

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

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

**AS OF
December 13, 2010**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
MARKET CONDUCT DIVISION**

Issued: February 1, 2011

HMO OF NORTHEASTERN PENNSYLVANIA
TABLE OF CONTENTS

I.	Introduction	2
II.	Scope of Examination	5
III.	Company History and Licensing	6
IV.	Forms	8
V.	Claims	9
A.	Subscriber Submitted Medical Insurance Claims	10
B.	Provider Submitted Medical Insurance Claims	10
C.	Provider Submitted Clean Insurance Claims Over 45 Days	11
D.	Mammography Insurance Claims Denied	11
E.	Mammography Insurance Claims Denied < Age 40	12
F.	Provider Submitted Emergency Room Claims Denied	14
VI.	Recommendations	15
VII.	Company Response	16

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 24 day of January, 2011, 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.



Michael F. Consedine

Michael F. Consedine
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
HMO OF NORTHEASTERN	:	Section 2166(A) of Act 68 of 1998
INSURANCE COMPANY	:	(40 P.S. §§ 991.2166)
19 North Main Street	:	
Wilkes-Barre, PA 18711-0302	:	
	:	
	:	
Respondent.	:	Docket No. MC11-01- 013

CONSENT ORDER

AND NOW, this 1 day of February, 2011, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

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

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

FINDINGS OF FACT

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

- (a) Respondent is HMO of Northeastern Pennsylvania, and maintains its address at 19 North Main Street, Wilkes-Barre, PA 18711-0302.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2008 to December 31, 2008.
- (c) On December 13, 2010, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on January 7, 2011.
- (e) The Examination Report notes violations of the following:
 - (i) 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.

CONCLUSIONS OF LAW

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

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

- (b) Respondent's violations of Section 2166(A) of Act 68 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.

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 pay Fifty Thousand Dollars (\$50,000.00) to the Commonwealth of Pennsylvania in settlement of all violations contained in the Report.
- (d) 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.
- (e) After a period of 18 months from the date of this Order, Respondent shall be re-examined to verify corrective actions have been implemented.

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

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

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

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

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

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

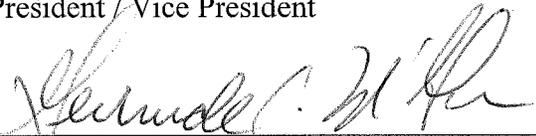
11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law

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

BY: HMO OF NORTHEASTERN PENNSYLVANIA,
Respondent



President / Vice President



Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on a Health Maintenance Organization; hereafter referred to as “HMO”, HMO of Northeastern Pennsylvania; hereafter referred to as “Company,” at the Company’s office located in Wilkes-Barre, Pennsylvania, February 8, 2010, through May 13, 2010. 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.

Yonise Roberts Paige
Market Conduct Division Chief

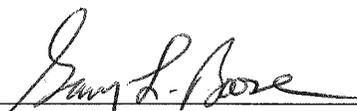
Gary L. Boose, LUTC MCM
Market Conduct Examiner

Lonnie Suggs
Market Conduct Examiner

Frank Kyazze
Market Conduct Examiner

Verification

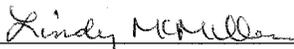
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



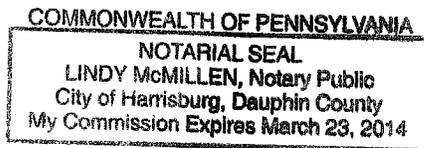
Gary L. Boose, Examiner in Charge

Sworn to and Subscribed Before me

This 13 Day of December, 2010



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2008, through December 31, 2008, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Forms, and Claim Handling Practices and Procedures.

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

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

III. COMPANY HISTORY AND LICENSING

HMO of Northeastern Pennsylvania, Inc. was incorporated in the Commonwealth of Pennsylvania on May 5, 1986 as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania d/b/a Blue Cross of Northeastern Pennsylvania. Effective October 31, 1986, the Company was issued a Pennsylvania Certificate of Authority as a non-profit health maintenance organization under the provisions of the Health Maintenance Organization Act, Act of December 29, 1972, P.L. 1701, No. 364 (40 P.S. 1551 et seq.). The Company commenced business on January 1, 1987 and was federally qualified on June 30, 1987.

The Company filed for and received approval of the fictitious name First Priority Health, effective August 22, 1995. At that time, HMO of Northeastern Pennsylvania began doing business as First Priority Health.

On April 29, 2005, Blue Cross of Northeastern Pennsylvania sold a 40% minority interest of the Company to Highmark Inc.

Regarding its physician network, HMO of Northeastern Pennsylvania is based on a mixed model since it contracts with both individual physicians and physician groups. HMO of Northeastern Pennsylvania is authorized to do business in the following counties: Bradford, Carbon, Clinton, Lackawanna, Luzerne, Lycoming, Monroe, Pike, Sullivan, Susquehanna, Tioga, Wayne and Wyoming.

HMO of Northeastern Pennsylvania provides a basic managed care product, BlueCare HMO, an open access HMO plan, BlueCare HMO Plus, and an HMO Individual Conversion product.

The Company's total Pennsylvania earned premium, as reported in their 2008 Annual Statement, was \$284,804,722. The total annual member months was reported as 1,027,364.

IV. FORMS

The Company was requested to provide a list and copies of all individual and group policy/certificate forms used during the experience period. The forms provided were reviewed to ensure compliance with the requirements of Title 31, Pennsylvania Code, Section 301.62, pertaining to operational standards for health maintenance organization utilizing subscriber contracts and evidences of coverage; the Accident and Health Reform Filing Act, No. 159 (40 P.S. §3803); and the Quality Health Care Accountability and Protection Act, No. 68, Section 2136 (40 P.S. §991.2136), Required Disclosure. No violations were noted.

In addition, contracts were reviewed for inclusion of the following state mandated coverage's.

Alcohol/Substance Abuse	New Born Children
Physically Handicapped/Mental Retarded Child	Conversion
Chemotherapy/Cancer Hormone Treatment	Childhood Immunizations
Diabetic Supplies and Education	Dependent Children
Coverage for Serious Mental Illnesses	Emergency Reimbursement
Gynecological Examination/Pap Smear	Mammography Screenings
Mastectomy/Reconstructive Surgery	Maternity
Medical/Nutritional Foods	

V. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following information:

- A. Facets Claims Processing User Guide and Supplement
 - 1. Claims Processing Overview
 - 2. How to Process a Claim
 - a. Processing a Medical Claim
 - b. Processing a Hospital Claim
 - 3. Pre-Pricing Claims
 - 4. Logging Claims
 - 5. Claims Adjudication Routine
 - 6. Claims Status
 - 7. Pre-Payment Audit
 - 8. Claims Payment
 - a. Remittance Review
 - b. EOB
 - c. Claims Interest Calculation
 - d. Prompt Payment
 - 9. Coordination of Benefits
 - 10. Processing Control Agent
 - 11. Adjustments
 - 12. Pended Claims
 - 13. External Claims (Electronically Submitted Claims)
 - 14. External Claims Adjudication
 - 15. External Claims Submission
 - 16. Electronic Adjudication
 - 17. Claims Inquiry
 - 18. Claims Security
 - 19. Archiving Claims
- B. Claims User Guide Supplement
- C. Claims Processing Daily Updates
- D. HMO Processing Guidelines

- a. Act 68
 - b. ER Claims
 - c. UB
- E. Claims Administration – Quality Assurance Program
- a. BlueCare HMO/POS Audit Process

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

A. Subscriber Submitted Medical Insurance Claims

The Company was requested to provide a list of all subscriber submitted medical claims finalized during the experience period. The Company identified a universe of 141 subscriber submitted medical claims received. A random sample of 25 claim files was requested, received and reviewed. The files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 – Unfair Insurance Practices. No violations were noted.

B. Provider Submitted Medical Insurance Claims

The Company was requested to provide a list of provider submitted medical claims finalized during the experience period. The Company identified a universe of 562,436 provider submitted medical claims received. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. No violations were noted.

C. Provider Submitted Clean Insurance Claims Over 45 Days

The Company was requested to provide a list of all clean medical and emergency provider submitted claims paid over 45 days from the date of receipt of the proof of loss, during the experience period. The Company identified a universe of 382 provider submitted clean claims paid over 45 days. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims. The following violations were noted:

50 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 50 clean claims were not paid within 45 days of receipt.

D. Mammography Insurance Claims Denied

The Company was requested to provide a list of mammography claims denied during the experience period. The Company identified a universe of 2,094 denied mammography claims. A random sample of 30 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. It was determined that some of the claims previously considered denied were actually paid claims. The following violations were noted:

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

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. The noted 4 clean claims were not paid within 45 days of receipt.

E. Mammography Insurance Claims Denied < Age 40

The Company was requested to provide a list of mammography claims denied for members that were under 40 years of age during the experience period. The Company identified a universe of 320 denied mammography claims. 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 state insurance laws and regulations. It was determined that some of the claims in the sample were subsequently paid. The following violations were noted:

18 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 18 clean claims were not paid within 45 days of receipt.

EXAMINATION NOTATION: During the course of the examination, the Company notified the Department that , “In mid 2009 it was discovered that commencing in 2007, the First Priority Health (dba HMO of Northeastern Pennsylvania) processing of mammography claims for women under the age of 40 may have been inconsistent with the Mandate language. This prompted a review of mammography claims processed

from 2007 through 2009. This review resulted in identifying that First Priority Health did not reimburse providers for certain screening mammograms for women under the age of 40. This discrepancy resulted from an error in our claims processing system.”

As a result, the Company has since reprocessed the claims in question and paid the servicing providers accordingly. All provider payments were accompanied by a letter informing them of the reason for the adjusted claim. Furthermore, all members affected were provided an explanation of benefits and a letter explaining the reason for the adjusted claim and the appropriate payment to the servicing provider. The letter also advised the member to contact the provider to ensure that they are properly reimbursed if they paid the provider for the service.

By initially denying the noted claims, the Company was in violation of the following law:

Insurance Company Law, Section 632 (40 P.S. §764c) Coverage for Mammographic Examinations

All group or individual health or sickness or accident insurance policies providing hospital or medical/surgical coverage and all group or individual subscriber contracts or certificates issued by any entity subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations), this act, the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act," the act of July 29, 1977 (P.L. 105, No. 38), known as the "Fraternal Benefit Society Code," or an employee welfare benefit plan as defined in section 3 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406, 29 U.S.C. § 1001 et seq.) providing hospital or medical/surgical coverage shall also provide coverage for Mammographic examinations. The minimum coverage

required shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women less than 40 years of age. Prior to payment for a screening mammogram, insurers shall verify that the screening mammography service provider is properly licensed by the department in accordance with the act of July 9, 1992 (P.L. 449, No. 93), known as the "Mammography Quality Assurance Act." Nothing in this section shall be construed to require an insurer to cover the surgical procedure known as mastectomy or to prevent application of deductible or co-payment provisions contained in the policy or plan.

F. Provider Submitted Emergency Room Claims Denied

The Company was requested to provide a list of all provider submitted emergency claims finalized during the experience period. The Company originally identified a universe of 67,446 provider submitted emergency room claims denied. This universe list included paid and \$0.00 claims. The Company indicated that the \$0.00 paid claims could be considered denied claims in almost every instance. With that information, the Department extracted all claims that had a \$0.00 paid amount and identified them as denied claims. From the universe of 67,446 claims, the Department extracted 7,223 denied claims. A random sample of 100 denied 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. No violations were noted.

VI. 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 the prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.
2. The Company must implement procedures to ensure compliance with Insurance Company Law, Section 632 (40 P.S. §764c) Coverage for Mammographic Examinations.

VII. COMPANY RESPONSE



BlueCross of Northeastern Pennsylvania

Independent Licensee of the Blue Cross and Blue Shield Association
®Registered Mark of the Blue Cross and Blue Shield Association

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

January 7, 2011

Yonise Roberts Paige
Chief, Life and Health Division
Pennsylvania Insurance Department
Market Action Bureau
1321 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 09-M24-021
HMO of Northeastern Pennsylvania (d/b/a, First Priority Health)

Dear Ms. Paige:

This letter is in response to your report of examination received on December 13, 2010 regarding the Pennsylvania Insurance Department's ("Department's") Market Conduct Examination of HMO of Northeastern Pennsylvania (d/b/a, First Priority Health ("FPH")) covering the period of January 1, 2008, through December 31, 2008 as of the close of business on December 10, 2010.

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

If you have any questions or require additional information, please contact me at (570) 200-1650 or trish.savitsky@bcnepa.com. Thank you.

Sincerely,

Trish Savitsky, CIPP, CIA
Vice President, Corporate Assurance & Compliance

Cc: Denise S. Cesare, President & Chief Executive Officer
Brian Rinker, Sr. Vice President - Service Operations



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

1. ***The Company must implement procedures to ensure compliance with the prompt payment of claims of Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Claims.***

First Priority Health Response: First Priority Health agrees with the Department's recommendation. The Company would like to note that of the 50 claims identified, 30 of those claims were related to the "lost claim" issue that was communicated to the PID during our initial meeting. We have put measures in place to ensure that all claims that are identified on the daily error report are reviewed daily and claims are entered timely for processing.

Of the remaining 20 violations, 7 were related to the incorrect provider number being used. This was due to providers being termed from one group and becoming effective under another group practice. The processors have been retrained on how to determine the active provider number for the specific date of service.

The remaining 13 violations were processor/system errors and have been addressed or corrected.

2. ***The Company must implement procedures to ensure compliance with Insurance Company Law, Section 632 (40 P.S. §764c) Coverage for Mammographic Examinations.***

First Priority Health Response: First Priority Health agrees with the Department's recommendation. We have taken the steps to ensure that our systems are corrected and the processing of claims for women under the age of 40 is consistent with the *Insurance Company Law, Section 632 (40 P.S. §764c) Coverage for Mammographic Examinations.*