

**REPORT OF  
MARKET CONDUCT EXAMINATION  
OF**

**HMO of Northeastern Pennsylvania  
Wilkes Barre, Pennsylvania**

**AS OF  
July 24, 2008**

**COMMONWEALTH OF PENNSYLVANIA**



**INSURANCE DEPARTMENT  
MARKET CONDUCT DIVISION**

**Issued: September 12, 2008**

# HMO OF NORTHEASTERN PENNSYLVANIA

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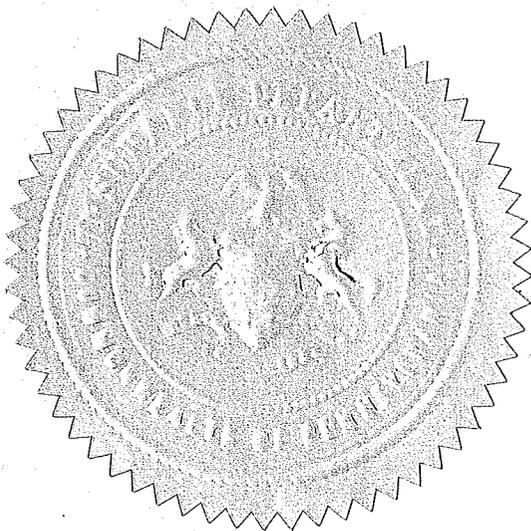
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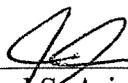
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BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22<sup>ND</sup> 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:  
: :  
HMO OF NORTHEASTERN : Sections 2166(A) and (B) of the Act  
PENNSYLVANIA : of June 17, 1998, P.L. 464, No. 68,  
19 North Main Street : (40 P.S. §§ 991.2166)  
Wilkes-Barre, PA 18711 :  
: Section 602-A of the Insurance  
: Company Law, Act of May 17, 1921,  
: P.L. 682, No. 284 (40 P.S. § 908-2)  
: :  
: Section 5 of the Insurance Company  
: Law of 1921, No. 150, Serious Mental  
: Illness (40 P.S. § 764g)  
: :  
: Section 1009-A of the Insurance  
: Company Law (40 P.S. § 981-9)  
: :  
: Title 31, Pennsylvania Code, Sections  
: 51.5 and 89.612  
: :  
Respondent. : Docket No. MC08-09-001

CONSENT ORDER

AND NOW, this *12<sup>th</sup>* day of *SEPTEMBER*, 2008, 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 HMO of Northeastern Pennsylvania, and maintains its address at 19 North Main Street, Wilkes-Barre, Pennsylvania 18711.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering various periods from January 1, 2005 through December 31, 2006.
- (c) On July 24, 2008, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on August 21, 2008.
- (e) The Examination Report notes violations of the following:

- (i) Section 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;
  
- (ii) Section 602-A of the Insurance Company Law (40 P.S. § 908-2), which states all group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act shall, in addition to other provisions required by this act, include within the coverage, those benefits for alcohol or other drug abuse and dependency as provided;
  
- (iii) Section 5 of the Insurance Company Law, Serious Mental Illness Coverage (40 P.S. § 764g), which requires 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;
- (iv) Section 1009-A of the Insurance Company Law (40 P.S. § 981-9), which states:
  - (a) Notification of the conversion privilege shall be included with each certificate of coverage issued under Section 621.2(D), and with any HMO subscriber agreement. Each certificate holder in an insured group and each HMO subscriber shall be given written notification of the conversion privilege and its duration within a period beginning fifteen (15) days before and ending thirty (30) days after the date of termination of the group coverage. The certificate holder or the holder's dependent shall have no less than thirty-one (31) days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder or subscriber or mailed to the certificate holder's or subscriber's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section; and
  - (b) The premium rates for individuals who purchase a comparable group conversion policy offered pursuant to applicable law shall be limited to 120% of the approved premium rates for comparable group coverage;
- (v) Title 31, Pennsylvania Code, Section 51.5, which states a company required to file an annual statement which is now or which hereafter becomes subject

to this chapter shall file with the Department with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth; and

- (vi) Title 31, Pennsylvania Code, Section 89.612, which states (a) non-hospital, residential alcohol treatment services which are included as a covered benefit shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services; (b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services; (c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital, residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b); and (d) Treatment services provided in subsections (a) through (c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full-session visits or equivalent partial visits.

## CONCLUSIONS OF LAW

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

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
  
- (b) Respondent's violations of Sections 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article; and
  
- (c) Respondent's violations of Section 1009-A of the Insurance Company Law (40 P.S. § 981-9) are punishable under 40 Purdon's Statutes, Section 981-10, which states upon satisfactory evidence of a violation of this article by an insurer or other person, the commissioner may pursue any one or more of the following penalties, not to exceed five hundred thousand dollars (\$500,000) in the aggregate during a single calendar year:
  - (i) Suspend, revoke or refuse to renew the license of the insurer or other person;
  - (ii) Enter a cease and desist order;
  - (iii) Impose a civil penalty or not more than five thousand dollars (\$5,000);

- (iv) Impose a civil penalty of not more than ten thousand dollars (\$10,000) for a willful violation of this article.

ORDER

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

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Twenty Thousand Dollars (\$20,000.00) 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 Ginny Baker, Administrative Assistant, Bureau of Licensing and Enforcement, 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.

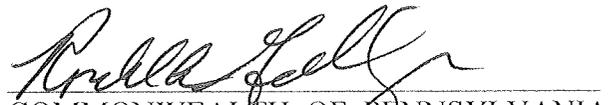
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

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: HMO OF NORTHEASTERN  
PENNSYLVANIA, 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 HMO of Northeastern Pennsylvania; hereafter referred to as "Company," at the Company's office located in Wilkes Barre, Pennsylvania, July 23, 2007, through November 16, 2007. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

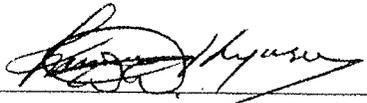
Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition 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.

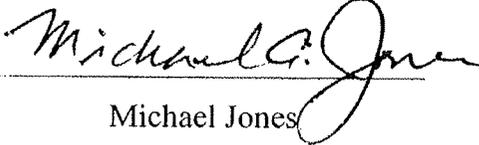
Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials 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 undersigned participated in the Examination and in the preparation of this Report.

  
Daniel Stemcosky, AIE, FLMI  
Market Conduct Division Chief

  
Frank Kyazze, AIE, ALHC, FLMI  
Market Conduct Examiner

  
Michael Jones  
Market Conduct Examiner

**Verification**

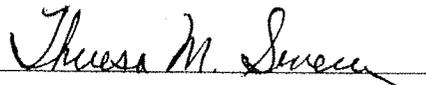
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



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

Sworn to and Subscribed Before me

This *13* Day of *May*, 2008



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

## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2006, through December 31, 2006, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Advertising, Consumer Complaints, Forms, Producer Licensing, Underwriting Practices and Procedures, 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**

HMO of Northeastern Pennsylvania was incorporated in the Commonwealth of Pennsylvania on April 24, 1986. Effective October 31, 1986, the Company was issued a Pennsylvania Certificate of Authority as a non-profit health maintenance organization under the provisions of the Health Maintenance Organization Act, Act of December 29, 1972, P.L. 1701, No. 364 (40 P.S. §1551 *et seq*). The Company commenced business on January 1, 1987, and was federally qualified on June 30, 1987.

A “doing business as” name change was filed in August of 1995, and subsequently approved. At that time, HMO of Northeastern Pennsylvania began doing business as, “First Priority Health”.

HMO of Northeastern Pennsylvania is based on an individual practice association (IPA) model. It is comprised of participating primary care physicians who are engaged in private practice in northeastern Pennsylvania. HMO of Northeastern Pennsylvania is authorized to do business in the following counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

HMO of Northeastern Pennsylvania provides a basic managed care (HMO) product, a Point of Service (POS) product, and an HMO Individual Conversion product.

The Company’s total Pennsylvania earned premium, as reported in their 2006 Annual Statement, was \$329,860,719. The total annual member months was reported as 1,269,893.

#### **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 copies of all advertising materials used for solicitation and sales during the experience period.

The Company was requested to provide a copy of the advertising certificate of compliance for the experience period. The Company did not provide the advertising certificate of compliance. The following violation was noted:

**1 Violation – Title 31, Pennsylvania Code, Section 51.5, Certificate of compliance.**

*A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth.*

The Company failed to file an advertising certificate of compliance.

## 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. In addition, the Company was requested to provide the total number of new members enrolled in groups during 2006. The Company identified 10,611 members enrolled in the Health Maintenance Organization (HMO) group contract and 1,113 members enrolled in the Point-of-Service (POS) group contract. The forms provided and the forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354, Insurance Company Law, Section 602-A (40 P.S. §908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud notice.

### **Concern:**

The Department is concerned that the Alcohol and/or Drug Abuse Treatment Benefits provision as stated in the contract forms utilized for the 11,724 members enrolled in 2006, is ambiguous and requires clarification to ensure compliance with the requirements of the alcohol and drug abuse mandated benefit coverage. The benefits provision under the contracts dictates that the substance abuse services are provided only when medically necessary and when the Company's referral center is notified by the participating provider or the member before the covered services are rendered and coordinates the members care. However, under the law (refer to Drug and Alcohol Use and Dependency Coverage; Notice 2003-06), the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral from a licensed physician or

licensed psychologist in all instances controls both the nature and duration of treatment. The provision as stated in the contract form can be misconstrued, and its application could be noncompliant with the mandated benefit, especially if the coverage is a Point-of-Service (POS) contract.

## **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 56 producers active and terminated during the experience period. The entire 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 reported 489 consumer complaints were received during the experience period. A random sample of 25 complaint files were 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 logs.

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 five (5) general segments.

- A. Underwriting Guidelines
- B. Group Policies Issued
- C. Group Policies Terminated
- D. Group Certificates Terminated
- E. Group Conversions

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 guidelines and manuals received were reviewed to ensure that underwriting guidelines were in place and being followed in a uniform and consistent manner and that 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.

## **B. Group Policies Issued**

The Company was requested to provide a list of all group policies issued during the experience period. The Company identified a universe of 258 group policies issued. A random sample of 25 claim files was requested, received and reviewed. The policy 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 472 group policies terminated. A random sample of 50 files was requested, received and reviewed. The files were reviewed to ensure compliance with contract provisions, applicable statutes, laws and regulations, and the proper return of any unearned premiums. No violations were noted.

## **D. Group Certificates Terminated**

The Company was requested to provide a list of all group certificates terminated during the experience period. The Company identified 16,850 group certificate holders terminated. A random sample of 100 files was requested, received and reviewed. Of the 100 files reviewed, 1 contract file was determined to be a self funded plan, which is out of the Department's jurisdiction. The remaining 99 files were reviewed for

compliance with contract provisions, applicable statutes, laws and regulations, and to ensure that terminations were not the result of any discriminatory underwriting practices. The following violations were noted:

**50 Violations - Insurance Company Law, Section 1009-A (40 P.S. §981-9)**

*(a) Notification of the conversion privilege shall be included with each certificate of coverage issued under section 621.2 (D), and with any HMO subscriber agreement. Each certificate holder in an insured group and each HMO subscriber shall be given written notification of the conversion privilege and its duration within a period beginning fifteen (15) days before and ending thirty (30) days after the date of termination of the group coverage. The certificate holder or the holder's dependent shall have no less than thirty-one (31) days following notification to exercise the conversion privilege. Written notification provided by the contract holder and supplied to the certificate holder or subscriber or mailed to the certificate holder's or subscriber's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section.*

*(b) The premium rates for individuals who purchase a comparable group conversion policy offered pursuant to applicable law shall be limited to one hundred twenty per centum (120%) of the approved premium rates for comparable group coverage.*

The required written notification of the conversion privilege upon termination was not provided to the members terminated in the 50 files noted.

### **E. Group Conversions**

The Company was requested to provide a list of all group contract holders converting group health insurance during the experience period. The Company identified a universe of 163 contract holders converting their group coverage upon termination to an optional non group conversion membership health insurance plan. A random sample of 50 conversion files was requested, received and reviewed. The files were reviewed to determine compliance to applicable issuance, conversion and underwriting statutes and regulations. No violations were noted.

## 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 Company provided the following claim manuals:

1. Facets User Guide Claims Processing Manual
2. MTM Direct Measures Program Guide
3. Excerpts of The Provider Bulletin
4. Behavioral Health Care First Priority Health Facility Manual – 2/2003

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. 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 nonhospital 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 procedures in the 2 documents listed in the table below detail directions for the providers that are not in compliance with the mandated benefit coverage.

<b>Document</b>	<b>Document Description</b>
Bulletin	The Provider Bulletin
Facility Manual	Behavioral Health Care First Priority Health Facility Manual – 2/2003

The claim file review consisted of 11 areas:

- A. Provider Submitted Medical Claims Paid Over 45 Days
- B. Provider Submitted Emergency Claims Paid Over 45 Days
- C. Subscriber Submitted Medical Claims
- D. Subscriber Submitted Emergency Claims
- E. Mental Health Denied Claims
- F. Denied Drug and Alcohol Claims
- G. Drug and Alcohol Rehabilitative Services Denied (2005)
- H. Drug and Alcohol Rehabilitative Services Denied (2006)
- I. Paid Alcohol and Drug Claims
- J. Emergency Clean Claims
- K. Medical Clean Claims

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. The life claims were additionally reviewed for compliance with Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b).

#### **A. Provider Submitted Medical Claims Paid Over 45 Days**

The Company was requested to provide a list of all provider submitted medical claims finalized during the 4<sup>th</sup> quarter of 2006 (October 1, 2006 through December 31, 2006). The Company identified a universe of 191,322 provider submitted medical claims finalized during the 4<sup>th</sup> quarter of 2006. The Department identified a universe of 6,078 provider submitted medical claims paid over 45 days. A random sample of 50 claims files 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:

#### **3 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 3 clean claims noted were not paid within 45 days of receipt.

## **B. Provider Submitted Emergency Claims Paid Over 45 Days**

The Company was requested to provide a list of all provider submitted emergency claims finalized during the 4<sup>th</sup> quarter of 2006 (October 1, 2006 through December 31, 2006). The Company identified a universe of 12,161 provider submitted emergency claims finalized during the 4<sup>th</sup> quarter of 2006. The Department identified a universe of 139 provider submitted emergency claims paid over 45 days. 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. The following violations were noted:

### **4 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 4 clean claims noted were not paid within 45 days of receipt.

## **C. Subscriber Submitted Medical Claims**

The Company was requested to provide a list of all subscriber submitted medical claims received during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 738 subscriber submitted claims received. A random sample of 50 claims was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

#### **D. Subscriber Submitted Emergency Claims**

The Company was requested to provide a list of all subscriber submitted emergency claims received during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 105 subscriber submitted emergency claims received. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

## **E. Mental Health Denied Claims**

The Company was requested to provide a list of mental health denied claims during the experience period of October 1, 2006 through December 31, 2006. The Company identified a universe of 383 mental health denied claims. A random sample of 50 claim files was requested, received and reviewed. Of the 50 claims received, 7 were duplicates and 6 were identified as drug and alcohol related claims. The remaining 37 claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract and, complying with pertinent state laws and regulations. The following violation was noted:

### **1 Violation - Insurance Company Law, No. 150, Section 5 (40 P.S. §764g) Coverage For Serious Mental Illnesses.**

*(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.*

The claim noted was denied inappropriately for no prior authorization. Prior authorization was noted in the claim file.

## **F. Denied Drug and Alcohol Claims**

The Company was requested to provide a list of alcohol and drug claims denied during the experience period from January 1, 2005 through December 31, 2005. The Company identified a universe of 822 alcohol and drug denied claims. A random sample of 132 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 Section 602-A of the Insurance Company Law (40 P.S. §908-2), as well as other pertinent 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.*

**And**

### **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.*

The denial of coverage for the 2 claims noted was not in compliance with the mandated benefit coverage.

### **G. Drug and Alcohol Rehabilitative Services Denied (2005)**

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, 2005. The Company identified a universe of 46 alcohol and drug rehabilitative services denied during the experience period. All 46 denial files were requested, received and reviewed. The files were reviewed to ensure that the Company's denial of alcohol and drug use and dependency coverage services did fulfill their obligation under Commonwealth Law in the 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. No violations were noted.

### **H. Drug and Alcohol Rehabilitative Services Denied (2006)**

The Company was requested to provide a list of alcohol and drug rehabilitative services denied during the experience period of January 1, 2006 to December 31, 2006. The Company identified a universe of 55 alcohol and drug rehabilitative services denied during the experience period. All 55 denial files were requested, received and reviewed. The files were reviewed to ensure that the Company's denial of alcohol and drug use and dependency coverage services did fulfill their obligation under Commonwealth Law in the provision of coverage for alcohol or other drug abuse and dependency benefits. The 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. No violations were noted.

## **I. Paid Alcohol and Drug Claims**

The Company was requested to provide a list of all paid alcohol and drug claims received during the experience period of January 1, 2005 through December 31, 2005. The Company identified a universe of 3,720 paid alcohol and drug claims received. A random sample of 50 claim files was requested, received and reviewed. The claim 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.

## **J. Emergency Clean Claims**

The Company was requested to provide a list of provider submitted 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 99 emergency clean claims paid over 45 days. 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. The following violations were noted:

### **15 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 15 clean claims noted were not paid within 45 days of receipt.

## **K. Medical Clean Claims**

The Company was requested to provide a list of provider submitted medical clean claims paid over 45 days during the experience period of January 1, 2006 through December 31, 2006. The Company identified a universe of 1,655 medical clean claims paid over 45 days. A random sample of 50 claim files was requested, received and reviewed. Of the 50 files reviewed 1 was determined to be outside of the experience period. The remaining 49 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:

### **16 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 16 clean claims noted were 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 procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.
2. The Company must review and revise internal control procedures and guidelines 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 for Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.
3. The Company must review and revise all certificates of coverage and policy contracts to clarify and ensure the required mandated benefit language for Alcohol/Drug Abuse and Dependency Mandated Policy Coverage is in 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.
4. The Company must review and revise internal control procedures to ensure compliance with the conversion notification requirements of Section 1009-A of the Insurance Company Law of 1921.
5. The Company must implement procedures to ensure compliance with the advertising certification requirements of Title 31, Pennsylvania Code, Chapter 51.

## **XI. COMPANY RESPONSE**



# BlueCross of Northeastern Pennsylvania

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

August 20, 2008

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

Re: **Examination Warrant Number: 06-M25-045**  
**HMO of Northeastern Pennsylvania (d/b/a, First Priority Health)**

Dear Mr. Stemcosky:

This letter is in response to your report of examination received on July 24, 2008 regarding the Insurance Department's ("Department's") Market Conduct Examination of the HMO of Northeastern Pennsylvania (d/b/a, First Priority Health ("FPH")) covering predominately the period of January 1, 2006 through December 31, 2006.

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

Sincerely,

Brian Rinker  
Senior Vice President Health Plan Operations

cc: Denise S. Cesare, President & Chief Executive Officer  
Edwin Goodlander, Esq., Sr. Vice President-Legal, General Counsel & Secretary  
J. Kenneth Suchoski, Sr. Vice President, Finance, Chief Financial Officer  
Trish Savitsky, Vice President, Corporate Assurance & Compliance  
Kimberly Kockler, Vice President, Government Affairs



Listed below are First Priority Health's responses to the recommendations made by the Department, as noted in the report.

- 1. The Company must review and revise 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.**

**First Priority Health Response:** First Priority Health agrees with the recommendation. We would like to note that of the thirty-eight claims noted, thirty six of these claims were related to adjusted claims. Only two original claims were processed in excess of the required forty five days. First Priority Health has created a daily report to monitor claims in various aging categories to ensure that all clean claims are handled within forty five days. In addition, this report can be used to identify claims over forty five days and validate why the claim is being held or whether the claim is an unclean claim. In addition, Claims Department personnel verify member eligibility by validating termination dates using our Common Membership and Billing System and related history. This enables us to identify terminations and retroactive re-instatements. Our Enrollment and Billing Unit provides Claims with a weekly listing of all members whose eligibility terminated and was reinstated retroactively. This process enables us to proactively and timely reprocess denials or overpayments when accounts/members terminate or are reinstated.

- 2. The Company must review and revise internal control procedures and guidelines 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 for Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options.**

**First Priority Health Response:** First Priority Health agrees with the recommendation. Our Provider Relations Department will place an article in the September 2008 Provider Bulletin clarifying the requirements for accessing Alcohol/Drug Abuse benefits. The article will state: "The only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification controls the nature and duration of the treatment." Regarding the manuals, the Mental Health/Chemical Recovery manual provided to the Insurance Department during the audit is no longer in use. The First Priority Health Facility, Specialist and PCP Manuals will be updated to include the above noted language. In addition, the following language will also be included in the manuals: "All other requests for Drug and Alcohol treatment by other than a licensed physician or licensed psychologist must be pre-certified by CBHNP before services are rendered and must meet medical necessity criteria. In all instances, services must be performed by a participating provider."

- 3. The Company must review and revise all certificates of coverage and policy contracts to clarify and ensure the required mandated benefit language for Alcohol/Drug Abuse and Dependency Mandated Policy Coverage is in 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.**

**First Priority Health Response:** First Priority Health added the required mandated benefit language for Alcohol/Drug Abuse and Dependency to its Group Master Contract for renewals beginning January 2007.

In December 2006, the First Priority Health Individual Conversion Contract was reviewed by the Insurance Department. As a result of this review, changes were recommended to the language of the Drug and Alcohol benefit. The language recommended by the Department at that time was as follows: "Benefits are available to a member who is certified by a licensed Physician or licensed Psychologist as a person who requires Substance Abuse treatment. Certification and referral by a licensed Physician or licensed Psychologist control the nature and duration of treatment for Inpatient and Outpatient Substance Abuse treatment. Except in an emergency, Covered Services are provided when the Regional Referral Center (RRC) is notified before Covered Services are rendered and coordinates the Member's care." Thereafter, First Priority Health, acting in good faith and based on the noted interpretation it had received concerning the Drug and Alcohol language since the August 3, 2003 Notice, made the consistent change to its Group Master Contract for renewals beginning January 2007 and is our current language.

As the PID noted during the course of the Market Conduct Exam, no services were inappropriately withheld from the member. The member received all services requested by the provider on the members' behalf. The member is held harmless if a provider does not follow the required procedures for notifying First Priority Health relative to the services being performed.

- 4. The Company must review and revise internal control procedures to ensure compliance with the conversion notification requirements of Section 1009-A of the Insurance Company Law of 1921.**

**First Priority Health Response:** First Priority Health implemented the applicable language on our creditable coverage certificate ("Statement of HIPAA Portability Rights"). The language is included on the "Statement of HIPAA Portability Rights" document that is issued with all portability certificates. This practice was implemented effective August 1, 2008.

The General Provisions section of the First Priority Health contract outlines the conversion process as follows: "The Contract Holder is responsible for providing written notice of the conversion privilege within 15 days before or after termination of coverage under this Contract." It is First Priority Health's position

that the written notification provided by the Contract Holder and supplied to the certificate holder or subscriber or mailed to the certificate holder's or subscriber's last known address or the last address furnished to the insurer by the contract holder or employer shall constitute full compliance with this section and that the obligation to do so rests with the Contract Holder.

**5. The Company must implement procedures to ensure compliance with the advertising certification requirements of Title 31, Pennsylvania Code, Chapter 51.**

**First Priority Health Response:** The Company agrees with the recommendation. First Priority Health has added the Advertising Certification document to our internal checklist of documents that need to be submitted along with the Annual Statement. The Advertising Certification document was included with First Priority Health's 2007 Annual Statement submitted to the Insurance Department.