

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

INDEPENDENCE BLUE CROSS
Philadelphia, PA

**AS OF
March 5, 2010**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: April 23, 2010

INDEPENDENCE BLUE CROSS

TABLE OF CONTENTS

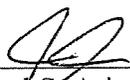
Order	
I.	Introduction 2
II.	Scope of Examination 5
III.	Company History and Licensing 6
IV.	Forms 7
V.	Underwriting 8
	A. Underwriting Guidelines 8
	B. Group Policies Terminated 9
	C. Group Certificates Terminated 9
	D. Group Conversions 11
VI.	Claims 12
	A. Mental Health Claims Denied 14
	B. Substance Abuse Claims Denied 15
	C. Substance Abuse Claims Paid 16
VII.	Recommendations 18
VIII.	Company Response 19

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:
: :
INDEPENDENCE BLUE CROSS : Section 602 of the Insurance Company
1901 Market Street : Law, Act of May 17, 1921, P.L. 682,
Philadelphia, PA 19103-1480 : No. 284 (40 P.S. §908-2)
: :
: Section 2701(e) of The Health Care
: Insurance Portability Act of June, 1997,
: P.L. 295, No. 29 (40 P.S. §1302.4)
: :
: Section 5(b)(c) of the Insurance
: Company Law, No. 150 (40 P.S. §764g)
: :
: Title 31, Pennsylvania Code, Section
: 146.3
: :
Respondent. : Docket No. MC10-04-004

CONSENT ORDER

AND NOW, this 23rd day of April, 2010, 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.

RECEIVED
Insurance Dept.

APR 23 2010

Bureau of Licensing & Enforcement
Licensing Division

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 Independence Blue Cross, and maintains its address at 1901 Market Street, Philadelphia, Pennsylvania 19103-1480.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005, through December 31, 2007, unless otherwise noted.
- (c) On March 5, 2010, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on April 5, 2010.

- (e) A revised response to the Examination Report was provided by Respondent on April 8, 2010.

- (f) The Examination Report notes violations of the following:
 - (i) 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;

 - (ii) Title XXVII, Section 2701(e), Adopted by the Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4 (40 P.S. §1302.4), which states
 - (1) Requirement for certification of period of credible coverage. A group health plan, and health insurance insurer offering group health insurance coverage, shall provide the certification.
 - (i) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision.
 - (ii) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

(iii) 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; and

(iv) Title 31, Pennsylvania Code, Section 146.3, which requires the claim files of the insurer shall be subject to examination by the Commissioner or by his

appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

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 2701(e) of the Health and Accident Reform Act, No. 159 (40 P.S. § 1302.4) are punishable under Section 13 of the Act:
 - (i) suspension or revocation of the license of the offending insurer or HMO;
 - (ii) refusal, for a period not to exceed one year, to issue a new license to the offending insurer or HMO;
 - (iii) a fine of not more than \$5,000 for each violation of this Act;
 - (iv) a fine of not more than \$10,000 for each willful violation of this Act;
 - (v) a fine of not more than \$25,000 for each wilful violation of Section 6.

(c) 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;

(d) Respondent's violations of Title 31, Pennsylvania Code, Section 146.3 are punishable under Section 9 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9):

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

(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).

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 Five Thousand Dollars (\$ 5,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the 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, Manager, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania

17120. Payment must be made no later than thirty (30) days after the date of this Order.

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 Insurance 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.

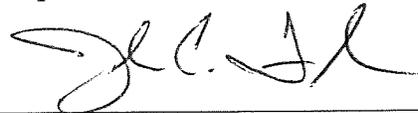
8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

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.

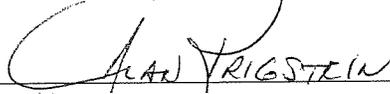
10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

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.

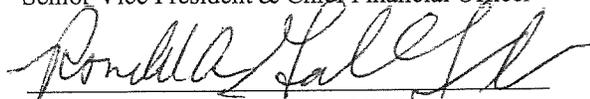
BY: INDEPENDENCE BLUE CROSS,
Respondent



Joseph A. Frick
President & Chief Executive Officer



Alan Krigstein
Senior Vice President & Chief Financial Officer



RONALD A. GALLAGHER, JR.,
Deputy Insurance Commissioner
Commonwealth of Pennsylvania

I. INTRODUCTION

The Market Conduct Examination was conducted on Independence Blue Cross; hereafter referred to as "Company," at the Company's office located in Philadelphia, Pennsylvania, August 18, 2008, through May 14, 2009. 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

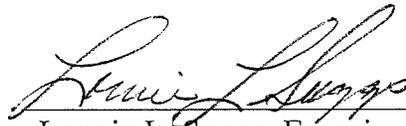
Lonnie L. Suggs
Market Conduct Examiner

Gary L. Boose, MCM
Market Conduct Examiner

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

Verification

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



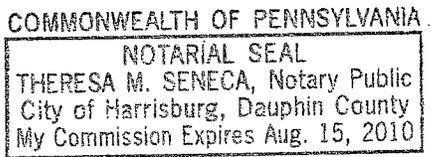
Lonnie L. Suggs, Examiner in Charge

Sworn to and Subscribed Before me

This *29* Day of *January*, 2010



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2005, through December 31, 2007, 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, Underwriting Practices 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

Independence Blue Cross began as the Associated Hospital Service of Philadelphia (AHSC). AHSC was incorporated on August 11, 1938. AHSC became licensed and started business on November 7, 1938. AHSC was the first prepaid hospitalization plan in Southeastern Pennsylvania. On October 19, 1973, AHSC changed its name to Blue Cross of Greater Philadelphia (BC). On March 12, 1990, BC changed its name to Independence Blue Cross (IBC).

Independence Blue Cross's current service area consists of the following five counties: Bucks, Chester, Delaware, Montgomery and Philadelphia. IBC is authorized to transact those classes of insurance described in the Pennsylvania Insurance Company Law, 40 Pa. C.S.A. §6101.

IBC's total Pennsylvania earned premium, as reported in their 2007 annual statement, was \$352,549,082.00.

IV. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with the Accident and Health Reform Filing Act, No. 159 (40 P.S. §3803) and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud notice. The following concern was noted:

Concern: The Department is concerned that the Alcohol and/or Drug Abuse Treatment Benefits provision as stated in the contract forms utilized in 2006, does not address any of the requirements to ensure compliance with the alcohol and drug abuse mandated benefits. The benefits provision under the contracts dictates that the substance abuse services are provided only when medically necessary and precertification is approved before services are rendered. However, under the law (refer to Drug and Alcohol Use and Dependency Coverage; Notice 2003-06), the only lawful 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 and referral from a licensed physician or licensed psychologist in all instances controls both the nature and duration of treatment.

V. UNDERWRITING

The Underwriting review was sorted and conducted in 4 general segments.

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

Each segment was reviewed for compliance with underwriting practices and included forms identification. Any issues relating to forms appear in the Forms section 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 documentation provided was reviewed to ensure 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.

The following guidelines were reviewed:

1. Section One. Overview: What is Insurance
2. Section Two. Rating Factors: Claims, Retention, Margin and Broker Commission.
3. Section Three. Types of Rating and Funding Arrangement Changes

B. Group Policies Terminated

The Company was requested to provide a list of all group policies terminated during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 17 group policies terminated. A random sample of 10 files was requested, received and reviewed. The 10 policy files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted. The following concern was noted:

Concern: The Department is concerned that the termination letter sent to the employer does not state the reason for termination or the effective date in which coverage ends. The Company should review this procedure to ensure account status and information is disclosed to the employers group.

C. Group Certificates Terminated

The Company was requested to provide a list of all group certificates terminated during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 4,043 group certificate holders terminated. A random sample of 25 files was requested, received and reviewed. The files were reviewed for compliance with contract provisions, applicable statutes and regulations and to ensure terminations were not the result of any discriminatory underwriting practice. The following violation and concern were noted:

1 Violation – Title XXVII Section 2701(e), Adopted by the Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4 (40 P.S. §1302.4)

(1) Requirement for certification of period of creditable coverage. A group health plan, and health insurance insurer offering group health insurance coverage, shall provide the certification.

(i) At the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision.

(ii) In the case of an individual becoming covered under such a provision, at the time the individual ceases to be covered under such provision.

The file noted did not indicate a certificate of creditable coverage was provided to the member at the time coverage was terminated.

Concern: Insurance Company Law, Section 1009-A (40 P.S. §981-9) requires notification upon termination of the certificate holder of the right of conversion to an individual contract as provided by the contract conversion provisions. Although the Company delegates this responsibility to the plan holder or group, the Company is still responsible if the plan holder fails to provide the conversion notice. The Department is concerned that the Company's procedure in delegating this responsibility does not provide for verification or proof of the conversion notification.

D. Group Conversions

The Company was requested to provide a list of all certificate holders converting group insurance during the experience period. The Company identified a universe of 1 certificate holder converting their group coverage upon termination to an optional insurance plan. The group conversion file was requested, received and reviewed. The files were reviewed to ensure compliance with applicable insurance conversion and underwriting statutes and regulations. No violations were noted.

VI. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. In addition, specific claim procedures for the handling of Alcohol and Substance Abuse claims were requested. The Company provided the "Claims Processing in PlanMate, Independence Blue Cross" manual and referenced the Company's website (www.ibx.com) and their Substance Abuse and Mental Health third party administrator's, website (www.MagellanHealth.com).

The claim manual, websites and claim procedures for the handling of Alcohol and Substance Abuse claims 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 following concern was noted:

Concern: As a result of the Department's request for claim procedures for the handling of Alcohol and Substance Abuse claims, the Company provided an internal claim handling document which stated that in order to invoke Act 106, alcohol and drug dependency minimum mandated benefits, the Company requires a written certification from a licensed physician or psychologist as to the nature and duration of the requested treatment.

The review of IBC's website, located at www.ibx.com, and Magellan's website located at www.MagellanHealth.com indicates that alcohol and substance abuse services require precertification/authorization. The utilization and authorization for treatment is based on medical necessity/clinical criteria. In addition, during the claims review

portion of the exam, no reference could be found where the Company or Magellan, disclosed as part of their precertification/authorization process, the Company's internal claim process requirements to invoke Act 106, alcohol and drug dependency minimum mandated benefits.

The Department is concerned that the use of the precertification/medical necessity guidelines by IBC and Magellan as posted on their respective websites and the omission and lack of disclosure of their internal claim process requirements to invoke Act 106, alcohol and drug dependency minimum mandated benefits is misleading.

By omitting and not providing instructions of the Company's internal claim procedures on the submission requirements to invoke the alcohol and drug abuse mandated benefit coverage, the providers are led to believe that the Company through a utilization review process determines and controls the nature and duration of treatment. When in fact and according to the Company's internal claim procedures, the written certification and referral from a licensed physician or licensed psychologist in all instances controls both the nature and duration of treatment.

The claim file review consisted of 3 areas:

- A. Mental Health Claims Denied
- B. Substance Abuse Claims Denied
- C. Substance Abuse Claims Paid

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

A. Mental Health Claims Denied

The Company was requested to provide a list of mental health claims denied during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 397 mental health claims denied. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent Commonwealth of Pennsylvania insurance laws and regulations. The following violations were noted:

1 Violation - Insurance Company Law of 1921, 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 claim noted was inappropriately denied.

B. Substance Abuse Claims Denied

The Company was requested to provide a list of claims denied during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 1,417 substance abuse denied claims processed using the PlanMate Claim system. From the original universe of 1,417 substance abuse denied claims, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the substance abuse mandated benefit. The extracted universe of denied claims was 1,183. Of the 1,183 denied claims, a random sample of 50 claim files was requested, received and reviewed. A random sample of 50 claims was requested, 49 files were received and reviewed and 1 file was not received. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract as well as pertinent state insurance laws and regulations. The following violations were noted:

1 Violation – Title 31, Pennsylvania Code, Section 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining

to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

The claim file noted was missing.

7 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) or Ch. 63 (relating to professional health services 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.

The 7 claims noted were inappropriately denied. The company failed to include the mandated alcohol and substance abuse coverage provision for a group contract as required.

C. Substance Abuse Claims Paid

The Company was requested to provide a list of claims received during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 981 substance abuse claim paid using their PlanMate Claims Processing system. A random sample of 25 claim files was requested, received and reviewed. The files were

reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and any insured submitted claims were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

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 the Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options as required by Section 602-A of the Insurance Company Law of 1921, (40 P.S. §908-2).
2. 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).
3. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.
4. The Company must review and revise internal control procedures to ensure 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.
5. The Company must review internal control procedures to ensure certificates of creditable coverage are provided at the time of coverage termination as required by Title XXVII, Section 2701(e), Adopted by Pennsylvania Health Care Insurance Portability Act, Act 29 Section 4 (40 P.S. §1302.4)
6. The Company must review internal control procedures to ensure compliance with claim file maintenance requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

VIII. COMPANY RESPONSE



Independence
Blue Cross

www.ibx.com

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

Via Federal Express

April 5, 2010

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

Re: Response of Independence Blue Cross to the Report of
Examination, Examination Warrant Number: 07-M25-050

Dear Mr. Stemcosky:

Enclosed is the response of Independence Blue Cross ("IBC) to the Report of Examination issued on March 5, 2010 covering the period January 1, 2005 through December 31, 2007.

The market conduct examination process has been useful and beneficial to IBC in that it allowed IBC to re-examine its business processes and internal controls to identify areas where improvements can be made. IBC is pleased with the outcome of the market conduct examination.

On behalf of IBC, I would like to thank you and your staff for your courtesy and cooperation during this market conduct examination. IBC will continue to work with the Insurance Department to ensure that all matters can be closed in a mutually acceptable manner. If you wish to discuss the Response, please call me at 215-241-3805.

Sincerely,

Richard F. Levins
Vice President and Deputy General Counsel

Enclosure

Response of Independence Blue Cross to the Report of Examination, Examination Warrant Number: 07-M25-050

On March 5, 2010, the Pennsylvania Insurance Department (“the Department”) issued a Report of Examination of Independence Blue Cross (“IBC”) covering the period January 1, 2005 through December 31, 2007. Pursuant to 40 P.S. §323.5, IBC submits the following response to the Report of Examination:

I. INTRODUCTION

IBC does not have a response to this section.

II. SCOPE OF EXAMINATION

IBC does not have a response to this section.

III. COMPANY HISTORY AND LICENSING

IBC does not have a response to this section.

IV. FORMS

The Department did not find any violations in this section but the Department did issue a “Concern” that “...the Alcohol and/or Drug Abuse Treatment Benefits provision as stated in the contract forms utilized in 2006, does not address any of the requirements to ensure compliance with the alcohol and drug abuse mandated benefits.” Consistent with its long-standing goal of compliance with the law, IBC is prepared to revise benefit language and take other steps necessary to clarify that coverage for drug/alcohol treatment services can be obtained through the Act 106/Notice 2003-06 physician/psychologist certification process. The content of any revised benefit language will be based on the Concern expressed by the Department, guidance that the Department may provide to IBC and to the public through the Department’s regulatory authority and the company’s review of the law.

V. UNDERWRITING

A. Underwriting Guidelines

IBC does not have a response to this section.

B. Group Policies Terminated

The Department did not find any violations in this section but the Department did issue a “Concern” that the “Department is concerned that the termination letter sent to the employer does not state the reason for termination of the effective date in which the coverage ends.” IBC will review this procedure to ensure that all necessary information is disclosed to the group.

C. Group Certificates Terminated

The Department found one violation of the Pennsylvania Health Care Insurance Portability Act, 40 P.S. §1302.4. IBC acknowledges the violation and has taken, or will take, the necessary actions to prevent future violations.

The Department also issued a "Concern" that IBC is delegating the responsibility to provide notification upon termination of the certificate holder of the right of conversion to an individual to the plan holder or group. IBC will review this procedure to ensure that the certificate holder receives appropriate notice of the right of conversion.

D. Group Conversions

IBC does not have a response to this section.

VI. CLAIMS

The Department issued a "Concern" that "...that the use of the precertification/medical necessity guidelines by IBC and Magellan as posted on their respective websites and the omission and lack of disclosure of their internal claim process requirements to invoke Act 106, alcohol and drug dependency minimum mandated benefits is misleading." Consistent with its long-standing goal of compliance with the law, IBC is prepared to revise its websites and/or internal claim process requirements and take other steps necessary to clarify that coverage for drug/alcohol treatment services can be obtained through the Act 106/Notice 2003-06 physician/psychologist certification process. The content of any revised websites and/or internal claim process requirements will be based on the Concern expressed by the Department, guidance that the Department may provide to IBC and to the public through the Department's regulatory authority and the company's review of the law.

A. Mental Health Claims Denied

The Department found one violation of the Insurance Company Law, 40 P.S. §764g (Coverage for Serious Mental Illness). IBC acknowledges the violation and has paid this claim. IBC has taken, or will take, the necessary actions to prevent future violations.

B. Substance Abuse Claims Denied

The Department found one violation of Title 31, Pennsylvania Code, Section 146.3. IBC acknowledges the violation and has taken, or will take, the necessary actions to prevent future violations.

The Department found seven violations of the Insurance Company Law, 40 P.S. §908-2 (Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options). These violations are related to claims for one IBC subscriber. The subscriber's group purchased the mandated alcohol and substance abuse coverage from an insurance company other than IBC. When the group purchased the mandated alcohol and substance abuse coverage from another insurance company, IBC believed that the group's decision to purchase the mandated alcohol and substance abuse coverage from a different insurance company was permissible pursuant 40

P.S. §908-2, which, at subsection (b), states that "The benefits specified in subsection (a) (Mandated Policy Coverages and Options) may be provided through a combination of such policies, contracts or certificates." Because the group purchased the mandated alcohol and substance abuse coverage from an insurance carrier other than IBC, the claims in question were denied by IBC. IBC acknowledges the violations and has taken, or will take, the necessary actions to prevent future violations. Specifically, IBC has reviewed the contracts with all of its insured groups and has determined that IBC provides the mandated alcohol and substance abuse coverage to all of its insured groups and their employees.

C. Substance Abuse Claims Paid

IBC does not have a response to this section.

VII. RECOMMENDATIONS

IBC acknowledges and will comply with the corrective measures outlined in the recommendations issued by the Department. On or before May 4, 2010, IBC will also provide to Department verification that IBC has paid any inappropriately denied claims.