 31, 2007. The Company identified a universe of 986 certificate holders converting their group health coverage upon termination to an optional individual plan. A random sample of 25 conversion files was requested, received and reviewed. The files were reviewed to determine compliance to applicable issuance, conversion and underwriting statutes and regulations. No violations were noted.

VI. 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 Company provided the following documentation for review:

1. Educational Material Manuals
2. County Access Guidelines – Behavioral Health Services
3. Alcohol and Drug Claims Guidelines
4. Mental Illness Claims Guidelines
5. Psychiatric /Psychological Guidelines
6. Alcohol and Drug Rehabilitation Guidelines
7. Behavioral Health Services Guidelines
8. Accumulator Descriptor Codes
9. Bulletin Releases
10. Network Provider News
11. MTM Direct Measures Guide – Claims Accuracy Audit/Quality Procedures

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 2 areas:

A. Mental Health Claims Denied
B. Alcohol and Drug Services 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 635.1 of the Insurance Company Law (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Mental Health Claims Denied

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2006, to December 31, 2006, for mental illness claims. The Company identified a universe of 1,561 claims denied. From the original universe, the Department extracted files that had denial codes that were considered most susceptible for non-compliance with the Mental Illness mandated benefit. The extracted universe of denied claims was 291 claims. Of the 291 denied claims, a random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

2 Violations - Insurance Company Law, 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 2 claims noted were not paid within the required 45 days.

B. Alcohol and Drug Services Denied

The Company was requested to provide a list of all services denied during the experience period of January 1, 2005, to December 31, 2006, for alcohol and drug rehabilitation services. The Company identified a universe of 3,048 alcohol and drug services denied in calendar year 2005, and 541 alcohol and drug services denied in calendar year 2006. From the original universe of services denied for 2005 and 2006, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied services for 2005 was 327 and for 2006, the extracted universe was 171. Of the 327 denied services for 2005, and the 171 denied services for 2006, 25 files for each year were randomly requested, received and reviewed. The files were reviewed to ensure that the Company's adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

3 Violations - Insurance Company Law, 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 3 clean claims noted were not paid within the required 45 days.

1 Violation - Insurance Company Law, 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 interest due on the noted claim was not paid when due.

CONCERN:

The Department is concerned that in a sample of 50 denied claims, seven claims submitted by the Department of Public Welfare (DPW) for reimbursement were denied for not being provided by a contracted provider. Although a procedure for submission by the DPW is in place to identify these claims under a certain provider code, the procedure should be reviewed, revised and clarified in order to prevent delays in the reimbursement of these claims.

VII. 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 requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

2. The Company must review 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 30 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claim noted in the examination.

3. The Company must review claim procedures to ensure claims submitted for reimbursement by the DPW are processed efficiently and expeditiously. Within 30 days of the Report issue date, the Company must provide to the Insurance Department proof of claim disposition on the seven claims noted in the examination.

VIII. COMPANY RESPONSE

March 23, 2009

Daniel A. Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief
Office of Market Regulation
Bureau of Market Conduct – Life and Health Division
1227 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 07-M27-059

Dear Mr. Stemcosky:

We hereby acknowledge receipt of the certified Report of Examination of Keystone Health Plan West, Inc., made as of the close of business December 31, 2007.

The attached Exhibit A contains our responses to your Recommendation on page 14 of the report.

Sincerely,

Elizabeth A. Farbacher
Senior Vice President & Chief Audit Executive

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Fifth Avenue Place • 120 Fifth Avenue • Pittsburgh PA 15222-3099
www.highmark.com

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association
LHP-035 (R1-05)

Attachment A

Report of Examination
PA Market Conduct Study – Keystone Health Plan West, Inc.
As of December 31, 2008
Responses to Recommendations

Current Examination

1. The Company must review 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.

   Response from KHPW, Inc.: It should be noted that the Company continually monitors claims inventory to less than 45 days by utilizing aging reports that show inventory of unprocessed claims by claim receipt date. Claims are presented to staff for handling in age order to ensure that claims will be finalized within the 45 day time frame. The Company also shifts resources within areas to manage inventories that have increased or aged. The company will continue to utilize these methods to ensure compliance with Section 2166 of the Insurance Company Law of 1921 (40P.S. §991.2166).

   The 5 claims noted as violations in the audit report were incorrectly finalized resulting in denials when the claims were initially processed. These claims were finalized within 45 days of receipt, consistent with our normal business practice of managing the claims inventory to finalize all claims within 45 days of receipt. The fact that these claims should have been paid, rather than denied, became known only pursuant to this examination, so the routine process and controls used to ensure compliance with Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims, would not apply. Upon determination that these claims had been finalized in error, adjustments were initiated and the claims, with interest, have been paid.

2. The Company must review internal control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40P.S. §991.2166). Within 30 days of the report issue date, the Company must provide to the Insurance Department proof of interest payment on the claim noted in the examination.

   Response from KHPW, Inc.: The Company has an automated process to calculate and pay interest on claims that are not paid timely. The claim identified as a violation in this examination was actually an adjustment to a previously processed claim. When the original claim was corrected, manual intervention caused the interest payment to not be generated. This error was immediately identified, and a new claim mirroring the original

was created in order to generate both the payment and the interest due. Proof of payment was forwarded to the Insurance Department on January 13, 2009.

3. The Company must review claim procedures to ensure claims submitted for reimbursement by the DPW are processed efficiently and expeditiously. Within 30 days of the Report issue date, the Company must provide to the Insurance Department proof of claim disposition on the seven claims noted in the examination.

   Response from KHPW, Inc.: The process to handle claims from the DPW changed effective April 2007. Under the new process, the DPW has access to validate coverage status with the Company to determine if an individual has active coverage at the time services are rendered. The DPW has agreed to send requests for reimbursement to the Company only after the data match validating active coverage occurred. This process should ensure that only eligible participant claims will be received which will expedite processing. The Company will provide proof of claim disposition on the seven claims noted in the examination within 30 days of the Report issue date. Please note that after further research, it has been determined that the seven claims in question will not generate reimbursement to the DPW as the services are either not covered under the benefit contracts or the member did not have active coverage with the Company on the date the services were provided.