

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

**GEISINGER INDEMNITY INSURANCE
COMPANY**

Danville, Pennsylvania

**AS OF
July 9, 2009**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT**

Issued: September 3, 2009

GEISINGER INDEMNITY INSURANCE COMPANY

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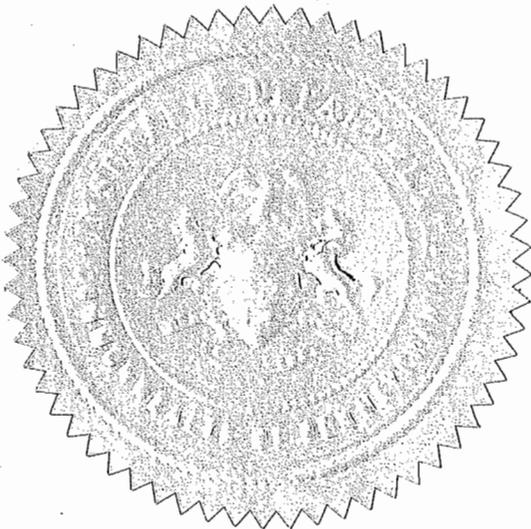
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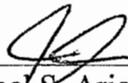
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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:
: :
GEISINGER INDEMNITY : Section 2166(A) of the Act of June 17,
INSURANCE COMPANY : 1998, P.L. 464, No. 68 (40 P.S. §991.2166)
100 North Academy Avenue : :
Danville, PA 17822 : Section 5(b)(c) of the Insurance Company
: Law, No. 150 (40 P.S. §764g)
: :
: Section 602-A of the Insurance Company
: Law, Act of May 17, 1921, P.L. 682 (40
: P.S. § 908-2)
: :
: Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and
: (vi) of the Unfair Insurance Practices Act,
: Act of July 22, 1974, P.L. 589, No. 205
: (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv),
: (v) and (vi))
: :
: Title 31, Pennsylvania Code, Section
: 89.612
: :
Respondent. : Docket No. MC09-08-014

CONSENT ORDER

AND NOW, this 3RD day of SEPTEMBER, 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 Geisinger Indemnity Insurance Company, and maintains its address at 100 North Academy Avenue, Danville, Pennsylvania 17822.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 through December 31, 2006.
- (c) On July 9, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on August 7, 2009.

- (e) After consideration of the August 7, 2009 response, the Insurance Department has modified the Examination Report as attached.

- (f) The Examination Report notes violations of the following:
 - (i) Section 2166(A) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides a licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim;

 - (ii) Section 5(b)(c) of the Insurance Company Law, Act 150 (40 P.S. § 764g), which states this section shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employees: Provided that this section shall not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS supplement, long-term care, disability income, workers' compensation or automobile medical payment.

- (c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:
 - (1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;

 - (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

 - (3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;

(4) cost-sharing arrangements, including, but not limited to, deductibles and co-payments for coverage of serious mental illnesses shall not prohibit access to care. The Department shall set up a method to determine whether any cost-sharing arrangements violate this subsection;

(iii) 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;

(iv) Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) states any of the following acts, if committed or performed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices:

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

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

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

(iv) Refusing to pay claims without conducting a reasonable investigation based

upon all available information;

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

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

(v) 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.

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 (40 P.S. § 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.

- (c) Section 5(b)(c) of the Insurance Company Law, Serious Mental Illness Coverage (40 P.S. § 764g), which requires (c) health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:
 - (1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;
 - (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;
 - (3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses.

(d) Respondent's violations of Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.5) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. § 1171.9):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(e) 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).

- (f) Respondent's violations of Title 31, Pennsylvania Code, Section 89.612 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.

ORDER

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

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Thirty Thousand Dollars (\$30,000.00) to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report.

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

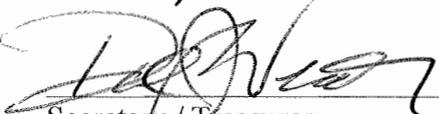
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

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: GEISINGER INDEMNITY 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 Geisinger Indemnity Insurance Company; hereafter referred to as "Company," at the Company's office located in Danville, Pennsylvania, July 28, 2008, through September 1, 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, MCM
Market Conduct Division Chief

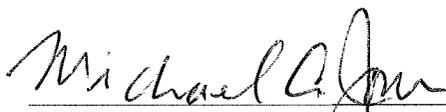
Michael A. Jones
Market Conduct Examiner

Michael T. Vogel, MCM
Market Conduct Examiner

Gerald P. O'Hara, Jr.
Market Conduct Examiner

Verification

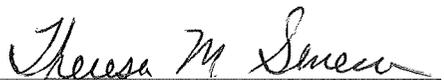
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This *22* Day of *June*, 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, 2005, through December 31, 2006, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

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

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

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

III. COMPANY HISTORY AND LICENSING

The Company was incorporated on May 18, 1995, as Geisinger Indemnity Insurance Company. It was formed as a for-profit domestic insurance corporation pursuant to NILS 15-3101 (15 PA CSA §3101). Funds to capitalize the Company were raised through sale of its stock to Geisinger Health System Foundation. The Company was incorporated with the intent to provide out-of-network and Medicare supplement insurance to be used in conjunction with the HMO product offered by Geisinger Health Plan, an affiliated company.

The Company received its Certificate of Authority to do business on February 29, 1996. On October 1, 1996, the Company enrolled its first policyholder.

On July 1, 1997, Geisinger Health System Foundation merged with Penn State Hershey Medical Center to form the Penn State Geisinger Health Plan. On October 22, 1987, an amendment to the Company's Articles of Incorporation was filed with the Pennsylvania Department of State, changing its name to PSGHS Indemnity Insurance Company, which was approved with an effective date of August 6, 1997. On March 1, 2000, the Company filed an amendment to its Articles of Incorporation to change its name from PSGHS Indemnity Insurance Company to Geisinger Indemnity Insurance Company. On June 30, 2000, the unwinding of the affiliation between Geisinger Health System Foundation and The Pennsylvania State University was completed.

Geisinger Indemnity Insurance Company's total Pennsylvania earned premium, as reported in their 2008 annual statement was \$12,006,405. The total annual member months was reported as 22,762.

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 of 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.

No violations were noted.

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 alcohol and substance abuse and mental illness claims during the experience period. The Company advised that two third party administrators were utilized to administrate their claims for alcohol and drug and mental illness during the experience period. The two vendors were United Behavioral Health (UBH) and Cigna Behavioral Health (CBH). The Company provided the following procedural guidelines and manuals:

1. United Behavioral Health (UBH) Delegation Agreement
2. United Behavioral Health (UBH) Administrative Service Agreement
3. Electronic Data Exchange Agreement
4. Mental Health and Substance Abuse Reinsurance Agreement
5. United Behavioral Health (UBH) Care Advocacy Policies and Procedures (Utilization Management) CD
6. United Behavioral Health (UBH) Care Advocacy Policies and Procedures (Compliance with PA Act 106) CD

The CDs, 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 5 areas:

- A. CBH Alcohol and Drug Claims Denied
- B. UBH Alcohol and Drug Claims Denied
- C. CBH Mental Illness Claims Denied
- D. UBH Mental Illness Claims Denied
- E. CBH 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 5 of the Insurance Company Law, No. 150 (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. CBH Alcohol and Drug Claims Denied

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 120 denied alcohol and drug claims administered by Cigna Behavioral Health (CBH). From the original universe, the Department utilized an audit program and extracted the following denial reasons: No approval or authorization, No authorization/no out-of-network benefits, Not a covered service and Service exceeds number authorization. As a result of the extraction, the new universe was 58 denied claims. All 58 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:

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

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

The 12 clean claims noted were not paid within 45 days of receipt.

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

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

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

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa. B. 4041 dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. The denial of coverage for the 8 claims noted is not in compliance with the requirement for alcohol and substance abuse mandated benefits.

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

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

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

- (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverage's at issue.*
- (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.*
- (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.*
- (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.*
- (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.*
- (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.*

The denial of the 8 claims noted, despite having valid certifications consistent with the Company's procedure guidelines, constitutes a business practice and is in violation of this act.

B. UBH Alcohol and Drug Claims Denied

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 18 denied alcohol and drug claims administered by United Behavioral Health (UBH). All 18 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. No violations were noted.

C. CBH Mental Illness Claims Denied

The Company was requested to provide a list of denied claims finalized during the experience period of January 1, 2005 to June 30, 2006. The Company identified a universe of 423 denied mental illness claims administered by Cigna Behavioral Health (CBH). A random sample of 25 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 insurance state laws and regulations.

As a result of the Company's response and further clarification and documentation of initially noted files, the violations of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166) , Title 31, Pennsylvania Code, Section 154.18, Section 2116 of the Insurance Company Law of 1921 (40 P.S. §991.2116) and Section 5(b)(c) of the Insurance Company Law, No. 150 (40 P.S. §764(g) have been reduced or removed. The following violations remain noted:

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

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 50 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company.

The 2 clean claims noted were not paid within the required 45 days of receipt.

D. UBH Mental Illness Claims Denied

The Company was requested to provide a list of denied claims finalized during the experience period of July 1, 2006 to December 31, 2006. The Company identified a universe of 113 denied mental illness claims administered by United Behavioral Health (UBH). A random sample of 25 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 insurance state laws and regulations. The following violations were noted:

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

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 50 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company.

The 4 clean claims noted were not paid within the required 45 days of receipt.

4 Violations - Insurance Company Law, No. 150, Section 5(b)(c)

(40 P.S. §764g) Coverage for Serious Mental Illnesses

(b) This section shall apply to any health insurance policy offered, issued or renewed on or after the effective date of this section in this Commonwealth to groups of fifty (50) or more employees: Provided that this section shall not include the following policies: accident only, fixed indemnity, limited benefit, credit, dental, vision, specified disease, Medicare supplement, CHAMPUS (Civilian Health and Medical Program for the Uniform Services) supplement, long-term care, disability income, workers' compensation or automobile medical payment.

(c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:

(1) Coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;

(2) A person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

(3) There shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;

(4) Cost-sharing arrangements, including, but not limited to, deductibles and co-payments for coverage of serious mental illnesses shall not prohibit access to care. The department shall set up a method to determine whether any cost-sharing arrangements violate this subsection.

The 4 claims noted were denied inappropriately.

E. CBH Alcohol and Drug Services Denied

The Company was requested to provide a list of alcohol and drug rehabilitative services denied during the experience period of January 1, 2005 to December 31, 2006. The Company identified a universe of 8 denied alcohol and drug rehabilitative services administered by Cigna Behavioral Health (CBH). All 8 denied services 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 insurance state laws and regulations.

As a result of the Company's response and further clarification and documentation of the initially noted file, the violation of Section 2116 of the Insurance Company Law of 1921 (40 P.S. §991.2116) was removed. The following violations remain noted:

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

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

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

And

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

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

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

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

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

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa. B. 4041, dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. However, the location of treatment is subject to the insuring entity's requirements regarding the use of participating providers. The denial of coverage for 2 claims and the reduction of coverage for 3 claims noted are not in compliance with the requirement for alcohol and substance abuse mandated benefits.

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 and revise internal control procedures to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. §908-2) and Title 31, Pennsylvania Code, Chapter 89, Section 89.612 Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.
2. The company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5).
3. The Company must review and revise internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. §764g)
4. 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.
5. The Company must review internal control procedures to ensure the timely payment of interest as required by Section 2166(B) of the Insurance Company Law of 1921 (40 P.S. §991.2166) and Title 31, Pennsylvania Code, Section 154.18.
6. The Company must provide to the Insurance Department within 60 days of the Report issue date, verification of claim payment and interest on the claims noted in the examination that were denied inappropriately.

VIII. COMPANY RESPONSE



FEDEX OVERNIGHT DELIVERY

August 6, 2009

Mr. Daniel A. Stemcosky, AIE, FLMI
Market Conduct Division Chief
Commonwealth of Pennsylvania
Insurance Department
Bureau of Enforcement
Market Conduct Division
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 007-M26-055
Geisinger Indemnity Insurance Company Market Conduct Examination

Dear Mr. Stemcosky:

Geisinger Indemnity Insurance Company (GIIC) has received the Pennsylvania Insurance Department's Report of Examination dated July 9, 2009 and is submitting the attached information in response to the recommendations and findings contained within that report.

In recognition of all of the time and effort put into completing this examination and publishing this report, GIIC would like to thank the Department and its auditors for sharing their observations and allowing us the opportunity to respond and to improve. GIIC takes any and all communications from the Department very seriously and believes that it has appropriately resolved the issues raised by the examination.

Furthermore, GIIC is committed to complying with all laws and regulations and structures its practices to reflect this intention. The report issued by the Department identified instances where the auditors determined our practices did not meet these requirements. For some of these findings, we have outlined in the attached response why we believe that our established practices were in conformity with the laws and regulations. We respectfully submit these explanations to the Department for consideration. In addition, the attached document addresses each recommendation included in the report.

We welcome the opportunity to discuss any of these issues further.

Sincerely,

A handwritten signature in black ink, appearing to read "David J. Weader", is written over the typed name.

David J. Weader
Vice President, Legal Services

Enclosures

VIII. COMPANY RESPONSE

Geisinger Indemnity Insurance Company (the “Company”) submits the following information in response to the final Market Conduct Examination Report of the Company (Examination Warrant Number: 007-M26-055) (the “Final Report”) issued by the Pennsylvania Insurance Department (the “Department”) on July 9, 2009:

V. CLAIMS:

A. CBH Alcohol and Drug Claims Denied

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

Response: The Company respectfully disagrees with the 2 violations pertaining to Samples 1 and 12. The Company’s understanding based on the Department’s comments in the March 30, 2009 Final Summary was that the violations for these samples were pending the Department’s receipt of adjusted payment information associated with these claims. Cigna Behavioral Health (“CBH”), the Company’s behavioral health vendor during the examination period associated with these claims, reprocessed and paid these claims on March 29, 2009. Due to the confidential nature of this claims information, the Company will submit this documentation under separate cover.

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

Response: The Company respectfully disagrees with the 2 violations pertaining to Samples 1 and 12. The Company’s understanding based on the Department’s comments in its March 30, 2009 Final Summary was that the violations for these samples were pending the Department’s receipt of adjusted payment information associated with these claims. CBH reprocessed and paid these claims on March 29, 2009. Due to the confidential nature of this claims information, the Company will submit this documentation under separate cover.

C. CBH Mental Illness Claims Denied

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

Response: The Company respectfully disagrees with the violations noted for Samples 7, 12, 21, 22 and 23 on the grounds that these claims were not clean claims.

With respect to Samples 7 and 23, the Company believes that these claims were properly administratively denied within the required timeframe for lack of out-of-network coverage. The Department has maintained that the providers in question for Sample 7 and

Sample 23 were within the Company's network as contracted providers. However, we respectfully believe that the Department is mistaken. As the Department is aware, during the examination period, the Company contracted with two different behavioral health vendors – CBH from the beginning of the examination period through June 30, 2006; and United Behavioral Health (“UBH”) from July 1, 2006 through the end of the examination period. While the two providers associated with Samples 7 and 23 did not have contracts with CBH during the examination period, these providers were contracted with UBH and would have been listed as part of UBH's provider network. We believe that the Department may have inadvertently associated the UBH participation status of these providers with CHB for the sample claims in questions.

With respect to Samples 12, 21, and 22, the Company continues to maintain that none of the claims were clean claims – all were missing the diagnostic codes necessary for the claims to be initially processed. CBH submitted timely requests to the billing providers for the additional diagnosis information necessary for CBH to process the claims. The Company believes that the Department's reference in its March 30 Final Summary to the inapplicability of the mixed-services protocol is not necessarily correct; CBH needed to see an admitting diagnosis on the provider claim in order to process the claim (and determine the applicability of the mixed services protocol), without that information, the claim could not be considered complete, could not be processed and therefore could not be considered clean. The CBH claims guidelines previously submitted to the Department set forth this requirement. CBH received the admitting diagnostic code from the provider for Sample 12 on 07/24/2006 and timely submitted payment to the provider on 07/28/2006. CBH never received the requested information from the provider for Samples 21 and 22.

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

Response: The Company respectfully disagrees that Sample 12 constitutes a violation of the above referenced provision. As noted above, Sample 12 was missing the diagnostic codes necessary for the claim to be initially processed. CBH submitted timely requests to the billing provider for the additional diagnosis information necessary for CBH to process the claims. CBH received the admitting diagnostic code from the facility for Sample 12 on 07/24/2006 and timely submitted payment to the facility on 07/28/2006. As the Company maintains that claims payment was timely submitted for Sample 12, the Company accordingly believes no late payment interest was due.

1 Violation – Title 31, Pennsylvania Code, Section 154.18(c)

Response: The Company respectfully disagrees that Sample 12 constitutes a violation of the above referenced provision. As noted above, Sample 12 was missing the diagnostic codes necessary for the claim to be initially processed. CBH submitted timely requests to the billing provider for the additional diagnosis information necessary for CBH to process the claims. CBH received the admitting diagnostic code from the facility for Sample 12

on 07/24/2006 and timely submitted payment to the facility on 07/28/2006. As the Company maintains that claims payment was timely submitted for Sample 12, the Company accordingly believes no late payment interest was due.

2 Violations – Insurance Company Law of 1921, Section 2116 (40 P.S. §2116)

Response: The Company respectfully disagrees that Samples 21 and 22 constitute violations of the above referenced provision. Please note that the Company does not dispute that the services in question were emergency room services. Emergency room services can be administered either through a member’s medical benefit or behavioral health benefit; without the presenting diagnosis, however, CBH cannot make a determination as to how the claim should be handled. As noted above, for these Samples, the providers submitted the claims without the presenting diagnosis, which is required by CBH for claims processing, and to determine whether the services in question should be administered under the member’s medical benefit or behavioral health benefit. The providers never provided CBH with the information necessary to process the claims. Accordingly, the Company believes that CBH appropriately denied the claims for missing information and that this action did not result in a violation of the above referenced provision.

3 Violations – Insurance Company Law, No. 150, Section 5(b)(c) (40 P.S. §764(g)), Coverage for Serious Mental Illness

Response: The Company respectfully disagrees with the violations noted for Samples 7, 21, and 23.

As noted above, with respect to Samples 7 and 23, the Company believes that these claims were properly administratively denied within the required timeframe for lack of out-of-network coverage. The Department has maintained that the providers in question for Sample 7 and Sample 23 were within the Company’s network as contracted providers. However, we respectfully believe that the Department is mistaken. As the Department is aware, during the examination period, the Company contracted with two different behavioral health vendors – CBH from the beginning of the examination period through June 30, 2006; and United Behavioral Health (“UBH”) from July 1, 2006 through the end of the examination period. While the two providers associated with Samples 7 and 23 did not have contracts with CBH during the examination period, these providers were contracted with UBH and would have been listed as part of UBH’s provider network. We believe that the Department may have inadvertently associated the UBH participation status of these providers with CHB for the sample claims in questions.

With respect to Sample 21, the Company continues to maintain that the claim did not include all required information, as it was missing the diagnostic codes necessary for the claims to be initially processed. CBH submitted timely requests to the billing provider for the additional diagnosis information necessary for CBH to process the claim. The

Company believes that the Department's reference in its March 30 Final Summary to the inapplicability of the mixed-services protocol is not necessarily correct; CBH needed to see a presenting diagnosis on the provider claim in order to process the claim (and determine the applicability of the mixed services protocol), without that information, the claim could not be considered complete, could not be processed and therefore could not be considered clean. The CBH claims guidelines previously submitted to the Department set forth this requirement. CBH never received the requested information from the provider for this claim.

E. CBH Alcohol and Drug Services Denied

1 Violation - Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166)

Response: While the Company has previously acknowledged this violation, the Company would like to provide the following additional information regarding Sample 1 for the Department's consideration.

When the provider contacted CBH on 05/23/2006, although the member was waiting in the provider's emergency room, the provider was not requesting authorization for emergency services – authorization was requested for an inpatient admission. Based upon the clinical information presented, the participant was clearly stable upon entering the facility and exhibited no need for emergency (i.e. acute inpatient) substance abuse services; accordingly, CBH denied authorization for the inpatient admission. Accordingly, based upon this information, it does not appear that there was a violation of the above referenced provisions.

VII. RECOMMENDATIONS

1. The Company must review and revise internal control procedures to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. § 908-2) and Title 31, Pennsylvania Code, Chapter 89, Section 89.612 Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.

Response: During the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for the Company since July 1, 2006 and administers these benefits currently. CBH administered behavioral health benefits for the Company from the beginning of the examination period until July 1, 2006.

The violations noted in the Department's Final Report regarding these provisions all occurred within the CBH experience period. The Company will continue to monitor its internal control procedures with UBH to ensure continued compliance with the noted statutory and regulatory provisions.

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

Response: As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for the Company since July 1, 2006 and administers these benefits currently. CBH administered behavioral health benefits for the Company from the beginning of the examination period until July 1, 2006.

The Company takes seriously its obligations under the Unfair Insurance Practices Act to ensure that none of its business practices constitute unfair claim settlements. The violations noted in the Department's Final Report regarding these provisions all occurred within the CBH experience period. The Company respectfully disagrees with the two of the violations applicable to these provisions, as noted above in the response under Section A – CBH Alcohol and Substance Abuse Claims Denied.

The Company will continue to monitor and enhance control procedures with UBH on an ongoing basis to ensure continued compliance with the noted regulations.

3. The Company must review and revise internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. § 764g).

Response: As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for the Company since July 1, 2006 and administers these benefits currently. CBH administered behavioral health benefits for the Company from the beginning of the examination period until July 1, 2006.

With respect to the violations from the CBH claims period identified by the Department regarding this provision, the Company respectfully disagrees with the violations, as noted above in the response under Section C – CBH Mental Illness Claims Denied.

With respect to the violations from the UBH claims period identified by the Department regarding this provision, the Company notes that two of the four violations involving clean claims that were not paid within 45 days of receipt were the result of processor errors. The Company has confirmed that UBH conducted internal training regarding these errors, during which the claims and prompt payment requirements were reviewed, and education was provided regarding how to prevent similar types of errors from occurring in the future. Another violation was the result of a provider being listed as a non-participating provider. The issue was corrected prior to the start of the examination and the provider is now correctly identified as a participating provider. The final violation resulted when no authorization was found in the system when the claim was processed. However, the claim was reprocessed and paid with interest once the authorization was received.

The Company will continue to monitor its internal control procedures with UBH to ensure compliance with the noted regulations.

4. 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.

Response: As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for the Company since July 1, 2006 and administers these benefits currently. CBH administered behavioral health benefits for the Company from the beginning of the examination period until July 1, 2006.

With respect to the violations from the CBH claims period identified by the Department regarding this provision, the Company respectfully disagrees with certain of these violations, as specifically noted above in the responses under Section A - CBH Alcohol and Substance Abuse Claims Denied, Section C – CBH Mental Illness Claims Denied and Section E – CBH Alcohol and Substance Abuse Services Denied.

With respect to the violations from the UBH claims period identified by the Department regarding this provision, the Company notes that two of the four violations involving clean claims that were not paid within 45 days of receipt were the result of processor errors. The Company has confirmed that UBH conducted internal training regarding these errors, during which the claims and prompt payment requirements were reviewed, and education was provided regarding how to prevent similar types of errors from occurring in the future. Another violation was the result of a provider being listed as a non-participating provider. The issue was corrected prior to the start of the examination and the provider is now correctly identified as a participating provider. The final violation resulted when no authorization was found in the system when the claim was processed. However, the claim was reprocessed and paid with interest once the authorization was received.

The Company takes its obligations under this statutory provision very seriously, and as such will continue to monitor its internal control procedures with UBH to ensure compliance with these requirements.

5. The Company must review internal control procedures to ensure the timely payment of interest as required by Section 2166(B) of the Insurance Company Law of 1921 (40 P.S. § 991.2166) and Title 31, Pennsylvania Code, Section 154.18.

Response: As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for GHP since July 1, 2006 and continues to administer the benefits currently. CBH administered behavioral health benefits for the Company until July 1, 2006.

The violations noted in the Department's Final Report regarding these provisions all occurred within the CBH experience period. The Company respectfully disagrees with the violations, as noted above in the response under Section C – CBH Mental Illness Claims Denied. Of course, the Company takes its obligations under this statutory provision very seriously, and as such will continue to monitor its internal control procedures with UBH to ensure continued ongoing compliance with these requirements.

6. The Company must review internal control procedures to ensure compliance with emergency requirements of Section 2116 of the Insurance Company Law of 1921 (40 P.S. §991.2116).

Response: As noted previously, during the experience period, the Company contracted with two different behavioral health administrators. UBH has administered behavioral health benefits for GHP since July 1, 2006 and continues to administer the benefits currently. CBH administered behavioral health benefits for the Company until July 1, 2006.

The violations noted in the Department's Final Report regarding these provisions all occurred within the CBH experience period. The Company respectfully disagrees with the violations, as noted above in the responses under Section C – CBH Mental Illness Claims Denied and Section E – CBH Alcohol and Substance Abuse Services Denied.

Of course, the Company takes its obligations under this statutory provision very seriously, and as such will continue to monitor its internal control procedures with UBH to ensure continued ongoing compliance with these requirements.

7. The Company must provide to the Insurance Department within 60 days of the Report issue date, verification of claim payment and interest on the claims noted in the examination that were denied inappropriately.

Response: The Company will provide any verification of claims payment and interest on the claims noted in the examination that were deemed to have been denied inappropriately that has not already been provided to the Department by September 7, 2009. Furthermore, the Company will cure any outstanding violation and provide proof of claim and interest payment, upon the direction of the Department after review of this response