

**REPORT OF  
MARKET CONDUCT EXAMINATION  
OF  
HEALTHASSURANCE PENNSYLVANIA, INC.  
Harrisburg, Pennsylvania**

**AS OF  
March 20, 2007**

**COMMONWEALTH OF PENNSYLVANIA**



**INSURANCE DEPARTMENT  
MARKET CONDUCT DIVISION**

**Issued: May 7, 2007**

# HEALTHASSURANCE PENNSYLVANIA, INC.

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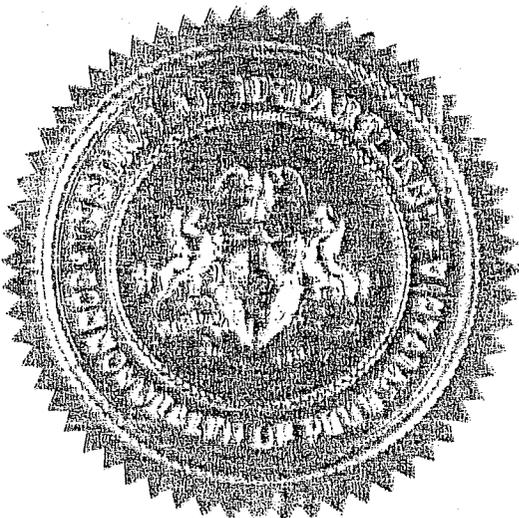
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BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

**ORDER**

AND NOW, this 20<sup>th</sup> day of February, 2007, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, 40 P.S. § 323.5, I hereby designate Terrance A. Keating, Deputy Chief Counsel, 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.



A handwritten signature in black ink, appearing to read "Randolph L. Rohrbaugh". The signature is written in a cursive style with large, sweeping loops.

\_\_\_\_\_  
Randolph L. Rohrbaugh  
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:  
: :  
HEALTHASSURANCE : Section 903 of the Insurance  
PENNSYLVANIA, INC. : Department Act, Act of May 17, 1921,  
3721 TecPort Drive : P.L. 789, No. 285 (40 P.S. § 323.3)  
Harrisburg, PA 17111 :  
: Sections 2166(A) and (B) of the  
: Insurance Company Law of 1921  
: (40 P.S. §§ 991.2166)  
: :  
: Unfair Insurance Practices Act, No. 205  
: (40 P.S. § 1171.1 et seq.)  
: :  
: Section 1 of the Insurance Company  
: Law, No. 81 (40 P.S. § 771)  
: :  
: Section 602-A of the Insurance  
: Company Law, Act of May 17, 1921,  
: P.L. 682, No. 284 (40 P.S. § 908-2)  
: :  
: Section 635.1 of the Insurance Company  
: Law of 1921, Serious Mental Illness  
: (40 P.S. § 764g)  
: :  
: Title 31, Pennsylvania Code, Sections  
: 51.5, 89.205, 89.612, 146.5, 146.6 and  
: 146.7  
: :  
Respondent. : Docket No. MC07-04-031

CONSENT ORDER

AND NOW, this *7<sup>th</sup>* day of *MAY*, 2007, 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.

3. Respondent neither admits nor denies that it violated any law or regulation of the Commonwealth.

#### FINDINGS OF FACT

4. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is HealthAssurance Pennsylvania, Incorporated, and maintains its address at 3721 TecPort Drive, Harrisburg, Pennsylvania 17111.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 through December 31, 2005.

(c) On March 20, 2007, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on April 19, 2007 and is attached hereto.

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

(i) Section 903(a) of the Insurance Department Act (40 P.S. § 323.3), which requires every company subject to examination to keep all books, records, accounts, papers, documents and any computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the Department may require in order that its representatives may readily verify the financial condition of the company, and ascertain whether the company has complied with the laws of this Commonwealth;

(ii) Section 2166(A) and (B) of Insurance Company Law of 1921 (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;

(iii) The Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.1, et seq.)

prohibits unfair claims settlement or compromise practices;

(iv) Section 5(a)(10)(i) through (vi) of Act 205 (40 P.S. § 1171.5), relating to

unfair or deceptive acts or practices in the business of insurance, states that

any of the following acts if committed or performed with such frequency as

to indicate a business practice shall constitute unfair claim settlement or

compromise practices:

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

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

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

(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

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

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

- (v) Section 1 of the Insurance Company Law, No. 81 (40 P.S. § 771), which requires all health insurance policies providing coverage on an expense-incurred basis and service or indemnity type contracts issued by a nonprofit corporation, and all health services provided by plans operating under the Voluntary Nonprofit Health Service Act of 1972, also provide that the health insurance benefits or health services applicable shall be payable with respect to a newborn child of the insured or subscriber the moment of birth;
- (vi) 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;
- (vii) Section 635.1 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;
- (viii) 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;
- (ix) Title 31, Pennsylvania Code, Section 89.205, which requires forms issued or renewed on or after November 29, 1975, shall provide at least the coverage specified in Act 81 as interpreted by this subchapter, either by amendatory rider or endorsement or appropriate revision of the form itself;
- (x) 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;

- (xi) Title 31, Pennsylvania Code, Section 146.5, which requires every insurer, upon receiving notification of a claim, shall within 10 working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated;
  
- (xii) Title 31, Pennsylvania Code, Section 146.6, which states that if an investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected; and

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

#### CONCLUSIONS OF LAW

5. 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 Insurance Company Law of 1921 (40 P.S. §§ 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.
- (c) Respondent's violations of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.1 and 1171.5) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. §1171.9):
- (i) cease and desist from engaging in the prohibited activity;
  - (ii) suspension or revocation of the license(s) of Respondent.

- (d) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:
- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
  - (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).
- (e) Section 635.1 of the Insurance Company Law, Serious Mental Illness Coverage (40 P.S. § 764g), which requires (c) health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:
- (1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;
  - (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;

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

(f) Respondent's violations of Title 31, Pennsylvania Code, Sections 146.5, 146.6 and 146.7 are punishable under Sections 9, 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9, 1171.10, 1171.11), as captioned above.

### ORDER

6. 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 One Hundred and Fifty Thousand Dollars (\$150,000.00) to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report.

(e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Office Manager, Bureau of Enforcement, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

7. 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.

8. 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.

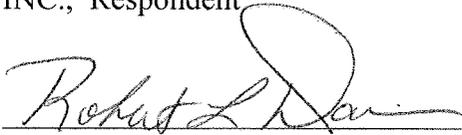
9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

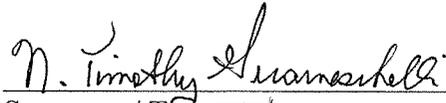
10. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

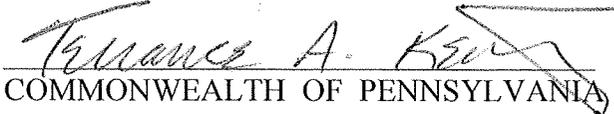
11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

12. 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: HEALTHASSURANCE PENNSYLVANIA,  
INC., Respondent

  
\_\_\_\_\_  
President / ~~Vice President~~

  
\_\_\_\_\_  
Secretary / ~~Treasurer~~

  
\_\_\_\_\_  
COMMONWEALTH OF PENNSYLVANIA  
By: Terrance A. Keating  
Deputy Chief Counsel

## **I. INTRODUCTION**

The Market Conduct Examination was conducted on HealthAssurance Pennsylvania, Inc., hereafter referred to as "Company," at the Company's office located in Harrisburg, Pennsylvania, May 1, 2006, through July 13, 2006. An additional review was conducted at Value Options, the Company's limited service, integrated delivery system (IDS) vendor in Troy, New York, December 18, 2006, through January 19, 2007. Subsequent review and follow-up was conducted in the offices 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.

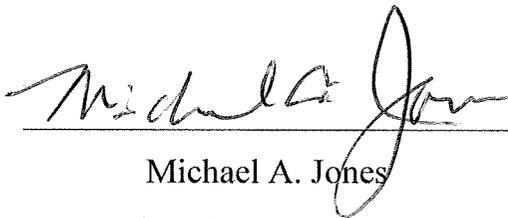
Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials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

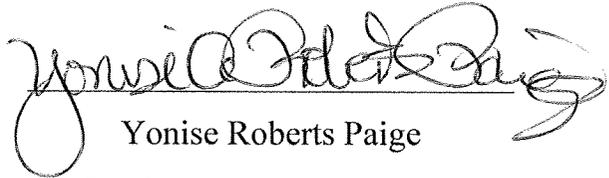
The undersigned participated in the Examination and in the preparation of this Report.



Daniel Stemcosky, AIE, FLMI  
Market Conduct Division Chief



Michael A. Jones  
Market Conduct Examiner



Yonise Roberts Paige  
Market Conduct Examiner



Michael Vogel  
Market Conduct Examiner

**VERIFICATION**

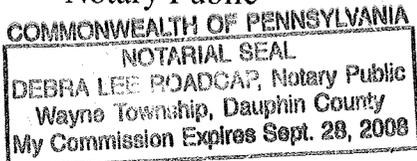
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

*Michael A. Jones*  
Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This *6<sup>th</sup>* Day of *March*, 2007

*Debra Lee Roadcap*  
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 examination experience period of January 1, 2005, through December 31, 2005. The experience period for the claims review was from April 1, 2005, to June 30, 2005, 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, and Claim Handling Practices and Procedures. In addition, the examination focused on the claim handling practices and procedures of Value Options, an integrated delivery system vendor, utilized by the Company for 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

HealthAssurance Pennsylvania, Inc. (HASPA) is a subsidiary of Coventry Health Care, Inc. (CHC).<sup>1</sup> On May 14, 2001, the Pennsylvania Departments of Health and Insurance granted HASPA a Certificate of Authority to operate as a “Risk-Assuming Non-Licensed Insurer” (RANLI). A RANLI is Pennsylvania’s term for a managed care plan that bears full insurance risk for either a Point of Service (POS) or a Preferred Provider Organization (PPO) plan, or both, but does not offer any indemnity or HMO products. HASPA offers both Coordinated Care PPO (POS) and PPO benefit plans.

The original license granted to HASPA in 2001, included service area authority for 36 Pennsylvania counties and covered 209,000 members in 10,500 PPO and POS groups. Authority to operate in six additional service area counties was granted by the Pennsylvania Department of Health in 2002. In 2003, authority to operate in 17 additional counties was granted for HASPA's POS product and 16 additional counties for HASPA's PPO product. In 2004, authority to operate in two additional counties was added for HASPA's POS product, and three additional counties for the PPO product. Also, in 2004, HASPA was granted authority to add Clarion and Bucks Counties to its licensed service area and in 2005, Bedford County was added bringing the total service area to 62 of Pennsylvania's 67 counties. Membership as of December 31, 2005, includes 292,344 commercial members.

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<sup>1</sup> Coventry Health Care is a national managed health care company based in Bethesda Maryland operating health plans, insurance companies, network rental / managed care services companies, and workers' compensation services companies. Coventry provides a full range of risk and fee-based managed care products and services, including HMO, PPO, POS, Medicare Advantage, Medicare Prescription Drug Plans, Medicaid, Workers' Compensation and Network Rental to a broad cross section of individuals, employer and government-funded groups, government agencies, and other insurance carriers and administrators in all 50 states as well as the District of Columbia and Puerto Rico.

As of their December, 2005, annual statement for Pennsylvania, HealthAssurance Pennsylvania, Inc. reported earned premium for accident and health insurance in the amount of \$842,924,322; and earned premium for Medicare and Medicaid in the amount of \$128,389,559.

#### **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 list of all Advertising and Marketing Material used during the experience period. The Company provided a list of 71 pieces of advertising utilized in the Commonwealth. The advertising consisted of: Letters, Direct Mailers, Brochures, Presentations, Radio and Television Scripts, Cards, Illustrations, Product Guides, Product Manuals and the Company’s web page. A random sample of 20 pieces of advertising was requested, received and reviewed. The 20 advertising pieces and the Company’s web site were reviewed to ascertain compliance with Act 205, Section 5 (40 P.S. §1171.5), Unfair Methods of Competition and Unfair or Deceptive Acts or Practices and Title 31, Pennsylvania Code, Chapter 51. The following violation was noted:

##### **1 Violation – Title 31, Pennsylvania Code, Section 51.5**

Each 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 Advertising Certificate of Compliance was not provided by the Company for the experience period.

## V. FORMS

Throughout the course of the examination, all underwriting files were reviewed to identify the policy contracts, member forms, conversion contracts, applications, riders, amendments and endorsements used in order to determine compliance with requirements of Insurance Company Law, Chapter 2, Section 354 (40 P.S. §477b), as well as provisions for various minimum mandated benefits coverage. Applications and claim forms were also reviewed to determine compliance with Title 18, Pennsylvania Consolidated Statutes, Section 4117(k). Subsequent to the on-site examination, the Company was requested to provide the number of certificates of coverage and group policyholders who were issued certificate of coverage forms: HAS PPO CERT 0401 or HAS GPPO COI 0401. The Company identified 132,134 subscribers and 10,021 group policyholders issued certificates of coverage, HAS PPO CERT 0401 and HAS GPPO COI 0401, respectively. The following violations were noted:

### **142,155 Violations - Insurance Company Law, Section 602-A (40 P.S. §908-2)**

Alcohol/Drug Abuse and Dependency Mandated Policy Coverage's 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. The following

Certificates of Insurance forms utilized by the Company contained the following statement in the Exclusions and Limitations Section of the certificate excluding: “Any services or supplies provided in connection with treatment of drug abuse or alcoholism not rendered according to a written treatment plan approved and monitored by a licensed physician or psychologist”. The exclusion is not in compliance with Alcohol and Drug Abuse Mandated Benefit Coverage. The form number, description and frequency of use are outlined in the table below:

<b>Form Number</b>	<b>Form Description</b>	<b>Number</b>
HAS PPO CERT 0401	Certificate Of Coverage	132,134
HAS GPPO COI 0401	Certificate Of Insurance	10,021

## VI. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2002, 2003, 2004, and 2005. The Company identified 1,641 consumer complaints received during the experience period. A random sample of 25 consumer complaint files was requested, received and reviewed. Of the 25 complaints identified, 4 were forwarded from the Department. The Company also provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et seq.). 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.

## **VII. UNDERWRITING**

The Underwriting review was sorted and conducted in 3 general segments.

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

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

### **A. Underwriting Guidelines**

The Company was requested to provide copies of all established written underwriting guidelines in use during the experience period. Underwriting guidelines were reviewed to ensure guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place which could possibly be considered discriminatory in nature or specifically prohibited by statute or regulation. No violations were noted.

The following guidelines were provided and reviewed:

1. Underwriting Controls - Eligible Employee Group Clients 2-50
2. Underwriting Controls - Eligible Employee Group Clients 51+
3. Underwriting Guidelines small groups
4. Underwriting Guidelines large groups

## **B. Group Policies Terminated**

The Company identified a universe of 4,611 group policies terminated during the experience period. A random sample of 100 group terminated files was requested, received and reviewed. The policy files were reviewed to determine compliance to issuance statutes and regulations. The following violation was noted:

### **1 Violation - Insurance Department Act, Section 903 (40 P.S. §323.3)**

(a) Every company or person subject to examination in accordance with this act must keep all books, records, accounts, papers, documents and any or all computer or other recordings relating to its property, assets, business and affairs in such manner and for such time periods as the department, in its discretion, may require in order that its authorized representatives may readily verify and ascertain whether the company or person has complied with the laws of this Commonwealth. Pertinent information was missing from the noted file.

## **C. Group Conversions**

The Company was requested to provide a list of all certificate holders enrolled during the experience period. The Company identified a universe of 112 certificate holders converting their group health coverage upon termination to an optional group health insurance plan. A random sample of 25 conversion files was requested, received and reviewed. The files were reviewed to ensure compliance with Section 621.2 of the Insurance Company Law of 1921, (40 P.S. §756.2). No violations were noted.

## VIII. 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. Eye Medical Claims, Compact Disc
2. On-Line Claims Processing Manual
3. Coverage and Payment Grid
4. Emergency Room Auto-Pay Diagnosis List
5. Value-Options
  - a. Field Descriptions Grids
  - b. Claims Reason Code List
  - c. Claims Manual
6. American Specialty Health Network (ASHN)
  - a. Claims Procedure Manual
7. InterQual Screening Criteria Manuals (McKesson)
  - a. Acute Criteria, Pediatrics
  - b. Acute Criteria, Adult
8. International Classification of Diseases 9<sup>th</sup> Revision (ICD9)
9. Current Procedure Terminology 2005 Standard Edition (CPT)

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

The Claim file review consisted of 15 areas:

- A. Medical Claims – Provider Submitted
- B. Emergency Claims – Subscriber Submitted
- C. Medical Claims – Subscriber Submitted
- D. Provider Submitted Emergency - Clean Claims
- E. Provider Submitted Medical – Clean Claims
- F. Provider Submitted Mental Illness - Clean Claims
- G. Alcohol and Drug Denied Claims
- H. Alcohol and Drug Unique Code Denied Claims
- I. Alcohol and Drug Coverage Denied for Medical Necessity
- J. Emergency Services Denied Claims
- K. Denied Claims
- L. Denied Claims – Services Not Eligible
- M. Denied Claims – Exceeds Authorized Visits
- N. Mental Illness and Substance Abuse Denied Claims
- O. Large Group Mental Illness and Substance Abuse Denied Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et seq.). The insured submitted claims were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices and the provider submitted claims were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. In addition, certain claims were reviewed for compliance with Insurance Company Law, Section 602-A (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options, Title 31, Pennsylvania Code, Section 89.612, Minimum covered services and Insurance Company Law of 1921, Section 635.1(40 P.S. §764g) Coverage For Serious Mental Illnesses.

### **A. Medical Claims – Provider Submitted**

The Company was requested to provide a list of all provider submitted medical claims finalized during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 652,109 provider submitted medical claims. A random sample of 150 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and the provider-submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted provider submitted clean claims were not paid within the required 45 days of receipt.

### **B. Emergency Claims – Subscriber Submitted**

The Company was requested to provide a list of subscriber submitted emergency claims finalized during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 1,819 claims. A random sample of 50 claims was requested, received and reviewed. Of the 50 claim files reviewed, 2

were determined to be Health America HMO claims and 1 claim was outside of the experience period. The remaining 47 claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

**21 Violations - Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the noted claims within 10 working days.

**1 Violation - Title 31, Pennsylvania Code, Section 146.6**

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

**15 Violations - Title 31, Pennsylvania Code, Section 146.7**

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

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

The Company was requested to provide a list of all subscriber-submitted medical claims finalized during the specific claims experience period of April 1, 2005, through June 30, 2005. The Company identified a universe of 915 subscriber submitted medical claims. A random sample of 25 claim files was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

#### **8 Violations - Title 31, Pennsylvania Code, Section 146.5**

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the noted claims within 10 working days.

#### **6 Violations - Title 31, Pennsylvania Code, Section 146.7**

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

#### **D. Provider Submitted Emergency - Clean Claims**

The Company was requested to provide a list of all provider submitted clean claims paid over 45 days from the date of receipt during the experience period of April 1, 2005, to June 30, 2005. The Company identified 573 emergency clean claims paid over 45 days. A random sample of 25 emergency clean claim 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 and Title 31, Pennsylvania Code, Chapter 154. The following violations were noted.

#### **12 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted clean claims were not paid within the required 45 days of receipt.

#### **E. Provider Submitted Medical – Clean Claims**

The Company was requested to provide a list of all provider submitted clean claims paid over 45 days from the date of receipt during the experience period of April 1, 2005, to June 30, 2005. The Company identified 13,470 medical clean claims paid over 45 days. A random sample of 100 medical clean claim files was requested, received and reviewed. The claim files were reviewed for compliance

with Title 31, Pennsylvania Code, Chapter 154 and the provider-submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. The following violations were noted:

**83 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. Claim files for the 100 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted claims were not paid within the required 45 days of being determined as a clean claim.

**F. Provider Submitted Mental Illness - Clean Claims**

The Company was requested to provide a list of all provider submitted clean claims paid over 45 days during the experience period of April 1, 2005, to June 30, 2005. The Company identified 42 mental illness clean claims paid over 45 days. A random sample of 25 mental illness clean claim 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.

**23 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted clean claims were not paid within the required 45 days of receipt.

### G. Alcohol and Drug Denied Claims

The Company was requested to provide a list of all alcohol and drug claims denied during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 2,219 alcohol and drug denied claims. A random sample of 50 claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and to ensure compliance with Section 602-A of the Insurance Company Law (40 P.S. §908-2).

The following chart is a synopsis of the company's claim denial reasons and the violations noted are listed below:

Code	Number	Reason	Percent
GF	11	Duplicate	22%
GD	10	Not authorized for date of service & provider	20%
G5	5	Date of service outside dates authorized	10%
G8	5	Level of care not authorized	10%
HQ	5	Services provided not authorized	10%
ET	2	Refer medical payor	4%
GL	2	Service not covered	4%
HT	2	Service not contracted	4%
AB6	1	Resubmit with valid cpt	2%
CLM	1	Received past 60 day resubmit	2%
E9	1	Non-covered benefit	2%
GI	1	Claim filed outside time limit	2%
GW	1	Member deductible limit reached	2%
J1	1	Resubmit on 1500 form	2%
JT	1	Resubmit with valid diagnosis code	2%
WF	1	Admin waiver/flex	2%
	50	TOTAL	100%

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

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

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

**And**

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

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

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

(c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital, residential alcohol

treatment days, shall be available in addition to the minimum required in subsections (a) and (b).

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

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

**10 Violations-Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et seq.)**

The Unfair Insurance Practices Act (“UIPA”) prohibits unfair claims settlement or compromise practices. The Company’s act of denying drug and alcohol coverage to individuals in spite of a certification and referral from a licensed physician or psychologist was committed with such frequency to indicate a business practice. Because such actions were made in direct contravention to the August 8, 2003 Notice, the noted claims constitute willful violations of which the Company knew or reasonably should have known (see, 40 P.S. §1171.11(1)).

**10 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 noted clean claims in spite of having the appropriate certification were not paid within the required 45 days of receipt.

**H. Alcohol and Drug Unique Code Denied Claims**

The Company was requested to provide a list of alcohol and drug claims denied during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 2,219 alcohol and drug denied claims. An auditing program analysis was performed on the 2,219 denied claims to further identify claims that were denied for the following 3 denial codes: GD (No Authorization for Date of Service and Provider), G8 (Level of Care not Authorized), and HQ (Service provided not Authorized). The result of that analysis identified a universe of 908 claims on 136 individuals. The claim with the first service date for each of the 136 individuals was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and ensure compliance with Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverages.

The following chart is a synopsis of the claims reviewed and the violations noted are listed below:

Code	Reason	Number of Claims	Number Reviewed
GD	No Authorization for Date of Service & Provider	429	53
G8	Level of Care Not Authorized	248	29
HQ	Service Provided Not Authorized	229	54
	Totals	908	136

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

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

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

**And**

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

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

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

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

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

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

**5 Violations -Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et seq.)**

The Unfair Insurance Practices Act (“UIPA”) prohibits unfair claims settlement or compromise practices. The Company’s act of denying drug and alcohol coverage

to individuals in spite of a certification and referral from a licensed physician or psychologist was committed with such frequency to indicate a business practice. Because such actions were made in direct contravention to the August 8, 2003 Notice, the noted claims constitute willful violations of which the Company knew or reasonably should have known (see, 40 P.S. § 1171.11(1)).

**5 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 noted claims were denied in spite of having the appropriate certification and referrals. The clean claims noted were not paid within the required 45 days of receipt.

**I. Alcohol and Drug Coverage Denied for Medical Necessity**

The Company was requested to provide a list of all individuals denied drug and alcohol coverage in spite of a certification and referral from a licensed physician or psychologist for the time period of August 8, 2003, through May 31, 2005. The Company identified a universe of 459 individuals denied coverage due to medical necessity in spite of the aforementioned certification and referral from a licensed physician or psychologist. The following violations were noted:

The following table represents the various levels of care sought and/or rendered including both the percentage and actual number of the 459 denied claims:

NUMBER	LEVEL of CARE	PERCENT
116	Acute Inpatient	25
49	Acute Residential	11
77	Inpatient DeTox	17
6	Intensive Out Patient	1
89	Partial Hospitalization	19
122	Residential Treatment HV	27
459	TOTAL	100%

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

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

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

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa.B. 4041 dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. The denial of coverage for the 434 noted individuals is not in compliance with the mandated benefit.

**434 Violations - Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et seq.)**

The Unfair Insurance Practices Act (“UIPA”) prohibits unfair claims settlement or compromise practices. The Company’s act of denying drug and alcohol coverage to 459 individuals due to medical necessity, in spite of a certification and referral from a licensed physician or psychologist, was committed with such frequency to indicate a business practice. Because such actions were made in direct contravention to the August 8, 2003 Notice, they constitute willful violations of which the Company knew or reasonably should have known (see, 40 P.S. § 1171.11(1))

**434 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 claim list for the 459 clean claims was received and identified by the Company as denied in spite of having the appropriate certification and referrals. The noted clean claims were not paid within the required 45 days of receipt.

**J. Emergency Services Denied Claims**

The Company was requested to provide a list of emergency service claims denied finalized during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 27,494 emergency services denied claims. A random sample of 50 claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was

adhering to the provisions of the policy contract. The following violation was noted:

**1 Violation - 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted provider submitted clean claim was not paid within the required 45 days of receipt.

**K. Denied Claims**

The Company was requested to provide a list all claims denied during the experience period. The Company provided a list of 149,108 claims denied during the experience period of April 1, 2005, to June 30, 2005. Of the 149,108 claims denied, 3,153 claims were labeled “Denied” with no further reason identified. A random sample of 50 of these nondescript denied claims was requested, received and reviewed. Of the 50 claim files reviewed, one file was determined to be outside the experience period. The remaining 49 claim files were reviewed to ensure the Company’s claims adjudication process was adhering to the provisions of the policy contract. No violations were noted.

## **L. Denied Claims – Services Not Eligible**

The Company was requested to provide a list all claims denied during the experience period. The Company provided a list of 149,108 claims denied during the experience period of April 1, 2005 to June 30, 2005. Of the 149,108 claims denied, 80,918 claims were denied for “Services Not Eligible”. A random sample of 50 “Services Not Eligible” denied claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violation was noted:

### **1 Violation - Insurance Company Law, No. 81, Section 1 (40 P.S. §771)**

#### **Newborn Children Coverage**

All health insurance policies providing coverage on an expense incurred basis and service or indemnity type contracts issued by a nonprofit corporation subject to 40 Pa.C.S., Chapter 61 (relating to Hospital Plan Corporations), Chapter 63 (relating to Professional Health Services Plan Corporations), Chapter 65 (relating to Fraternal Benefit Societies), and all health services provided by plans operating under the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Voluntary Nonprofit Health Service Act of 1972," also provide that the health insurance benefits or health services applicable shall be payable with respect to a newborn child of the insured or subscriber the moment of birth.

**And**

#### **Title 31, Pennsylvania Code, Section 89.205**

Forms issued or renewed on or after November 29, 1975, shall provide at least the coverage specified in Act 81 as interpreted by this subchapter, either by amendatory rider or endorsement or appropriate revision of the form itself.

(1) The form provision shall provide that the newborn child coverage is included automatically for each newborn child for 31 days after birth and that the insured or subscriber shall have the right upon application if such is required by the insurer within the 31 day period to continue coverage beyond the 31 day period if the form provides for coverage of dependents.

(2) If the form does not provide for coverage of dependents, the insured or subscriber shall have the right, upon application within 31 days of the birth of the newborn, to convert to a form which shall provide substantially similar benefits, or to add an appropriate coverage rider to the existing form.

The denial of the noted claim was not justified. The mandated benefit provides for coverage within 31 days of birth.

#### **M. Denied Claims – Exceeds Authorized Visits**

The Company was requested to provide a list all claims denied during the experience period. The Company provided a list of 149,108 claims denied during the experience period of April 1, 2005, to June 30, 2005. Of the 149,108 claims denied, 458 claims were denied for “Exceeds Authorized Visits”. A random sample of 25 “Exceeds Authorized Visits” claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted provider submitted clean claims were not paid within 45 days of receipt.

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

(B) If a licensed insurer or a Managed Care Plan Fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than two (\$2) dollars. The required interest of \$5.20 was not paid in the noted claim.

**5 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)  
(40 P.S. §1171.5)**

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

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

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

The denial of the noted claims was not justified. The contract provisions require payment.

#### **N. Mental Illness and Substance Abuse Denied Claims**

The Company was requested to provide a list of mental illness and substance abuse claims denied during the experience period of April 1, 2005, to June 30, 2005. The Company identified a universe of 10,920 denied claims. A random sample of 25 claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract. The following violations were noted:

**1 Violation - 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted clean claim was not paid within the required 45 days of receipt.

**2 Violations – Unfair Insurance Practices Act, No. 205, Section 5(a)(10) (40 P.S. §1171.5)**

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

- (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
- (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.
- (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
- (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
- (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

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

The denial of the noted claims was not justified. The contract provisions require payment.

### **O. Large Group Mental Illness and Substance Abuse Denied Claims**

The Company was requested to provide a list of mental illness and substance abuse denied claims for individuals whose coverage was provided by groups comprised of 50 individuals or more. The Company identified a universe of 5,575 denied claims during the experience period of April 1, 2005, to June 30, 2005. A random sample of 100 claims was requested, received and reviewed. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract and ensure compliance with Section 635.1 of the Insurance Company Law of 1921, (40 P.S. §764g) Coverage For Serious Mental Illnesses. 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 noted claim was missing the final resolution of the claim.

**1 Violation – Unfair Insurance Practices Act, No. 205, Section 5(a)(10)**

**(40 P.S. §1171.5)**

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

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

The denial of the noted claim was not justified. The contract provisions require payment.

**1 Violation - Insurance Company Law of 1921, Section 635.1, (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 denial of the noted claim was not justified. The contract provision under the group health benefit terms requires payment for major depressive disorder as a mandated benefit.

**1 Violation - 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. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company. The noted clean claim was not paid within the required 45 days of receipt.

## **IX. 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 implement procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 51, Section 51.5 Certificate of compliance.
2. The Company must remove exclusions from their Certificates of Insurance to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. §908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.
3. The Company must implement 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 compliance with requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
5. The Company must review and revise internal control procedures to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. §908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.
6. The Company must review and revise internal control procedures to ensure compliance with Minimum Covered Services of Title 31, Pennsylvania Code, Chapter 89, Section 89.612 for Alcohol treatment services.
7. The Company must review internal control procedures to ensure compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.1 et. seq.).
8. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171.5).

9. The Company must revise control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166).
10. The Company must review internal control procedures to ensure compliance with Insurance Company Law, Section 635.1 (40 P.S. §764g) concerning Coverage For Serious Mental Illnesses.
11. The Company must review internal control procedures to ensure compliance with Insurance Company Law, No. 81, Section 1 (40 P.S. §771) and Title 31, Pennsylvania Code, Section 89.205 concerning Newborn Children Coverage.
12. The Company must provide to the Insurance Department within 60 days of the Report issue date, verification of claim payment and interest on the claims noted in the examination that were denied inappropriately.

**X. COMPANY RESPONSE**



HEALTH AMERICA  
HEALTH ASSURANCE  
*Coventry Health Care Plans*

April 18, 2007

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

*Via Email & Overnight Delivery*

**Re: Examination Warrant No: 05-M25-068  
HealthAssurance Pennsylvania, Inc. Market Conduct Examination**

Dear Mr. Stemcosky:

The following information is provided in response to the Report of Examination dated March 20, 2007 ("Report") resulting from the Insurance Department's Market Conduct Examination of HealthAssurance Pennsylvania, Inc. ("HealthAssurance").

HealthAssurance, by the attached document, will respond to all of the Department's recommendations, which will incorporate responses to specific alleged violations and concerns. HealthAssurance appreciates the opportunity to respond to the Report as prepared by the Insurance Department and further anticipates positive benefits to emanate from the audit where operational deficiencies have been identified.

You will note, upon review of HealthAssurance's response, that the Company has specific concerns regarding certain Findings, but at the same time, would advise the Department that the Company is committed to maintaining full compliance with all applicable laws and regulations. As such, the Company will undertake the requisite corrective action to remedy any concerns or issues of the Department where appropriate and necessary. While HealthAssurance believes there has been compelling evidence presented that serves to mitigate or in certain instances represent cause to remove specific violations, the Company is respectful of the Department's ultimate position and will implement procedures to correct said violations. HealthAssurance also believes that market conduct examinations serve a useful purpose in identifying opportunities to enhance our operations and administrative procedures.

As I am sure you can appreciate, this industry is highly complex by nature, involving numerous constituencies (regulators, employers, providers, members and brokers, to name a few), as well as legal and regulatory requirements. These aforesaid factors constantly challenge our business from both a systems and operational perspective. While perfection is our ultimate goal, reality is that circumstances arise which, in certain instances, result in outcomes which are less than optimal from both a regulatory and business perspective. We

trust that the Department will take these factors into consideration when finalizing this market conduct examination.

HealthAssurance, as a good corporate citizen, has endeavored to maintain compliance with the laws of the Commonwealth and stands ready to take prompt, corrective action where appropriate to ensure its future compliance with laws. The Company takes its obligations to comply with the laws of the Commonwealth very seriously and strives to make every effort to ensure it operates within all requisite rules and regulations.

HealthAssurance is appreciative of the support of the Department throughout the examination and has made every effort to respond to all requests and inquiries and to assist the Department in conducting the examination. The Department's comments and suggestions, where appropriate, will be utilized to improve all aspects of our operations as we endeavor to better serve our members, employer groups and providers. We would also like to extend our thanks and appreciation to Mr. Jones, Ms. Paige and Mr. Vogel for their work throughout the onsite portion of the examination as well as to you and Mr. Shoop for allowing us the opportunity to meet and review the Exit Summaries.

The attached document responds to each of the Department's Recommendations in the order presented. In addressing the Recommendations, the Company will also address certain of the violations related thereto. Accordingly, HealthAssurance respectfully submits this response to the Report of Examination.

Respectfully Submitted,



N. Timothy Guarneschelli  
Vice President & General Counsel

- cc: Robert L. Dawson, President & Chief Executive Officer  
Mary Lou Osborne, Regional President, Western Pennsylvania  
Stephen R. Dengler, Vice President & Chief Financial Officer  
Thomas C. Zielinski, Senior Vice President & General Counsel  
Jonathan Weinberg, Vice President & Deputy General Counsel  
Joe Harris, Vice President, Customer Service Operations  
John Proto, Vice President, Employer Services  
Krista G. Maddigan, Director, Regulatory Compliance  
Bernard J. LaPine, Manager, Regulatory Compliance

## X. COMPANY RESPONSE

The following is the Company's response to the Recommendations made by the Department. In responding to these Recommendations, the Company will also address certain resolutions and concerns noted in the Report.

**1. The Company must implement procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Chapter 51, Section 51.5 Certificate of Compliance.**

**Response:**

Immediately after learning of this issue, the Company filed the Advertising Certificate of Compliance required by 31 Pa. Code § 51.5 for calendar year 2005 and implemented procedures to ensure that the Advertising Certificate of Compliance is included with its Annual Financial Statement filing. Specifically, the Company added the Certificate of Compliance to its master checklist of regulatory filing requirements and re-educated its legal, communications and finance departments concerning the requirement. The addition of the Certificate to the master checklist ensures that the appropriate departments are aware of the filing requirement. In compliance with the regulation and its procedures, the Company included the Certificate of Compliance for calendar year 2006 with its 2006 Annual Financial Statement filing.

**2. The Company must remove exclusions from their Certificates of Insurance to ensure compliance with Section 602-A of the Insurance Company Law of 1921, (40 P.S. § 908-2) Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.**

**Response:**

The Company has drafted and distributed an amendment which removes the exclusion noted in the Report from its Certificates of Insurance. The distribution of the amendment was completed on April 2, 2007.

However, the Company respectfully disagrees that the noted exclusion is in violation 40 P.S. § 908-2 ("Act 106"). Act 106, with regard to the mandated non-hospital residential and outpatient services, states as follows:

*...Before an insured may qualify to receive benefits under this section, a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment. (40 P.S. §908-4 & 5)*

It is the Company's contention that the exclusion at issue is consistent with the mandated coverages specified by Act 106. In addition, the Company respectfully suggests that the uncertainty created by the Department's decision to issue Department Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003) ("2003 Notice"), which has not yet been resolved by the Pennsylvania Commonwealth Court, militates against a finding of any violations under Act 106.

The Company believes that it has complied and continues to comply with Act 106 and the Department's interpretation thereof. Specifically, for over a decade insurers and managed care entities relied on an interpretation of Act 106 articulated by the Department in an April 5, 1993 Department Notification ("1993 Notice"). In the 1993 Notice, the Department actually *invited* insurers and managed care entities to submit form and rate filings for Department approval that apply managed care principles, including utilization review, to the delivery of Act 106 benefits:

Act 106 of 1989 established the mandated benefit for drug and alcohol treatment in group health insurance policies approved for use in Pennsylvania. *With the increased emphasis on eliminating unnecessary costs and managing care in this particular area*, many insurance companies have expressed an interest in offering a product that uses a pre-certification system to determine appropriateness of treatment for substance abuse patients.

....

It is now possible for the Department of Insurance *to approve products of licensed health insurers that have pre-certification as part of the process for determining appropriateness of treatment. The Department will accept filings which use managed care techniques in the treatment of substance abuse . . . .*

As standards and processes are developed, insurers will be expected to keep their pre-certification systems current.

*Please distribute this notification to staff who may be preparing filings.*  
(Emphasis Added)

Accordingly, what the Department identified as a violation of Act 106, (i.e. the use of a written treatment plan to manage a members care) is actually consistent with a prior interpretation of Act 106 announced by the Department and that stood unchallenged for over a decade.

The Department has evidenced acceptance of this interpretation through its May 18, 2001 approval of the above referenced exclusion in the HealthAssurance Pennsylvania, Inc. filings numbered A460730001.

What complicates this matter, however, is the 2003 Notice, which represents a dramatic shift in the Department's decade-old interpretation of Act 106. Though Act 106 did not change in the interim, the 2003 Notice offers a new interpretation that actually forecloses, rather than invites, pre-certification utilization review of Act 106 benefits. Under these circumstances, it was not unreasonable for managed care entities, including the Company, to be confused as to which Department interpretation (*i.e.*, the 1993 Notice or the 2003 Notice) is, in fact, the correct interpretation of Act 106.

The 2003 Notice is, at best, a statement of policy and represents only the Department's current interpretation of Act 106, as was equally true of the 1993 Notice. Given the differing and irreconcilable interpretations of Act 106 present by these Notices, the Company, and other insurers and managed care entities, first sought a dialogue with the

Department to achieve some clarity. When this dialogue did not yield any clear guidance as to the true meaning of Act 106, the Company, along with others (“Petitioners”), sought the aid of the Pennsylvania Commonwealth Court in resolving the uncertainty in January 2004. Working *with the Department*, the Petitioners and the Department jointly sought expedited review by the Commonwealth Court of this important issue. Indeed, in one of its filings with the Pennsylvania Supreme Court in the case, the Department specifically recognized that the dispute over the meaning of Act 106 created by the issuance of the 2003 Notice “is concrete, purely legal, and had industry-wide application.”

Since the Department issued the 2003 Notice, the Company has worked cooperatively with the Department until the issue over the proper interpretation of Act 106 is resolved by the Commonwealth Court. Initially, from August 8, 2003 through May 31, 2005, the Company continued to abide by the Department’s 1993 Notice. Where, however, a plan participant or insured complained to the Department about the Company’s findings in the pre-certification process for Act 106 benefits and where the Department raised the complaint with the Company, the Company voluntarily agreed to provide the requested benefit *under protest*. In response to an April 25, 2005 demand from the Department that the Company comply with the 2003 Notice, pending resolution of the issues in Commonwealth Court, the Company again cooperated and acquiesced (under protest), as confirmed in a May 4, 2005 letter to the Department.

Specifically, any request for services from a licensed physician or psychologist was and is continuing to be processed for payment in accordance with the Department’s direction as outlined under the 2003 Notice. Such approvals have been and continue to be processed without regard to whether or not a treatment plan exists. The Company’s compliance with the 2003 Notice subsequent to May 2005 was noted by the Department in its review of a limited sample of authorization requests from July 2005. Consequently, while the noted exclusion remained in the Company’s Certificates of Insurance, it has not been applied since May 2005.

In short, the Company has been and continues to be cooperative with the Department with respect to Act 106 while what even the Department acknowledges to be a concrete dispute is resolved by the Commonwealth Court. The Company voluntarily came into compliance with the Department’s latest interpretation of Act 106 when the Department demanded that it do so, notwithstanding the pending litigation and a recognized reasonable and concrete dispute over the true meaning of Act 106.

**3. The Company must implement procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. § 991.2166) relating to prompt payment of provider claims.**

**Response:**

The Company takes seriously its obligations under Act 68 to pay claims promptly and to pay interest to providers when clean claims are not paid promptly. This is evidenced by the Company’s commitment to continual auditing and quality review of the accuracy of manually-adjudicated and system-adjudicated claims. As of year-end 2006, Financial Accuracy (calculated as absolute value of overpayments and underpayments, divided by the total correct approved dollars in the sample) was 99%; Payment Accuracy (calculated as number of claims paid correctly, divided by the total

number of claims reviewed) was 99%; Overall Accuracy (calculated as number of claims processed correctly, divided by the total number of claims reviewed), which includes both statistical errors (documentation, coding, etc.) and payment errors, was 97%; and 99% of claims were adjudicated within 30 days.

Although several sections of the Report reference violations of Act 68, the Company's response is focused on those violations identified under Sections A. Medical Claims Provider Submitted, D. Provider Submitted Emergency – Clean Claims, E. Provider Submitted Medical – Clean Claims and F. Provider Submitted Mental Illness – Clean Claims. The violations of Act 68 listed in the other Report sections are inherent to the underlying violations referenced by the Department and the corrective actions identified by the Company for those sections.

It is important to highlight that the “clean claim” populations reviewed by the Department for Sections D. and E. were not limited to claims that were “clean” when originally received by the Company and paid after 45 days from receipt. The Company acknowledged that during the period examined, the data from its claims system (due to limitations with the system) could not accurately pinpoint a new clean date for claim adjustments\*. This resulted in all claims paid over 45 days from the original receipt date being included in the Department's population, rather than just clean claims paid over 45 days.

\*(The Company does not pend claims. Rather, the denial or payment of a claim creates a finalized claim. If additional information is received, a new claim number is assigned and the claim is adjusted appropriately. The claim population provided to the Department was comprised primarily of these adjusted claims. That is, the population provided to the Department contained claims that were not “clean” upon receipt, but which became clean at a later date and then were subsequently adjusted for payment).

In contrast to the clean claim populations under Sections D. and E. referenced in the Report, the Company also provided the Department with a list of claims from the third quarter of 2005 that were “clean” when originally received and then paid after 45 days from receipt. This list displayed that only 257 medical clean claims and 38 emergency clean claims were paid after 45 days from receipt. These combined numbers represent an extremely small percentage (0.045%) of the overall number of claims finalized during the third quarter of 2005 (approximately 649,858 claims). Consequently, these revised lists demonstrate that the previous medical and emergency clean claim populations provided to the Department overstate the true population of clean claims paid beyond 45 days.

Furthermore, we highlight the fact that the Company identified only 13,470 medical claims and 573 emergency claims paid over 45 days from receipt of the original claim. As indicated above, for a majority of these claims, the original claim received by the Company was not clean. Utilizing these numbers, of the approximately 657,000 claims finalized during the three-month experience period, only 2.1% resulted in a total processing timeframe, including adjustments, of greater than 45 days from original claim receipt.

Each of the violations listed by the Department under Sections A, D, and E, involves an adjusted claim. Adjustments to paid claims are provided for under 31 Pa. Code §154.18(d):

*...If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the re-adjudication is provided to the plan. Additional moneys which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter...*

Many of these adjustments resulted from contract implementation activities and renegotiated contract terms, which are permitted under the terms of the Company's provider contracts. The Company would also note that each adjusted claim was comprised of additional payment to the provider, not withdrawal of payment from the provider. As such, the adjustments were not detrimental to the provider and, in the case of contract renegotiation, were agreed to in advance by the provider.

While every effort is made to minimize adjustments to claims already paid, situations do arise where such adjustments may be necessary. The ability to make these adjustments is critical to the correct implementation of the provider contract.

Examples of unavoidable adjustments include, but are not limited to, the following:

- Because rates are often based on a percentage of CMS's Medicare fee schedule, changes made to the Medicare schedule, but not distributed timely to the public can result in retroactive changes to the Company's contracted reimbursement rates. Adjustments may be necessary after the contract is implemented and initial payments are made to reflect the changes in the Medicare fee schedule.
- During contract negotiations, the Company and the provider agree on the codes billable and the reimbursement levels associated with each. Due to the complexity of these contracts, even the most carefully drafted contracts contain terms that may be interpreted differently by each contracting party. Additional negotiations over differing contract interpretations are occasionally required after the contract is executed. These additional negotiations can result in mutually agreed upon modifications to the fee schedule, retroactive to the original contract execution date. Adjustments may be necessary after the contract is implemented and initial payments are made to reflect the parties agreed upon interpretation.
- Occasionally, adjustments are made due to errors in contract implementation. As noted previously, in the event that an adjustment was made due to internal error, the Company applies the applicable interest to the adjusted amount in accordance with the Prompt Payment law.

In order to reduce the number of these adjustments, in 2006 the Company developed contract implementation teams and quality auditing teams to oversee the process. This has resulted in a significant decrease in the number of adjustment projects that are necessary once fee schedules are loaded into the Company's system.

The Company has also implemented processes to ensure that all claims are adjudicated promptly and accurately. One important aspect of these processes is the Company's referenced commitment to continual auditing and quality review of the accuracy of

manually-adjudicated and system-adjudicated claims. The Company utilizes both a team and individual based monitoring and educational process. When certain claim adjudication trends are identified, the Company provides training to the claim processing team or individual depending on the specific issue and educational need. Cross departmental training is also provided should a claim processing issue involve more than one department. The results of this approach are evidenced by the Company's high level of accuracy in its claim adjudication.

Concerning those claims referenced under Section F. Provider Submitted Mental Illness – Clean Claims, during the examination period, the Company contracted with ValueOptions, Inc. as its behavioral health administrator. The contract with ValueOptions included claims payment services. Providers were instructed in their contracts with ValueOptions to send all claims for behavioral health services directly to ValueOptions. Since these behavioral health providers were contracted with ValueOptions and not with the Company, they were contractually bound to submit claims directly to ValueOptions for payment when services were rendered to the Company's members.

The 42 mental illness and substance abuse claims identified as paid over 45 days represents an extremely small percentage (.07%) of the overall number of mental illness and substance abuse claims finalized during the second quarter of 2005 (60,414 claims). In addition, several of the claim lines reviewed by the Department were lines from the same claim and 20 of the 25 claims found in violation were related to a benefit set-up issue concerning one group. This further evidences that the total population of mental illness and substance abuse clean claims paid over 45 days is extremely small in comparison to the total number of claims finalized.

As of September 1, 2006, the Company entered into an arrangement with a new behavioral health administrator, United Behavioral Health (UBH). As with ValueOptions, providers submit claims directly to UBH for processing. Prompt claims payment is a performance guarantee of the contract between the Company and UBH and the Company is constantly monitoring UBH to ensure the applicable standard is met.

To reiterate, the Company is committed to adjudicating all claims in accordance with Act 68. The Company's policy is to adjudicate claims as quickly as feasible while maintaining accuracy, efficiency and provider and member relations.

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

**Response:**

As with Act 68, the Company takes its obligation to acknowledge and process claims within the timeframes identified under Chapter 146 of Title 31 of the Pennsylvania Code very seriously.

For purposes of this response, it should be noted that the claims reviewed by the Department under Sections B. Emergency Claims – Subscriber Submitted and C. Medical Claims – Subscriber Submitted included claims submitted directly to the

Company by both subscribers and non-contracted providers. For those claims submitted to the Company by the provider, the review was limited to claims where payment was sent directly to the subscriber rather than the provider of services. For those claim items listed in violation under Sections B. and C., only six (6) claims were submitted to the Company directly by the subscriber. The remaining claims listed in violation were submitted to the Company by the provider of services.

The Company utilizes an established process for handling claims submitted by the subscriber. To further ensure that claims are handled in compliance with this process, the Company has provided the additional training necessary to its claim representatives, supervisors and managers staffed to handle subscriber reimbursement claims to ensure that claims submitted by subscribers are processed correctly and within the Chapter 146 timeframes. This additional training was provided immediately after the Company learned of these violations. To verify that the additional training was successful, the Company is also reviewing a weekly report of claims paid to the subscriber to confirm that these claims were processed within the appropriate timeframes. These corrective actions, in addition to the current defined process, will ensure that claims submitted by the subscriber are processed in accordance with Chapter 146.

Claims submitted by the provider and paid to the subscriber were included in the Department's review because the Department's position is that claims submitted by non-contracted providers and paid directly to the member qualify as subscriber submitted claims under 31 Pa. Code §146. Specifically, the Department's position is that because there is no obligation by a health care entity to pay or provide an explanation of benefits to a nonparticipating provider, that 31 Pa. Code §146, et.al. is applicable to claims submitted by non-contracted providers when payment is made directly to the member.

However, it is the Company's position that 31 Pa. Code §146 is not applicable to provider submitted claims and that provider submitted claims are solely governed by the Quality Health Care Accountability and Protection Act, No. 68, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims. This position is supported by the provisions of 40 P.S. § 991.2102 and 2166 (Quality Health Care and Accountability and Protection), 31 Pa. Code § 146 (Unfair Insurance Practices) and 31 Pa. Code § 154.18 (Prompt Payment).

A "Health care provider" is defined under 40 P.S. § 991.2102 as:

"...A licensed hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide health care services under the laws of this Commonwealth, including a physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide behavioral health services."

This definition does not distinguish between contracted and non-contracted health care providers. Furthermore, 40 P.S. § 991.2166 makes no reference to the contracted status of the provider submitting the claim. Consequently,

is it reasonable to interpret these provisions as including all claims submitted by providers, contracted or non-contracted, even if payment is sent directly to the member.

The Company's position is further supported by the definition of Claimant and First-party claimant under 31 Pa. Code § 146.2 Claimant and First-party claimant are defined as follows:

*“Claimant—*Except as provided in § 146.10 (relating to written notice to claimants of payment of claim in third-party settlements), either a first-party claimant, a third-party claimant, or both, and including the claimant's attorney and a member of the claimant's immediate family designated by the claimant.”

*“First-party claimant—*An individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract.”

When a member submits a claim for payment, they are asserting a right to payment for any resulting loss they incurred for the health care services received based on the health insurance policy. A non-contracted provider does not have the equivalent right to payment because there is no direct contract with an insurer to support or require payment. Consequently, a reasonable interpretation of the definition of “Claimant” is that it does not include non-contracted provider submitted claims.

The provisions of 31 Pa. Code § 154.18 Prompt Payment also support the Company's contention that provider submitted claims paid to the member are not subject to 31 Pa. Code §146. The Department has interpreted these provisions as not prohibiting payment directly to a member when a claim is submitted by a non-contracted provider of services. This interpretation, in addition to the Prompt Payment regulation, which directs insurers to disclose to non-contracted providers the data elements necessary to insure that a claim is clean, confirm that claims submitted by non-contracted providers were intended to exclusively be subject to the Prompt Payment law and not 31 Pa. Code §146, et.al. The regulation provides clear direction that claims submitted by non-contracted providers are subject to 40 P.S. §991.2166 as it states:

“(e) Licensed insurers and managed care plans shall provide written disclosure to health care providers of all the data elements necessary to insure that a claim is without defect or impropriety and meets the definition of clean claim under the act.

(1) Licensed insurers and managed care plans shall provide this information to currently participating health care providers by April 10, 2000. For health care providers entering into a participation agreement with the licensed insurer or managed care plan after March 11, 2000, the licensed insurer or managed care plan shall provide this information within 30 days of the parties entering into a participation agreement. If changes are made to the required data elements, this information shall be provided to

participating health care providers at least 30 days before the effective date of the changes.

**(2) For nonparticipating health care providers, a licensed insurer or managed care plan shall provide this information within 45 days of an oral or written request from the health care provider.” (31 Pa. Code § 154.18(3)(1) and (2)).” [emphasis added]**

Neither 40 P.S. § 991.2166 or 31 Pa. Code § 154.18 provide an explicit exception for non-contracted provider submitted claims paid to the subscriber or otherwise indicate that the timeframes under 31 Pa. Code §146 are applicable to these claims.

Therefore, the Company submits that based on a reasonable interpretation of the provisions of 40 P.S. § 991.2166 and 31 Pa. Code § 154.18, the direction provided by the Department under the Prompt Payment Regulation and by the Bureau of Accident and Health Insurance, that all provider submitted claims are subject to the Prompt Payment law rather than the provisions of 31 Pa. Code § 146.5, 146.6 and 146.7.

Although the Company disagrees with the Department’s position that claims submitted by non-contracted providers and paid to the subscriber are subject to the timeframes under 31 Pa. Code §146, the Company has modified this process and ceased rendering payment directly to the subscriber in these situations. Should the Company decide to again implement a process of direct subscriber payment, it will ensure that claims submitted by non-contracted providers and paid to the subscriber are handled within the Section 146 timeframes. In addition, effective February 2006, the Company highlights that it did begin sending Remittance Advice Forms (i.e. EOBs) to the non-contracted provider when payment was made directly to the subscriber.

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

**Response:**

The Report references two separate time periods for review of the Company’s compliance with 40 P.S § 908-2 (“Act 106”). Sections G. Alcohol and Drug Denied Claims, and H. Alcohol and Drug Unique Code Denied Claims, identify claims reviewed during the examination experience period of April 1, 2005 to June 30, 2005. Section I. Alcohol and Drug Coverage Denied for Medical Necessity, identifies authorizations reviewed for the time period August 8, 2003 through May 31, 2005.

The difference in these time periods is noteworthy, especially when viewed in light of the Company’s implemented corrective action. During the time period reviewed, the Company contracted with ValueOptions as its behavioral health administrator. From August 2003 through May 2005, ValueOptions’ process was to review each request for services as defined under Act 106 for medical necessity. If such services did not meet the applicable medical necessity criteria, a denial of authorization was rendered. This process was applied regardless of whether a licensed physician or psychologist, as defined under Act 106, made the request for services.

Effective May 2005, this process was subsequently modified to approve for payment those requests for services rendered under Act 106. Specifically, any request for services from a licensed physician or psychologist was and is continuing to be processed for payment in accordance with the Department's direction as outlined under Department Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003) ("2003 Notice"). Compliance with the 2003 Notice was noted by the Department during its review of a sample of authorization requests from July 2005.

As of September 1, 2006, the Company entered into an arrangement with a new behavioral health administrator, United Behavioral Health (UBH). The Company has also specifically instructed UBH to authorize and pay claims for services under Act 106 in compliance with the 2003 Notice.

It should be noted that subsequent to May 2005, utilization review is still performed. However, any corresponding utilization review decision does not limit the request for services by the licensed physician or licensed psychologist. The continuation of the utilization review process was contemplated in the 2003 Notice and is significant in coordinating patient care and in meeting quality standards such as those outlined by the National Committee for Quality Assurance.

Notwithstanding the Company's voluntary compliance with the 2003 Notice and its acknowledgment that it did perform medical necessity review for those authorizations referenced in violation under Section I. of the Report, the Company respectfully suggests that the uncertainty created by the Department's decision to issue the 2003 Notice, which has not yet been resolved by the Pennsylvania Commonwealth Court, militates against a finding of any violations under Act 106.

The Company believes that it has complied and continues to comply with Act 106 and the Department's interpretation thereof. Specifically, for over a decade insurers and managed care entities relied on an interpretation of Act 106 articulated by the Department in an April 5, 1993 Department Notification ("1993 Notice"). In the 1993 Notice, the Department actually *invited* insurers and managed care entities to submit form and rate filings for Department approval that apply managed care principles, including utilization review, to the delivery of Act 106 benefits:

Act 106 of 1989 established the mandated benefit for drug and alcohol treatment in group health insurance policies approved for use in Pennsylvania. *With the increased emphasis on eliminating unnecessary costs and managing care in this particular area*, many insurance companies have expressed an interest in offering a product that uses a pre-certification system to determine appropriateness of treatment for substance abuse patients.

. . . .

It is now possible for the Department of Insurance *to approve products of licensed health insurers that have pre-certification as part of the process for determining appropriateness of treatment. The Department will accept filings which use managed care techniques in the treatment of substance abuse . . . .*

As standards and processes are developed, insurers will be expected to keep their pre-certification systems current.

*Please distribute this notification to staff who may be preparing filings.*  
(Emphasis Added)

Accordingly, what the Department identified as violations of Act 106 is actually consistent with a prior interpretation of Act 106 announced by the Department and that stood unchallenged for over a decade.

What complicates this matter, however, is the 2003 Notice, which represents a dramatic shift in the Department's decade-old interpretation of Act 106. Though Act 106 did not change in the interim, the 2003 Notice offers a new interpretation that actually forecloses, rather than invites, pre-certification utilization review of Act 106 benefits. Under these circumstances, it was not unreasonable for managed care entities, including the Company, to be confused as to which Department interpretation (*i.e.*, the 1993 Notice or the 2003 Notice) is, in fact, the correct interpretation of Act 106.

The 2003 Notice is, at best, a statement of policy and represents only the Department's current interpretation of Act 106, as was equally true of the 1993 Notice. Given the differing and irreconcilable interpretations of Act 106 present by these Notices, the Company, and other insurers and managed care entities, first sought a dialogue with the Department to achieve some clarity. When this dialogue did not yield any clear guidance as to the true meaning of Act 106, the Company, along with others ("Petitioners"), sought the aid of the Pennsylvania Commonwealth Court in resolving the uncertainty in January 2004. Working *with the Department*, the Petitioners and the Department jointly sought expedited review by the Commonwealth Court of this important issue. Indeed, in one of its filings with the Pennsylvania Supreme Court in the case, the Department specifically recognized that the dispute over the meaning of Act 106 created by the issuance of the 2003 Notice "is concrete, purely legal, and had industry-wide application."

As indicated above, since the Department issued the 2003 Notice, the Company has worked cooperatively with the Department until the issue over the proper interpretation of Act 106 is resolved by the Commonwealth Court. Initially, from August 8, 2003 through May 31, 2005, the Company continued to abide by the Department's 1993 Notice. Where, however, a plan participant or insured complained to the Department about the Company's findings in the pre-certification process for Act 106 benefits and where the Department raised the complaint with the Company, the Company voluntarily agreed to provide the requested benefit *under protest*. In response to an April 25, 2005 demand from the Department that the Company comply with the 2003 Notice, pending resolution of the issues in Commonwealth Court, the Company again cooperated and acquiesced (under protest), as confirmed in a May 4, 2005 letter to the Department.

In short, the Company has been and continues to be cooperative with the Department with respect to Act 106 while what even the Department acknowledges to be a concrete dispute is resolved by the Commonwealth Court. The Company voluntarily came into compliance with the Department's latest interpretation of Act 106 when the

Department demanded that it do so, notwithstanding the pending litigation and a recognized reasonable and concrete dispute over the true meaning of Act 106.

**6. The Company must review and revise internal control procedures to ensure compliance with Minimum Covered Services of Title 31, Pennsylvania Code, Chapter 89, Section 89.612 for Alcohol treatment services.**

**Response:**

The Company's response to this recommendation is similar to the response it provided under Paragraph 5 above as 31 Pa. Code § 89.612 is the regulation which implements the mandated benefits for the treatment of alcohol and drug abuse dependency under 40 P.S. § 908-2 ("Act 106").

During the time period reviewed, the Company contracted with ValueOptions as its behavioral health administrator. From August 2003 through May 2005, ValueOptions' process was to review each request for services as defined under Act 106 for medical necessity. If such services did not meet the applicable medical necessity criteria, a denial of authorization was rendered. This process was applied regardless of whether a licensed physician or psychologist, as defined under Act 106, made the request for services.

Effective May 2005, this process was subsequently modified to approve for payment those requests for services rendered under Act 106. Specifically, any request for services from a licensed physician or psychologist was and is continuing to be processed for payment in accordance with the Department's direction as outlined under Department Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003) ("2003 Notice"). Compliance with the 2003 Notice was noted by the Department during its review of a sample of authorization requests from July 2005.

As of September 1, 2006, the Company entered into an arrangement with a new behavioral health administrator, United Behavioral Health (UBH). The Company has also specifically instructed UBH to authorize and pay claims for services under Act 106 in compliance with the 2003 Notice.

It should be noted that subsequent to May 2005, utilization review is still performed. However, any corresponding utilization review decision does not limit the request for services by the licensed physician or licensed psychologist. The continuation of the utilization review process was contemplated in the Notice and is significant in coordinating patient care and in meeting quality standards such as those outlined by the National Committee for Quality Assurance.

Notwithstanding the Company's voluntary compliance with the 2003 Notice, the Company respectfully suggests that the uncertainty created by the Department's decision to issue the 2003 Notice, which has not yet been resolved by the Pennsylvania Commonwealth Court, militates against a finding of any violations under Act 106 and 31 Pa. Code § 89.612.

The Company believes that it has complied and continues to comply with Act 106 and the Department's interpretation thereof. Specifically, for over a decade insurers and managed care entities relied on an interpretation of Act 106 articulated by the

Department in an April 5, 1993 Department Notification (“1993 Notice”). In the 1993 Notice, the Department actually *invited* insurers and managed care entities to submit form and rate filings for Department approval that apply managed care principles, including utilization review, to the delivery of Act 106 benefits:

Act 106 of 1989 established the mandated benefit for drug and alcohol treatment in group health insurance policies approved for use in Pennsylvania. *With the increased emphasis on eliminating unnecessary costs and managing care in this particular area*, many insurance companies have expressed an interest in offering a product that uses a pre-certification system to determine appropriateness of treatment for substance abuse patients.

. . . .

It is now possible for the Department of Insurance *to approve products of licensed health insurers that have pre-certification as part of the process for determining appropriateness of treatment. The Department will accept filings which use managed care techniques in the treatment of substance abuse . . . .*

As standards and processes are developed, insurers will be expected to keep their pre-certification systems current.

*Please distribute this notification to staff who may be preparing filings.*  
(Emphasis Added)

Accordingly, what the Department identified as violations of Act 106 and 31 Pa. Code § 89.612 is actually consistent with a prior interpretation of Act 106 announced by the Department and that stood unchallenged for over a decade.

What complicates this matter, however, is the 2003 Notice, which represents a dramatic shift in the Department’s decade-old interpretation of Act 106. Though Act 106 did not change in the interim, the 2003 Notice offers a new interpretation that actually forecloses, rather than invites, pre-certification utilization review of Act 106 benefits. Under these circumstances, it was not unreasonable for managed care entities, including the Company, to be confused as to which Department interpretation (*i.e.*, the 1993 Notice or the 2003 Notice) is, in fact, the correct interpretation of Act 106.

The 2003 Notice is, at best, a statement of policy and represents only the Department’s current interpretation of Act 106, as was equally true of the 1993 Notice. Given the differing and irreconcilable interpretations of Act 106 present by these Notices, the Company, and other insurers and managed care entities, first sought a dialogue with the Department to achieve some clarity. When this dialogue did not yield any clear guidance as to the true meaning of Act 106, the Company, along with others (“Petitioners”), sought the aid of the Pennsylvania Commonwealth Court in resolving the uncertainty in January 2004. Working *with the Department*, the Petitioners and the Department jointly sought expedited review by the Commonwealth Court of this important issue. Indeed, in one of its filings with the Pennsylvania Supreme Court in the case, the Department specifically recognized that the dispute over the meaning of

Act 106 created by the issuance of the 2003 Notice “is concrete, purely legal, and had industry-wide application.”

As indicated above, since the Department issued the 2003 Notice, the Company has worked cooperatively with the Department until the issue over the proper interpretation of Act 106 is resolved by the Commonwealth Court. Initially, from August 8, 2003 through May 31, 2005, the Company continued to abide by the Department’s 1993 Notice. Where, however, a plan participant or insured complained to the Department about the Company’s findings in the pre-certification process for Act 106 benefits and where the Department raised the complaint with the Company, the Company voluntarily agreed to provide the requested benefit *under protest*. In response to an April 25, 2005 demand from the Department that the Company comply with the 2003 Notice, pending resolution of the issues in Commonwealth Court, the Company again cooperated and acquiesced (under protest), as confirmed in a May 4, 2005 letter to the Department.

In short, the Company has been and continues to be cooperative with the Department with respect to Act 106 while what even the Department acknowledges to be a concrete dispute is resolved by the Commonwealth Court. The Company voluntarily came into compliance with the Department’s latest interpretation of Act 106 when the Department demanded that it do so, notwithstanding the pending litigation and a recognized reasonable and concrete dispute over the true meaning of Act 106.

**7. The Company must review internal control procedures to ensure compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. § 1171.1 et. seq.).**

**Response:**

The Company’s response to this recommendation is similar to the response it provided under Paragraph 5 above as the referenced violations of 40 P.S. § 1171.1 et. seq. are listed under Sections G. Alcohol and Drug Denied Claims, H. Alcohol and Drug Unique Code Denied Claims and I. Alcohol and Drug Coverage Denied for Medical Necessity, of the Report.

The Report references two separate time periods for review of the Company’s compliance with 40 P.S. § 908-2 (“Act 106”). Sections G. and H. identify claims reviewed during the examination experience period of April 1, 2005 to June 30, 2005. Section I. identifies authorizations reviewed for the time period August 8, 2003 through May 31, 2005.

The difference in these time periods is noteworthy, especially when viewed in light of the Company’s implemented corrective action. During the time period reviewed, the Company contracted with ValueOptions as its behavioral health administrator. From August 2003 through May 2005, ValueOptions’ process was to review each request for services as defined under Act 106 for medical necessity. If such services did not meet the applicable medical necessity criteria, a denial of authorization was rendered. This process was applied regardless of whether a licensed physician or psychologist, as defined under Act 106, made the request for services.

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services from a licensed physician or psychologist was and is continuing to be processed for payment in accordance with the Department's direction as outlined under Department Notice 2003-06, 33 Pa. Bull. 4041 (Aug. 9, 2003) ("2003 Notice"). Compliance with the 2003 Notice was noted by the Department during its review of a sample of authorization requests from July 2005.

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Notwithstanding the Company's voluntary compliance with the 2003 Notice and its acknowledgment that it did perform medical necessity review for those authorizations referenced in violation under Section I. of the Report, the Company respectfully suggests that the uncertainty created by the Department's decision to issue the 2003 Notice, which has not yet been resolved by the Pennsylvania Commonwealth Court, militates against a finding of any violations under Act 106 and 40 P.S. § 1171.1 et. seq.

The Company believes that it has complied and continues to comply with Act 106 and the Department's interpretation thereof. Specifically, for over a decade insurers and managed care entities relied on an interpretation of Act 106 articulated by the Department in an April 5, 1993 Department Notification ("1993 Notice"). In the 1993 Notice, the Department actually *invited* insurers and managed care entities to submit form and rate filings for Department approval that apply managed care principles, including utilization review, to the delivery of Act 106 benefits:

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As standards and processes are developed, insurers will be expected to keep their pre-certification systems current.

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(Emphasis Added)

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In short, the Company has been and continues to be cooperative with the Department with respect to Act 106 while what even the Department acknowledges to be a concrete dispute is resolved by the Commonwealth Court. The Company voluntarily came into compliance with the Department's latest interpretation of Act 106 when the Department demanded that it do so, notwithstanding the pending litigation and a recognized reasonable and concrete dispute over the true meaning of Act 106.

**8. The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices act, No 205 (40 P.S. § 1171.5).**

**Response:**

The Department's recommendation concerning 40 P.S. § 1171.5 is attributable to violations noted under Sections M. Denied Claims – Exceeds Authorized Visits, N. Mental Illness and Substance Abuse Denied Claims and O. Large Group Mental Illness and Substance Abuse Denied Claims.

For seven (7) of the eight (8) referenced violations, the initial claim denial resulted from a claim processing error by the Company or its previously contracted behavioral health administrator, ValueOptions. Because of the uniqueness of each processing error, the Company respectfully disagrees with the Department that these errors amount to a violation of 40 P.S. § 1171.5(a)(10). That is, each processing error was significantly dissimilar so as not to be committed or performed with such frequency to indicate a business practice. In addition, where appropriate, the Company corrected the errors and processed the applicable claims for payment.

As the Department is aware, the receipt, review and adjudication of health care claims is a complex process. While the Company strives for 100% claims processing accuracy, the reality is that errors do occasionally occur. To minimize claim adjudication errors, the Company has implemented processes to ensure that claims are adjudicated accurately. One important aspect of this process is the Company's commitment to continual auditing and quality review of the accuracy of manually-adjudicated and system-adjudicated claims. The Company utilizes both a team and individual based monitoring and educational process. When certain claim adjudication trends are identified, the Company provides training to the claim processing team or individual depending on the specific issue and educational need. Cross departmental training is also provided should a claim processing issue involve more than one department.

The results of this approach are evidenced by the Company's high level of accuracy in its claim adjudication. As of year-end 2006, Financial Accuracy (calculated as absolute value of overpayments and underpayments, divided by the total correct approved dollars in the sample) was 99%; Payment Accuracy (calculated as number of claims paid correctly, divided by the total number of claims reviewed) was 99%; Overall Accuracy (calculated as number of claims processed correctly, divided by the total number of claims reviewed), which includes both statistical errors (documentation, coding, etc.) and payment errors, was 97%; and 99% of claims were adjudicated within 30 days.

To reiterate, the Company is committed to adjudicating all claims as quickly as feasible while maintaining accuracy, efficiency and provider and member relations.

**9. The Company must revise control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. § 991.2166)**

The Company takes seriously its obligations under Act 68 to pay claims promptly and to pay interest to providers when clean claims are not paid promptly. The Company has an established set of claim processing guidelines which outline in detail the interest requirement under Act 68. Each claim representative receives training on these guidelines for both automated and manually adjudicated claims. To minimize claim adjudication errors, the Company has implemented processes to ensure that claims are adjudicated accurately. One important aspect of these processes is the Company's commitment to continual auditing and quality review of the accuracy of manually-adjudicated and system-adjudicated claims. The Company utilizes both a team and individual based monitoring and educational process. When certain claim adjudication trends are identified, the Company provides training to the claim processing team or individual depending on the specific issue and educational need. Cross departmental training is also provided should a claim processing issue involve more than one department.

This approach is evidenced by the Company's commitment to continual auditing and quality review of the accuracy of manually-adjudicated and system-adjudicated claims. As of year-end 2006, Financial Accuracy (calculated as absolute value of overpayments and underpayments, divided by the total correct approved dollars in the sample) was 99%; Payment Accuracy (calculated as number of claims paid correctly, divided by the total number of claims reviewed) was 99%; Overall Accuracy (calculated as number of claims processed correctly, divided by the total number of claims reviewed), which includes both statistical errors (documentation, coding, etc.) and payment errors, was 97%; and 99% of claims were adjudicated within 30 days.

The Company respectfully objects to the violation cited under 40 P.S. § 991.2166. The Company provided sufficient evidence to the Department that it applied the correct amount of interest from the date the claim was clean to the paid date for the claim at issue.

To reiterate, the Company is committed to adjudicating all claims in accordance with Act 68. The Company's policy is to adjudicate claims as quickly as feasible while maintaining accuracy, efficiency and provider and member relations.

**10. The Company must implement internal control procedures to ensure compliance with Insurance Company Law, Section 635.1 (40 P.S. §764g) concerning coverage for Serious Mental Illness.**

**Response:**

The Department noted one violation of 40 P.S. §764g in the Report. The Company has implemented the appropriate internal control procedures to ensure compliance with 40 P.S. §764g. Each of the Company's Certificates of Insurance provided to employers with 50 or more employees contain language evidencing the applicability of the mandate.

During the time period reviewed, ValueOptions served as the Company's behavioral health administrator. Effective September 1, 2006, the Company contracted with United Behavioral Health as its new behavioral health administrator. United Behavioral Health has also implemented the appropriate internal controls to ensure that benefits are provided in accordance with the Serious Mental Illness mandate. As part of its delegation of administrative services, the Company is constantly monitoring United Behavioral Health to ensure that the mandated provisions of 40 P.S. §764g are applied and processed appropriately.

**11. The Company must review internal control procedures to ensure compliance with Insurance Company Law, No. 81, Section 1 (40 P.S. §771) and Title 31, Pennsylvania Code, Section 89.205 concerning Newborn Children Coverage.**

**Response:**

The Department noted one violation of 40 P.S. §771 and 31 Pa.Code 89.205 in the Report. As the Company communicated to the Department, this matter involved a set of unique circumstances which ultimately resulted in the Company denying the claim in error for services not eligible. Because notification of the birth was not received by the Company until three (3) months after the birth occurred and the initial claim submission was not received by the Company until almost one year after the services were rendered, the claim should have been denied because it was not submitted timely.

Although these circumstances were unique, the Company has implemented additional internal control procedures to ensure compliance with 40 P.S. §771 and 31 Pa.Code 89.205. Specifically, the Company has added internal controls to its claim adjudication system to enhance the identification process for claims for services provided to newborns within the first thirty-one (31) days from birth. These controls also prompt the Company's enrollment Department to review and update as necessary the eligibility status of the newborn if the Company has not otherwise been notified of the birth by the parent or parent's employer.

This control, in addition to the current established process for adjudicating newborn claims, will ensure that all claims for services rendered thirty-one (31) days from birth are adjudicated appropriately.

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

The Company notes that it has already processed and paid many of the claims referenced as violations by the Department in the Report. The Company will provide the Department with verification of claim payment and interest on all claims listed by the Department as denied inappropriately.