REPORT OF
MARKET CONDUCT EXAMINATION
OF

FIRST PRIORITY LIFE
INSURANCE COMPANY
Wilkes-Barre, PA

AS OF
December 13, 2010

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: February 1, 2011

FIRST PRIORITY LIFE INSURANCE COMPANY

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 24 day of January, 2011, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.

Michael F. Consedine
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
FIRST PRIORITY LIFE	:	Section 2166(A) of Act 68 of 1998
INSURANCE COMPANY	:	(40 P.S. §§ 991.2166)
19 North Main Street	:	
Wilkes-Barre, PA 18711-0302	:	Title 31, Pennsylvania Code, Sections
	:	146.5(a), (b), (c) and (d), 146.6 and 146.7
	:	
	:	
Respondent.	:	Docket No. MC11-01- 012

CONSENT ORDER

AND NOW, this 1 day of February, 2011 , 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 First Priority Life Insurance Company and maintains its address at 19 North Main Street, Wilkes-Barre, PA 18711-0302.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2008 to December 31, 2008.

(c) On December 13, 2010, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on January 7, 2011.

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

(i) Section 2166(A) of Act 68 (40 P.S. § 991.2166), which requires a licensed insurer or managed care plan to pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

(ii) Title 31, Pennsylvania Code, Section 146.5(a), which states every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice, unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated;

(iii) Title 31, Pennsylvania Code, Section 146.5(b), which states every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with an adequate response to the inquiry;

(iv) Title 31, Pennsylvania Code, Section 146.5(c), which states an appropriate reply shall be made within ten working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected;

(v) Title 31, Pennsylvania Code, Section 146.5(d), requires an insurer, upon receiving notification of a claim, shall provide within ten working days

necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with policy conditions and reasonable requirements of the insurer;

(vi) 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; and

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

CONCLUSIONS OF LAW

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

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Respondent's violations of Section 2166(A) of Act 68 of 1998 (40 P.S. § 991.2166) are punishable under Section 2182 of Act 68 of 1998 (40 P.S. § 991.2182), which states the Department may impose a penalty of up to five thousand dollars ($5,000.00) for a violation of this article.

(c) Respondent's violations of Sections 146.5(a), (b), (c), (d), 146.6 and 146.7 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 pay Fifty Thousand Dollars ($50,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

(d) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of

Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

(e) After a period of 18 months from the date of this Order, Respondent shall be re-examined to verify corrective actions have been implemented.

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: FIRST PRIORITY LIFE INSURANCE COMPANY, 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 First Priority Life Insurance Company; hereafter referred to as "Company," at the Company's office located in Wilkes-Barre, Pennsylvania, February 8, 2010, through May 13, 2010. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

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

Yonise Roberts Paige
Market Conduct Division Chief

Gary L. Boose, LUTC MCM
Market Conduct Examiner

Lonnie Suggs
Market Conduct Examiner

Frank Kyazze
Market Conduct Examiner

Verification

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

Gary L. Boose, Examiner in Charge

Sworn to and Subscribed Before me

This 13 Day of December , 2010

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
LINDY McMILLEN, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires March 23, 2014

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, 2008, through December 31, 2008, 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.

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

First Priority Life Insurance Company, Inc. was incorporated on July 15, 1997 with the name Eastern American Life Insurance Company, Inc., as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania. The Company was formed primarily to market and administer a non-gatekeeper preferred provider product; however, it could also expand to offer other products authorized for life insurance companies in the future.

The Company filed for and received approval of the fictitious name First Priority Life, effective August 4, 1997.

On December 30, 1997, the Company filed an Amendment to its Articles of Incorporation to change its legal name to First Priority Life Insurance Company, Inc.

Effective August 18, 1998, the Company was issued a Certificate of Authority to issue policies and otherwise transact the business of insurance in the Commonwealth of Pennsylvania under Section 202, subdivision (a), Paragraphs (1) Life and Annuities, and (2) Accident and Health, of the Act of May 17, 1921, as amended, (40 P.S. § 382) in accordance with its Charter and the Laws of the Commonwealth of Pennsylvania.

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

The Company commenced business selling a Preferred Provider Organization (PPO) product, BlueCare Qualified High Deductible, November 6, 2006. The Company is

currently selling both group and individual PPO products and commenced selling an Exclusive Provider Organization (EPO) product in 2008.

The Company's total Pennsylvania earned premium, as reported in its 2008 Annual Statement, was $387,883,743. The total annual member months reported was 1,228,444.

IV. Forms

The Company was requested to provide a list and copies of all individual and group policy/certificate forms used during the experience period. The forms provided were reviewed to ensure compliance with the requirements of 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. No violations were noted.

In addition, contracts were reviewed for inclusion of the following state mandated coverage's.

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

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 Company provided the following information:

1. OSCAR Claims Manual
    - Claims Forms Overview
    - Claim Overview
    - Institutional Claims Processing
    - OSCAR Claim Flow Overview
    - Claims Processing Reference Manuals
    - Professional Claims Processing
    - OSCAR Claims Processing
    - Pennsylvania State Mandates
    - Medical Policies Overview
    - Claims Processing Reference Manuals
    - History Claims
    - Managed Care
    - Return Development Processing
2. Claims Administration – Quality Assurance Program
    - Mission/Purpose/Goals/Objective
    - Audit Scope
    - Roles And Responsibilities
    - Performance Measures
    - Review Process
    - Reporting
3. Claims Processing Daily Updates

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

A. Subscriber Submitted Medical Insurance Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 1,056 subscriber submitted medical claims received. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. The following violations were noted:

15 Violations - Title 31, Pennsylvania Code, Section 146.5 Failure to acknowledge pertinent communications.

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The

Company failed to acknowledge or the Department could not verify that the Company acknowledged a claim within 10 working days for the 15 noted files.

13 Violations - 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 status letters in the 13 noted files.

14 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. The Company failed to provide notice of acceptance or denial within 15 working days in the noted 14 files.

B. Provider Submitted Medical Insurance Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 857,361 claims received. A random sample of 75 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. No violations were noted.

C. Provider Submitted Clean Insurance Claims Over 45 Days

The Company was requested to provide a list of all provider submitted clean claims over 45 days received during the experience period. The Company identified a universe of 879 provider submitted clean claims over 45 days. A random sample of 50 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. The following violations were noted:

46 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The noted 46 clean claims were not paid within 45 days of receipt.

D. Mammography Insurance Claims Denied

The Company was requested to provide a list of mammography claims denied during the experience period. The Company identified a universe of 2,904 mammography claims denied. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

E. Mammography Insurance Claims Denied Less Than 40 years of age

The Company was requested to provide a list of mammography claims denied under age 40 during the experience period. The Company identified a universe of 133 mammography claims denied under age 40. A random sample of 20 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

F. Subscriber Submitted Emergency Room Claims Denied

The Company was requested to provide a list of emergency claims denied during the experience period. The Company originally provided a universe of 18 subscriber submitted emergency claims denied. This universe list included paid and $0.00 claims. The Company indicated that the $0.00 paid claims could be considered denied claims in almost every instance. With that information, the Department extracted all claims that had a $0.00 paid amount and identified them as denied claims. From the new universe of 18 claims, the Department extracted 15 claims that were denied and selected all 15 for the sample. All 15 denied claim files were 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:

3 Violations - 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 status letters for the 3 noted files.

G. Provider Submitted Emergency Room Claims Denied

The Company was requested to provide a list of all provider submitted emergency claims denied during the experience period. The Company originally provided a universe of 46,100 provider submitted emergency claims denied. This universe list included paid and $0.00 claims. The Company indicated that the $0.00 paid claims could be considered denied claims in almost every instance. With that information, the Department extracted all claims with a $0.00 paid amount and identified them as denied claims. From the universe of 46,100 claims, the Department extracted a new universe of 5,203 claims that were denied. From the new universe, a random sample of 100 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company claims adjudication process was adhering to the provisions of the policy contract as well as complying with pertinent state insurance laws and regulations. No violations were noted.

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

XII. COMPANY RESPONSE

BlueCross
of Northeastern Pennsylvania
Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Mark of the Blue Cross and Blue Shield Association

19 North Main Street, Wilkes-Barre, Pennsylvania 18711-0302

January 7, 2011

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

Re: Examination Warrant Number: 09-M24-020
First Priority Life Insurance Company (d/b/a, First Priority Life)

Dear Ms. Paige:

This letter is in response to your report of examination received on December 13, 2010, regarding the Pennsylvania Insurance Department's ("Department's") Market Conduct Examination of First Priority Life Insurance Company (d/b/a, First Priority Life ("FPLIC")) covering the period January 1, 2008, through December 31, 2008 as of the close of business on December 10, 2010.

Thank you for the opportunity to review the Department's report of examination. Enclosed, please find FPLIC's responses to the Department's recommendations contained in the Market Conduct Examination Report.

If you have any questions or require additional information, please contact me at (570) 200-1650 or trish.savitsky@bcnepa.com. Thank you.

Sincerely,

Trish Savitsky

Trish Savitsky, CIPP, CIA
Vice President, Corporate Assurance & Compliance

Cc: Denise S. Cesare, President & Chief Executive Officer
Brian Rinker, Sr. Vice President - Service Operations

Listed below are First Priority Life's responses to the following recommendations noted within 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.***

   First Priority Life Response: The Company acknowledges the Department's recommendation as it relates to *Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.*

   First Priority Life would like to note that the majority of claims noted were a direct result of system issues due to the migration to a new claims processing system during the 2007-2008 timeframe (Oscar). The system issues related to the claims noted have been corrected. Additional education has been and continues to be provided in regards to the importance of proactively testing the current system and any enhancements to ensure that appropriate notice is provided on all claims received.

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

   First Priority Life Response: The Company acknowledges the Department's recommendation as it relates to the prompt payment of claims of *Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.*

   First Priority Life would like to note that the majority of claims noted were a direct result of system issues due to the migration to a new claims processing system during the 2007-2008 timeframe (Oscar). First Priority Life has enhanced its reporting capabilities to ensure accurate tracking of all claims inventory regardless of where the claim is located within the Oscar claims processing system. In addition, First Priority Life has supplemented the claims inventory tracking process with additional reporting functionality and trained both its operational Supervisors and operational Senior Claims Representatives to monitor the aging of claims daily to ensure timely claims processing. We also feel that it is worth noting that for 2008 full year, the Company processed 99.21% of all claims on the Oscar claims processing system within 30 days.