

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

CAPITAL BLUE CROSS
Harrisburg, Pennsylvania

AS OF
January 21, 2009

COMMONWEALTH OF PENNSYLVANIA



INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT

Issued: March 19, 2009

CAPITAL BLUE CROSS

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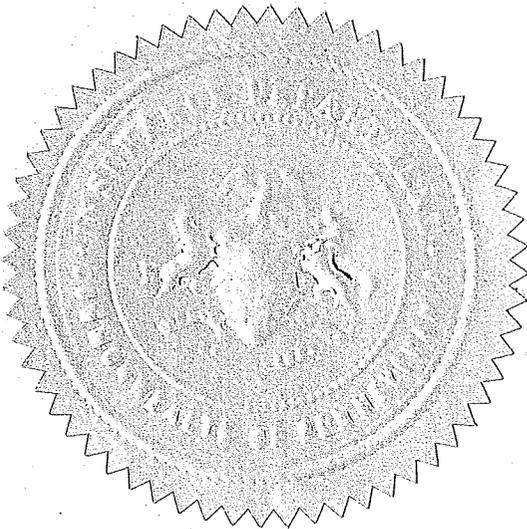
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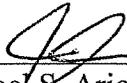
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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:
	:	
CAPITAL BLUE CROSS	:	Sections 354, 602-A, 2166(A) and
2500 Elmerton Avenue	:	2166(B) of the Insurance Company
Harrisburg, PA 17110	:	Law, Act of May 17, 1921, P.L. 682,
	:	No. 284 (40 P.S. § 477b, 908-2 and
	:	991.2166)
	:	
	:	Section 3(A) of the Health and
	:	Accident Reform Act, No. 159 (40
	:	P.S. §3803)
	:	
	:	Title 31, Pennsylvania Code, Sections
	:	89.612, 89.784, 154.18(c), 146.5,
	:	146.6 and 146.7
	:	
	:	Title 18, Pennsylvania Consolidated
	:	Statutes, Section 4117k
	:	
Respondent.	:	Docket No. MC09-02-034

CONSENT ORDER

AND NOW, this *19th* day of *MARCH*, 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 Capital Blue Cross, and maintains its address at 2500 Elmerton Avenue, Harrisburg, Pennsylvania 17110.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 to December 31, 2006.
- (c) On January 21, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on February 20, 2009.
- (e) The Examination Report notes violations of the following:

- (i) Section 354 of the Insurance Company Law (40 P.S. § 477b), which prohibits issuing, selling, or disposing of any policy, contract or certificate until the forms have been submitted to, and formally approved by, the Insurance Commissioner;

- (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) 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;

- (iv) Section 2166(B) of Act 68 (40 P.S. § 991.2166), which provides requires that if a licensed insurer or 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;

- (v) Section 3(A) of Act 159 (40 P.S. § 3803(a)), which requires each insurer and HMO to file with the Department any form which it proposes to issue in this Commonwealth;

- (vi) Title 31, Pennsylvania Code, Section 89.612, which states: (a) Non-hospital, residential 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 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; and (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) (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;

- (vii) Title 31, Pennsylvania Code, Section 89.784, states application forms shall include the following requirements and questions designed to elicit

information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used;

(viii) 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;

(ix) 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;

(x) Title 31, Pennsylvania Code, Section 146.6 states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the

insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;

- (xi) 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; and
- (xii) Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), which requires all applications for insurance and all claim forms shall contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties”.

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.
- (c) Respondent's violations of Section 354 of the Insurance Company Law, No. 284 (40 P.S. §477b) are punishable by the following, under 40 P.S. § 625-10: Upon determination by hearing that this act has been violated, the commissioner may issue a cease and desist order, suspend, revoke or refuse to renew the license, or impose a civil penalty of not more than \$5,000 per violation.
- (d) Respondent's violations of Sections 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2166), and Title 31, Pennsylvania Code, Section 154.18(c), are punishable under Section 2182 of Act 68, which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.
- (e) Respondent's violations of Section 3(A) of the Health and Accident Reform Act, No. 159 (40 P.S. § 3803) are punishable under Section 13 of the Act:
- (i) suspension or revocation of the license of the offending insurer or HMO;
 - (ii) refusal, for a period not to exceed one year, to issue a new license to the offending insurer or HMO;
 - (iii) a fine of not more than \$5,000 for each violation of this Act;

- (iv) a fine of not more than \$10,000 for each willful violation of this Act;
- (v) a fine of not more than \$25,000 for each willful violation of Section 6.

(f) Respondent's violations of Title 31, Pennsylvania Code, Sections 89.612 and 89.784, are punishable under Section 354 of the Insurance Company Law (40 P.S. § 477b) by suspension or revocation of the license(s) of Respondent; refusal, for a period not to exceed one year thereafter, to issue a new license to Respondent; or imposition of a fine of not more than one \$1,000.00 for each act in violation of the Act.

(g) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5, 146.6 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.

(h) 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 Twenty-Five Thousand Dollars (\$25,000.00) 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 Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of Bureau of Market Conduct, 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.

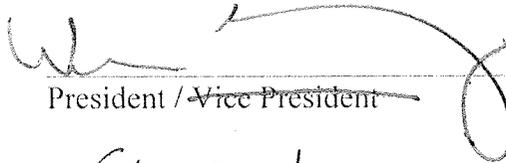
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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.

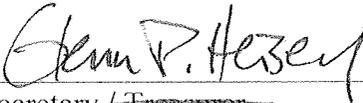
11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law

contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: CAPITAL BLUE CROSS, 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 Capital Blue Cross; hereafter referred to as "Company," at the Company's office located in Harrisburg, Pennsylvania, November 28, 2007, through April 11, 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

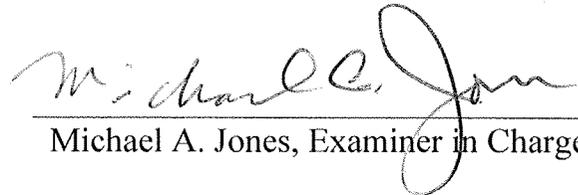
Gerald P. O'Hara Jr.
Market Conduct Examiner

Michael T. Vogel, MCM
Market Conduct Examiner

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

Verification

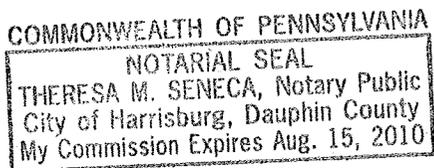
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).


Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This *21* Day of *January*, 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, 2006, 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: Advertising, Consumer Complaints, 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

Capital Blue Cross was incorporated under the laws of Pennsylvania on September 1937, as a non-profit hospital plan and commenced business in Pennsylvania on February 24, 1938. Prior to 2002, Capital Blue Cross worked with Pennsylvania Blue Shield to provide health coverage options within the Capital Blue Cross service area.

In 2002, Capital Blue Cross moved forward as a fully integrated and independent provider of a variety of health care coverage services and products to individuals and group customers. The Capital Blue Cross service area consists of the twenty-one counties of Central Pennsylvania and the Lehigh Valley.

Capital Blue Cross, headquartered in Harrisburg, Pennsylvania, is one of the area's largest employers, with more than 2,300 employees.

A Certificate of Authority was granted by the Insurance Commissioner on February 24, 1938, to establish, maintain and operate throughout the Commonwealth of Pennsylvania a Non-Profit Hospital Plan whereby hospitalization may be provided in accordance with and subject to the provision of the Non-Profit Corporation Act of 1933, P.L. 289 as amended by The Act of June 21, 1937, P.L. 198.

The Company's total Pennsylvania health premiums earned, as reported in their 2007 Annual Statement, was \$199,381,752. The total annual member months was reported as 1,544,504.

IV. ADVERTISING

Title 31, Pennsylvania Code, Section 51.2(c) provides that “Any advertisements, whether or not actually filed or required to be filed with the Department under the provisions of this Regulation may be reviewed at any time at the discretion of the Department.” The Department, in exercising its discretionary authority for reviewing advertising, requested the Company to provide a copy of the advertising certificate of compliance as required by Title 31, Pennsylvania Code, Section 51.5. No violations were noted.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354 and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud notice.

2 Violations – Title 18, Pennsylvania Consolidated Statutes, Section 4117(k)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: “Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.”

The application and health statement did not contain or have attached the required fraud statement in the 2 files noted.

23 Violations - Insurance Company Law, Section 354 (40 P.S. §477b)

It shall be unlawful for any insurance company, association, or exchange, including domestic mutual fire insurance companies, doing business in this Commonwealth, to issue, sell, or dispose of any policy, contract, or certificate, covering life, health, accident, personal liability, fire, marine, title, and all forms of casualty insurance or contracts pertaining to pure endowments or annuities, or any other contracts of insurance, or use applications, riders, or endorsements, in connection therewith, until

the forms of the same have been submitted to and formally approved by the Insurance Commissioner.

Evidence of Department's approval could not be established for the forms noted. The application form description and frequency of use is listed in the table below.

Form #	Description	Frequency Of Use
C-129 (11/2003)	Supplemental Application	4
C-129 (4/2002)	Supplemental Application	3
C-83 (3/2005)**	Notice Security Replace	6
GR-M6-381 indd (10/13/05)	Medigap Replace Notice	4
C-129 (11/2002)	Supplemental Application	1
C-129 (7/2005)	Supplemental Application	1
C-98 (9/2005)	Ind. Conversion Application	4

**23 Violations - Accident and Health Filing Reform Act, No. 159, Section 3(A)
(40 P.S. §3803)**

Each insurer and HMO shall file with the Department any form which it proposes to issue in this Commonwealth except a type or kind of form which, in the opinion of the Commissioner, does not require filing.

Verification of Department form filing could not be verified for the forms noted. The application form description and frequency of use is listed in the table below.

Form #	Description	Frequency Of Use
C-128 (5/2003)	Supplement Agreement	4
C-99 (6/2005)	Individual Application	14
C-128 (4/2002)	Supplement Agreement	4
C-99 (9/2002)	Individual Application	1

VI. PRODUCER LICENSING

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of or as a representative of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all producer terminations to the Department.

The Company provided a list of 3,342 active and terminated producers. A random sample of 100 producers was requested, received and reviewed. The list was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on producers identified on applications reviewed in the policy issued sections of the exam. No violations were noted.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2002, 2003, 2004 and 2005. The Company identified 1,323 consumer complaints received during the experience period. A random sample of 25 complaint files was requested, received and reviewed. The Company also provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices. No violations were noted.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in seven (7) general segments.

- A. Underwriting Guidelines
- B. Group Policies Issued
- C. Group Policies Terminated
- D. Group Certificates Terminated
- E. Group Conversions
- F. Individual Policies Issued
- G. Individual Long Term Care Policies Terminated

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Underwriting Guidelines

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following is a list of Underwriting Guidelines received and reviewed:

Underwriting Guidelines

- 2006 Compliance Booklet
- FAQ
- Cancellation e-mail Procedures
- Sun Group Pricing 2006
- Marketing Alert (Participation Requirement 2-19 Segment)
- Marketing Alert (Pricing Change Small Groups)

B. Group Policies Issued

The Company was requested to provide a list of all group policies issued during the experience period. The Company identified 7,930 group policies issued. A random sample of 25 policy files was requested, received and reviewed. The files were reviewed to determine compliance to issuance statutes and regulations. No violations were noted.

C. Group Policies Terminated

The Company was requested to provide a list of all group policies terminated during the experience period. The Company identified a universe of 7,056 group policies terminated. A random sample of 25 policy files was requested, received and reviewed. The 25 files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and the proper return of any unearned premium. No violations were noted.

D. Group Certificates Terminated

The Company was requested to provide a list of all policies declined during the experience period. The Company identified 7 group certificates terminated. All 7 files were requested, received and reviewed. The files were reviewed to ensure that the terminations were not the result of any discriminatory underwriting practice. No violations were noted.

E. Group Conversions

The Company was requested to provide a list of all certificate holders converting group health insurance during the experience period. The Company identified a universe of 3,321 group conversions. A random sample of 25 group conversion files was requested, received and reviewed. The files were reviewed to determine compliance to applicable issuance, conversion and underwriting statutes and regulations. The following violations were noted:

8 Violations - Title 31, Pennsylvania Code, Section 89.784.

Requirements for application forms and replacement coverage. Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used.

The Security Replacement Notice document in the 8 files noted was not in compliance with this regulation.

F. Individual Policies Issued

The Company was requested to provide a list of all policies issued during the experience period. The Company identified a list of 1,065 individual health policies issued. A random sample of 25 policy files was requested, received and reviewed. The files were reviewed to determine compliance to issuance, underwriting, and replacement statutes and regulations. No violations were noted.

G. Individual Long Term Care Policies Terminated

The Company was requested to identify all individual health policies terminated during the experience period. The Company identified 30 individual long term care policies terminated. A random sample of 10 terminated files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and the proper return of any unearned premium. No violations were noted.

IX. 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 16 areas:

- A. Traditional Provider Submitted Claims Finalized
- B. Medicare Supplement Provider Submitted Claims Finalized
- C. Traditional Provider Submitted Emergency Claims Finalized
- D. Medicare Supplement Provider Submitted Emergency Claims Finalized
- E. Long Term Care Claims Finalized
- F. Traditional Denied Claims
- G. Medicare Supplement Denied Claims
- H. Traditional Clean Claims Paid Over 45 Days
- I. Medicare Supplement Clean Claims Paid Over 45 Days
- J. Traditional Emergency Clean Claims Paid Over 45 Days
- K. Medicare Supplement Emergency Clean Claims Paid Over 45 Days
- L. Traditional Alcohol and Drug Denied Claims
- M. Traditional Alcohol and Drug Services Denied
- N. Medicare Supplement Alcohol and Drug Claims Denied
- O. Traditional Alcohol and Drug Claims Paid
- P. Medical Supplement Alcohol and Drug Claims Paid

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Traditional Provider Submitted Claims Finalized

The Company was requested to provide a list of claims finalized during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 186,451 traditional provider submitted claims. A random sample of 25 claim files was 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, and other pertinent state laws and regulations. No violations were noted.

B. Medicare Supplement Provider Submitted Claims Finalized

The Company was requested to provide a list of all claims received during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 283,813 Medicare supplement provider submitted emergency claims finalized during the experience period. A random sample of 25 claims 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, and other pertinent state insurance laws and regulations. No violations were noted.

C. Traditional Provider Submitted Emergency Claims Finalized

The Company was requested to provide a list of all claims received during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 3,549 traditional provider submitted emergency claims finalized. A random sample of 25 claim files was 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, and other pertinent state insurance laws and regulations. No violations were noted.

D. Medicare Supplement Provider Submitted Emergency Claims Finalized

The Company was requested to provide a list of all claims received during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 4,171 Medicare supplement provider submitted emergency claims finalized. A random sample of 25 claim files was 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, and other pertinent state insurance laws and regulations. No violations were noted.

E. Long Term Care Claims Finalized

The Company was requested to provide a list of all claims received during the experience period. The Company identified a universe of 40 long-term care claims received. All 40 claim files were requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

14 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 14 claims noted within 10 working days.

1 Violation - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

The Company failed to provide the status letter in the claim file noted.

3 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 for the 3 claim files noted.

F. Traditional Denied Claims

The Company was requested to provide a list of all claims denied during the experience period. The Company identified a universe of 63,392 traditional denied claims. A random sample of 75 claim files was requested, received and reviewed. The files were reviewed to ensure compliance with pertinent state insurance laws and regulations, and that the Company's claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

2 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 on the 2 claims noted in the amount of \$141.54 was not paid within 30 days of the payment date.

3 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 45 days of receipt.

G. Medicare Supplement Denied Claims

The Company was requested to provide a list of all claims denied during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 102,165 Medicare supplement 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, and that the Company was in compliance with Pennsylvania insurance laws and regulations. No violations were noted.

H. Traditional Clean Claims Paid Over 45 Days

The Company was requested to provide a list of traditional clean claims paid over 45 days during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 9,466 claims. A random sample of 50 claims 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. The following violations were noted:

7 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 7 clean claims noted were not paid within 45 days of receipt.

I. Medicare Supplement Clean Claims Paid Over 45 Days

The Company was requested to provide a list of Medicare supplement clean claims paid over 45 days during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 6,784 claims. A random sample of 25 claims 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 and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

8 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 8 clean claims noted were not paid within 45 days of receipt.

2 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 2 claims noted in the amount of \$6.88 was not paid as required.

J. Traditional Emergency Clean Claims Paid Over 45 Days

The Company was requested to provide a list of traditional emergency clean claims paid over 45 days during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 390 traditional emergency clean claims. A random sample of 25 claims 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 and Title 31 Section 146. The following violations were noted:

6 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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.

K. Medicare Supplement Emergency Clean Claim Paid Over 45 Days

The Company was requested to provide a list of Medicare Supplement Emergency Clean Claims Paid over 45 days during the experience period. The Company identified a universe of 119 claims. A random sample of 25 claims 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 and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

10 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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.

L. Traditional Alcohol and Drug Denied Claims

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 1,035 alcohol and drug denied claims. A random sample of 100 claims was requested, received and reviewed. The claim files were reviewed to ensure compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b) and Section 602-A of the Insurance Company Law (40 P.S. §908-2). The following violations were noted.

14 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 14 clean claims noted were not paid within 45 days of receipt.

8 Violations – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 in the amount of \$48.23 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.

The interest payment on the 8 claims noted was not paid within 30 days of the claim payment.

M. Traditional Alcohol and Drug Services Denied

The Company was requested to provide a list of traditional alcohol and drug services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 2 alcohol and drug request for services that were denied. Both claim 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 Commonwealth Laws does include the specific provision of coverage for alcohol or other drug abuse and dependency benefits. These denied services are subject to provisions set forth in Section 602-A of the Insurance Company Law (40 P.S. §§ 908-1-908-8) as well as other pertinent state laws and regulations. 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.

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 requests for service is not in compliance with this mandated benefit for the 2 claims noted.

2 Violations - Title 31, Pennsylvania Code § 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.

Failure to provide coverage for the services which were requesting eligibility for drug and/or alcohol use and dependency coverage does constitutes a violation of the Pennsylvania Code Minimum Covered Services for Non-hospital, residential alcohol treatment in the 2 claims noted.

N. Medicare Supplement Alcohol and Drug Claims Denied

The Company was requested to provide a list of claims denied during the experience period. The Company identified a universe of 81 Medicare supplement alcohol and drug claims denied. A random sample of 25 claims 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. No violations noted.

O. Traditional Alcohol and Drug Claims Paid

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 3,039 traditional alcohol drug claims paid. A random sample of 50 claims were requested, received and reviewed. 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 and for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

1 Violation – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 clean claim noted was not paid within 45 days of receipt.

P. Medicare Supplement Alcohol and Drug Claims Paid

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 189 medical supplement alcohol drug claims paid. A random sample of 25 claims was requested, received and reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violation was noted:

1 Violation – Insurance Company Law, Section 2166 (40 P.S. §991.2166)

Prompt Payment of 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 clean claim noted was not paid within 45 days of receipt.

X. 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 and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
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 30 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. The Company must review internal control procedures to ensure compliance with forms filing and approval requirements of Section 354 of the Insurance Company Law of 1921 (40 P.S. §477b) and Accident and Health Filing Reform Act, No. 159, Section 3A (40 P.S. §3803).

7. The Company must review and revise internal control procedures to ensure compliance with replacement notice requirements of Title 31, Pennsylvania Code, Section 89.784.
8. The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes Section 4117(k).

XI. COMPANY RESPONSE



Capital BlueCross

Glenn P. Heisey
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February 19, 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: 06-M25-046
Response to Report of Examination of Capital BlueCross**

Dear Mr. Stemcosky:

On behalf of Capital BlueCross, please allow this letter to serve as our response to the Report of Market Conduct Examination Warrant Number 06-M25-046 (the Report), which was received with your cover letter dated January 21, 2009. We have reviewed the Report and respectfully submit this response.

Our responses addressing the Department's eight recommendations beginning on page 30 of the Report follow:

- 1. The Company must review and revise internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.**

Capital BlueCross accepts this recommendation. Capital BlueCross has discussed the Department's concerns with MedAmerica, the third party engaged by Capital BlueCross to administer the long term care claims payment process. Capital BlueCross will continue to monitor MedAmerica's compliance with the cited regulation.

- 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.**

Capital BlueCross accepts this recommendation. Capital BlueCross has put in place 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.**

Capital BlueCross accepts this recommendation. Capital BlueCross believes that it has a well-earned reputation for prompt and accurate processing and payment of provider claims. Nevertheless, we continue to strive for improvements, and we are reviewing our claims procedures with regard to the cited statute.

- 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 30 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.**

Capital BlueCross accepts this recommendation and has revised its prompt payment interest procedures to ensure compliance with the cited statute. Within thirty days of the Report issue date Capital BlueCross 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.**

Capital BlueCross accepts this recommendation and has revised its interest payment procedures to ensure compliance with the cited regulation.

- 6. The Company must review and revise internal control procedures to ensure compliance with forms filing and approval requirements of Section 354 of the Insurance Company Law of 1921 (40 P. S. §477b) and Accident and Health Filing Reform Act, No. 159, Section 3A (40 P.S. §3803).**

Capital BlueCross accepts this recommendation. The forms cited by the Department are either obsolete and no longer in use, or the current version of the forms comply with the filing and approval requirements of the applicable statutes. We have revised our internal control procedures to ensure that, in the case of

forms that require Department approval, revised forms are filed with the Department for review and approval.

7. **The Company must review and revise internal control procedures to ensure compliance with replacement notice requirements of Title 31, Pennsylvania Code, Section 89.784.**

Capital BlueCross accepts this recommendation. The cited regulation applies to forms used in conjunction with Medicare Supplemental coverage. Capital BlueCross has Department approval for the Security Replacement Notice currently in use. Capital BlueCross has revised its internal control procedures to ensure ongoing compliance.

8. **The Company must implement procedures to ensure compliance with the fraud statement notice requirements of Title 18, Pennsylvania Consolidated Statutes Section 4117(k).**

Capital BlueCross accepts this recommendation. Capital BlueCross no longer uses the two forms that gave rise to the cited violations. In addition, we have reviewed all member enrollment forms to confirm that they contain the required fraud statement notice requirements.

* * * * *

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