REPORT OF
MARKET CONDUCT EXAMINATION
OF

KEYSTONE HEALTH PLAN EAST, INC.
Philadelphia, PA

AS OF
March 23, 2010

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION

Issued: May 11, 2010

KEYSTONE HEALTH PLAN EAST, INC.

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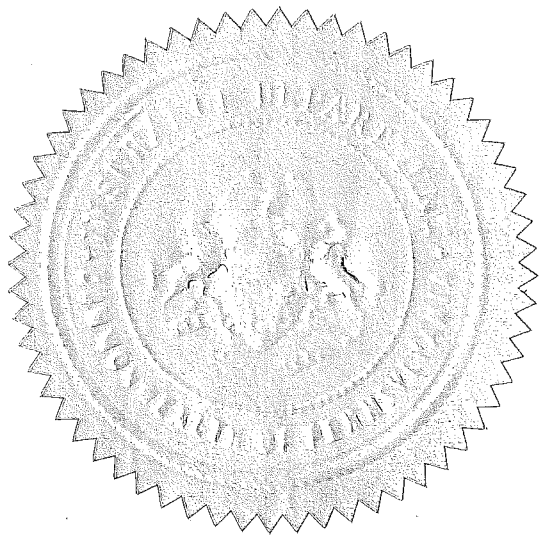
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22ND day of July, 2008, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
KEYSTONE HEALTH PLAN EAST, INC. 1901 Market Street Philadelphia, PA 19103-1480	:	Section 903 of the Insurance Company Law, Act of May 17, 1921, P.L. 789, No. 285 (40 P.S. § 323.3)
	:	Title XXVII, Section 2701(e) of The Health Care Insurance Portability Act of June, 1997, P.L. 295, No. 29 (40 P.S. § 1302.4)
	:	Sections 2166(A) and (B) of the Act of June 17, 1998, P.L. 464, No. 68 (40 P.S. §§991.2166)
	:	Title 31, Pennsylvania Code, Sections 89.612, 154.18(c), 146.3
Respondent.	:	Docket No. MC10-04-008

CONSENT ORDER

AND NOW, this 11th day of May, 2010, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

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

(a) Respondent is Keystone Health Plan East, Inc., and maintains its address at 1901 Market Street, Philadelphia, PA 19103-1480.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2005 through December 31, 2007.

(c) On March 23, 2010, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on April 23, 2010.

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

(i) 40 Purdons Statutes, Section 323.3(a), which requires every company subject to examination keep all records and documents relating to its business in such manner as may be required in order that the Department may verify whether the company has complied with the laws of this Commonwealth;

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

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

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

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

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

(iv) Section 2166(B) of Act 68 (40 P.S. § 991.2166), which provides requires that if a licensed insurer or managed care plan fails to remit the 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;

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

treatment services and 120 outpatient, full-session visits or equivalent partial visits;

(vi) Title 31, Pennsylvania Code, Sections 154.18(c), states that interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim; and

(vii) Title 31, Pennsylvania Code, Section 146.3, which requires the claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

CONCLUSIONS OF LAW

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

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

(b) Respondent's violations of Section 2701(e) of the Health and Accident Reform Act, No. 159 (40 P.S. § 1302.4) are punishable under Section 13 of the Act:

(i) suspension or revocation of the license of the offending insurer or HMO;

(ii) refusal, for a period not to exceed one year, to issue a new license to the offending insurer or HMO;

(iii) a fine of not more than $5,000 for each violation of this Act;

(iv) a fine of not more than $10,000 for each willful violation of this Act;

(v) a fine of not more than $25,000 for each wilful violation of Section 6.

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

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

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(e) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 - 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. § § 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

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

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the attached Report.

(d) Respondent shall pay Fifteen Thousand Dollars ($ 15,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.

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

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein, may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Insurance Department may enforce the provisions of

this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

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

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

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

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained

herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: KEYSTONE HEALTH PLAN EAST,
Respondent

President and Chief Executive Officer

Senior Vice President, Chief Financial Officer and Treasurer

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

I. INTRODUCTION

The Market Conduct Examination was conducted on Keystone Health Plan East, Inc., hereafter referred to as "Company," at the Company's office located in Philadelphia, Pennsylvania, August 18, 2008, through May 14, 2009. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

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

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

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

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

Daniel Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief

Lonnie L. Suggs
Market Conduct Examiner

Gary L. Boose, MCM
Market Conduct Examiner

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

Verification

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

Lonnie L. Suggs, Examiner in Charge

Sworn to and Subscribed Before me

This 29 Day of January, 2010

Notary Public

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

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2005, through December 31, 2007, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

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

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

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

III. COMPANY HISTORY AND LICENSING

Keystone Health Plan East, Inc., (KHPE) was incorporated and founded in 1986, as a wholly owned subsidiary of Pennsylvania Blue Shield.

In January 1991, Independence Blue Cross acquired a 50% share of KHPE's ownership. In 1997, Independence Blue Cross acquired the 50% share of KHPE previously owned by Pennsylvania Blue Shield. Since 1997, KHPE has been a wholly owned subsidiary of Independence Blue Cross.

KHPE's current service area consists of the following five counties: Bucks, Chester, Delaware, Montgomery and Philadelphia. Current lines of business include HMO group commercial, Point of Service (POS) group commercial, Medicare Risk and Medicaid managed care. The POS group commercial product is administered through a joint service agreement with QCC Insurance Company.

KHPE's total Pennsylvania earned premium, as reported in their 2007 annual statement, was $3,950,901,713.

IV. FORMS

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

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

V. UNDERWRITING

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

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

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

A. Underwriting Guidelines

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The documentation provided was reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following guidelines were reviewed:

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

B. Group Policies Terminated

The Company was requested to provide a list of all group policies terminated during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 1,346 group policies terminated. A random sample of 25 files was requested, received and reviewed. The 25 policy files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

C. Group Certificates Terminated

The Company was requested to provide a list of all group certificates terminated during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 143,472 group certificate holders terminated. A random sample of 50 files was requested. Of the 50 files requested, 49 were received and reviewed. The files were reviewed for compliance with contract provisions, applicable statutes, laws and regulation to ensure terminations were not the result of any discriminatory underwriting practice. The following violations and concern were 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, at its discretion, may require in order that its authorized representatives may readily ascertain whether the Company or person has complied with the laws of this Commonwealth.

The file noted was missing.

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

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

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

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

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

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

D. Group Conversions

The Company was requested to provide a list of all certificate holders converting group insurance during the experience period. The Company identified a universe of 549 certificate holders converting their group coverage upon termination to an optional group insurance plan. A random sample of 25 files was requested, received and reviewed. The files were reviewed to ensure compliance with applicable insurance conversion and underwriting statutes and regulations. No violations were noted.

VI. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. In addition, specific claim procedures for the handling of Alcohol and Substance Abuse claims were requested. The Company provided 18 claim manuals and referenced IBC's family of Company's website (www.ibx.com) and their Substance Abuse and Mental Health third party administrator's, website (www.MagellanHealth.com).

The claim manuals, websites and claim procedures for the handling of Alcohol and Substance Abuse claims were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted. The following concern was noted:

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

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

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

The Department is concerned that the use of the precertification/medical necessity guidelines by KHPE and Magellan as posted on their respective websites and the omission and lack of disclosure of their internal claim process requirements to invoke Act 106, alcohol and drug dependency minimum mandated benefits is misleading. By omitting and not providing instructions of the Company's internal claim procedures on the submission requirements to invoke the alcohol and drug abuse mandated benefit coverage, the providers are led to believe that the Company through a utilization review process determines and controls the nature and duration of treatment. When in fact and according to the Company's internal claim procedures, the written certification and referral from a licensed physician or licensed psychologist in all instances controls both the nature and duration of treatment.

The claim file review consisted of 7 areas:

A. Mental Health Claims Denied
B. Substance Abuse Claims Denied
C. Substance Abuse Claims Paid
D. Mental Health (Magellan) Claims Denied
E. Substance Abuse (Magellan) Claims Denied
F. Substance Abuse (Magellan) Claims Paid
G. Substance Abuse (Magellan) Services Denied

All claim files sampled were reviewed for compliance with requirements of Section 602-A of the Insurance Company Law of 1921, Alcohol/Drug Abuse and Dependency Mandated Policy Coverages; Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. §764g) Serious Mental Illnesses Mandated Benefit, the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Section 2166 of the Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims.

A. Mental Health Claims Denied

The Company was requested to provide a list of mental health claims denied during the experience period of January 1, 2007 through December 31, 2007. The Company identified a universe of 14,435 mental health claims denied. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claim adjudication process was adhering to the provisions of the policy contract; as well as complying with pertinent Commonwealth of Pennsylvania insurance laws and regulations. The following violations were noted:

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

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

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

2 Violations – Insurance Company Law, Section 2166 (B)

(40 P.S. §991.2166), Prompt Payment of Provider Claims

(B) If a licensed insurer or a managed care plan fails to remit the 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 shall not be required to pay any interest calculated to be less than two ($2) dollars.

The required interest was not paid on the 2 claims noted.

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

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

Interest was not paid within 30 days of claim payment.

B. Substance Abuse Claims Denied

The Company was requested to provide a list of claims denied during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 7,378 substance abuse claims denied and processed on their Managed Healthcare System (MHS). From the original universe of substance abuse claim denied, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the substance abuse mandated benefit. The extracted universe of denied substance abuse claims was 2,808. Of the

2,808 denied substance abuse claims, a random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claim adjudication process was adhering to the provisions of the policy contract as well as pertinent state insurance laws and regulations. The following violations were noted:

7 Violations – Insurance Company Law, Section 2166 (A)

(40 P.S. §991.2166), Prompt Payment of Provider Claims

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

The 7 clean claims noted were not paid within 45 days of receipt.

7 Violations – Insurance Company Law, Section 2166 (B)

(40 P.S. §991.2166), Prompt Payment of Provider Claims

(B) If a licensed insurer or a managed care plan fails to remit the 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 shall not be required to pay any interest calculated to be less than two ($2) dollars.

The required interest was not paid on the 7 clean claims noted.

7 Violations – Title 31, Pennsylvania Code, Section 154.18(c)

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

The interest was not paid within 30 days of claim payment for the 7 claims noted.

C. Substance Abuse Claims Paid

The Company was requested to provide a list of all paid claims for alcohol and substance abuse during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 27,517 substance abuse claims processed and paid using MHS claim processing system. A random sample of 25 claims was requested. Of the 25 claim files requested, 24 were received and reviewed. All 25 claims reviewed were provider submitted claims. The files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. No violations were noted.

D. Mental Health (Magellan) Claims Denied

The Company was requested to provide a list of all mental health claims denied during the experience period of January 1, 2007 to December 31, 2007. The Company identified a universe of 25,930 mental health claims denied. The claims were processed and paid by the company's mental health provider (Magellan). A random sample of 25 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent commonwealth insurance laws and regulations. No violations were noted.

E. Substance Abuse (Magellan) Claims Denied

The Company was requested to provide a list of claims denied during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 17,550 substance abuse claims denied that was processed directly by Magellan Behavioral Health during the exam period. From the original universe of substance abuse claim denied for the period, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the substance abuse mandated benefit. The extracted universe of denied substance abuse claims was 6,149. Of the 6,149 denied substance abuse claims, a random sample of 50 claim files was requested, received and reviewed. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

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

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the 157 sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company.

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

F. Substance Abuse (Magellan) Claims Paid

The Company was requested to provide a list of all claims paid during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 29,509 substance abuse claims paid. A random sample of 25 claim files were requested, received and reviewed. All 25 files reviewed were submitted by providers. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims. No violations were noted.

G. Substance Abuse (Magellan) Services Denied

The Company was requested to provide a list of all services denied for alcohol and drug rehabilitative services during the experience period of January 1, 2005 to December 31, 2007. The Company identified a universe of 90 denied services. All 90 files were requested and received. Of the 90 files received, 60 were reviewed to ensure that the Company was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations and concern 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 file noted was missing a copy of the providers Act 106 Certification request. Verification of the provider's complete certification was inadequate.

1 Violation - 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).

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

The company failed to provide the minimum covered benefits for the requested service.

Concern: In the review of the denied service files, the contents of the files often indicated that correspondence between the providers and the Company and/or Magellan was not complete or omitted. The Department is concerned that the omissions may have provided more insight into the nature and aspects of the denied services and allowed a clearer understanding if any compliance issues were present.

VII. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review internal control procedures to ensure compliance with claim file maintenance requirements of Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

2. The Company must review and revise internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

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

4. The Company must review internal control procedures to ensure certificates of creditable coverage are provided at the time of coverage termination as required by Title XXVII, Section 2701(e), Adopted by Pennsylvania Health Care Insurance Portability Act, Act 29, Section 4 (40 P.S. §1302.4).

5. The Company must review internal control procedures to ensure compliance with requirements of Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.

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

7. The Company should review and take note of all the Concerns listed in the Report and consider appropriate changes in order to enhance disclosure and compliance.

VIII. COMPANY RESPONSE

Independence
Blue Cross

www.ibx.com

1901 MARKET STREET
PHILADELPHIA, PA 19103-1480

April 22, 2010

Christopher R. Monahan, Director
Pennsylvania Insurance Department
Office of Market Regulation
Bureau of Market Actions
1227 Strawberry Square,
Harrisburg, PA 17120

Re: **Response of Keystone Health Plan East to the Report of Examination, Examination Warrant Number: 07-M25-051**

Dear Mr. Monahan:

Enclosed is the Response of Keystone Health Plan East ("KHPE") to the Report of Examination issued on March 5, 2010 covering the period January 1, 2005 through December 31, 2007.

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

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

Sincerely,

Richard F. Levins
Vice President and Deputy General Counsel

Enclosure

Response of Keystone Health Plan East, Inc. to the Report of Examination, Examination Warrant Number: 07-M25-051

On March 23, 2010, the Pennsylvania Insurance Department ("the Department") issued a Report of Examination of Keystone Health Plan East, Inc. ("KHPE") covering the period January 1, 2005 through December 31, 2007. Pursuant to 40 P.S. §323.5, KHPE submits the following response to the Report of Examination:

I. INTRODUCTION

KHPE does not have a response to this section.

II. SCOPE OF EXAMINATION

KHPE does not have a response to this section.

III. COMPANY HISTORY AND LICENSING

KHPE does not have a response to this section.

IV. FORMS

The Department did not find any violations in this section but the Department expressed a concern that "...the Alcohol and/or Drug Abuse Treatment Benefits provision as stated in the contract forms utilized in 2006, does not address any of the requirements to ensure compliance with the alcohol and drug abuse mandated benefits." In order to address the Department's concern, KHPE is prepared to work with the Department to provide additional clarity about Act 106/Notice 2003-06 to KHPE's groups and participants.

V. UNDERWRITING

A. Underwriting Guidelines

KHPE acknowledges that the Department found no violations in this section.

B. Group Policies Terminated

KHPE acknowledges that the Department found no violations in this section.

C. Group Certificates Terminated

The Department found one violation of the Insurance Department Act, 40 P.S. §323.3 and one violation of the Pennsylvania Health Care Insurance Portability, 40 P.S. §1302.4. KHPE acknowledges the violations noted in this section. In conjunction with this examination, KHPE has taken steps to assure that the violations were not the result of systemic issues. Appropriate operational personnel have received information from

this examination in order to better understand the violations and eliminate future errors.

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

D. Group Conversions

KHPE acknowledges that the Department found no violations in this section.

VI. CLAIMS

The Department expressed a concern that certain "precertification/medical necessity guidelines by KHPE and Magellan" may be misleading. In order to address the Department's concern, KHPE will review its websites and claim processes and take steps to assure better clarity to its groups and participants about Act 106 and Notice 2003-06.

A. Mental Health Claims Denied

The Department found four violations of the Insurance Company Law, 40 P.S. §§991.2166 (Prompt Pay of Claims). There were two claims cited for violations in this section; each claim received two prompt pay violations. The Department also found one violation of Pennsylvania Code, Section 154.18(c) for failure to pay interest on a claim. This violation was for one of the claims cited above for prompt pay violations. KHPE acknowledges the violations noted in this section. In conjunction with this examination, KHPE has taken steps to assure that the violations were not the result of systemic issues. Appropriate operational personnel have received information from this examination in order to better understand the violations and eliminate future errors.

B. Substance Abuse Claims Denied

The Department found 14 violations of the Insurance Company Law, 40 P.S. §§991.2166 (Prompt Pay of Claims). There were seven claims cited for violations in this section; each claim received two prompt pay violations. The Department also found seven violations of Pennsylvania Code, Section 154.18(c) for failure to pay interest on a claim. These violations were for the same seven claims cited for prompt pay violations. KHPE acknowledges the violations noted in this section. In conjunction with this examination, KHPE has taken steps to assure that the violations were not the result of systemic issues. Appropriate operational personnel have received information from this examination in order to better understand the violations and eliminate future errors.

C. Substance Abuse Claims Paid

KHPE acknowledges that the Department found no violations in this section.

D. Mental Health (Magellan) Claims Denied

KHPE acknowledges that the Department found no violations in this section.

E. Substance Abuse (Magellan) Claims Denied

The Department found three violations of the Insurance Company Law, 40 P.S. §§991.2166 (Prompt Pay of Claims). KHPE acknowledges the violations noted in this section. In conjunction with this examination, KHPE has taken steps to assure that the violations were not the result of systemic issues. Appropriate operational personnel have received information from this examination in order to better understand the violations and eliminate future errors.

F. Substance Abuse (Magellan) Claims Paid

KHPE acknowledges that the Department found no violations in this section.

G. Substance Abuse (Magellan) Services Denied

The Department found one violation of Title 31, Pennsylvania Code, and Section 146.3 and found one violation of Title 31, Pennsylvania Code, Section 89.612 (Minimum Covered Services). KHPE acknowledges the violations noted in this section. In conjunction with this examination, KHPE has taken steps to assure that the violations were not the result of systemic issues. Appropriate operational personnel have received information from this examination in order to better understand the violations and eliminate future errors.

The Department also expressed a concern that KHPE's files may not have included certain correspondence between providers and KHPE. KHPE will review its procedures to ensure that all necessary correspondence is being maintained in KHPE's files.

VII. RECOMMENDATIONS

KHPE acknowledges and will comply with the corrective measures contained in the recommendations issued by the Department. On or before May 22, 2010, KHPE will also provide to Department verification that KHPE has paid any inappropriately denied claim and that KHPE has also paid interest on the unpaid claim, when applicable.