REPORT OF MARKET CONDUCT EXAMINATION OF

CAPITAL ADVANTAGE INSURANCE COMPANY

Harrisburg, Pennsylvania

AS OF July 30, 2009

COMMONWEALTH OF PENNSYLVANIA



INSURANCE DEPARTMENT BUREAU OF MARKET CONDUCT

Issued: September 18, 2009

CAPITAL ADVANTAGE INSURANCE COMPANY

TABLE OF CONTENTS

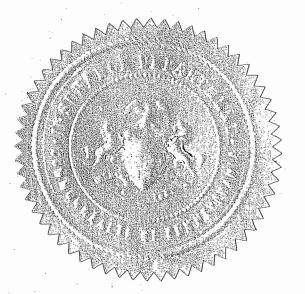
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I.	Introduction	2
II.	Scope of Examination	5
III.	Company History and Licensing	6
IV.	Forms	8
v.	Claims	10
	A. Alcohol & Drug Claims Denied	11
	B. Alcohol & Drug Services Denied	14
	C. Mental Illness Claims Denied	15
VI.	Recommendations	16
VII.	Company Response	17

BEFORE THE INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 2200 day of Gulf, 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:

CAPITAL ADVANTAGE : Sections 2166(A) and (B) of the Act of INSURANCE COMPANY : June 17, 1998, P.L. 464, No. 68 (40 P.S.

2500 Elmerton Avenue : §§991.2166) Harrisburg, PA 17110 :

: Section 5(c) of the Insurance Company

Law, No. 150 (40 P.S. §764g)

Section 3(A) of the Health and AccidentReform Act, No. 159 (40 P.S. §3803)

: Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and : (vi) of the Unfair Insurance Practices Act,

Act of July 22, 1974, P.L. 589, No. 205 (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv),

(v) and (vi))

: Title 31, Pennsylvania Code, Section

89.612

Respondent. : Docket No. MC09-09-002

CONSENT ORDER

AND NOW, this /8 day of SEPTEMBER, 2009, 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 Capital Advantage Insurance Company, and maintains its address at 2500 Elmerton Avenue, Harrisburg, Pennsylvania 17110.
 - (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2007 through December 31, 2007.
 - (c) On July 30, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.
 - (d) A response to the Examination Report was provided by Respondent on August 28, 2009.

- (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;
 - (ii) 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;
 - (iii) Section 5(c) of the Insurance Company Law, Act 150 (40 P.S. §764g), which states health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:
 - (1) coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;
 - (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for-two basis;
 - (3) there shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses;

- (iv) Section 3(a) of Act 159 (40 P.S. § 3803(a)), which requires each insurer and HMO to file with the Department any form which it proposes to issue in this Commonwealth;
- (v) Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) states 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 insurable policies;
 - (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurable 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; and

(vi) Title 31, Pennsylvania Code, Section 89.612, which states: (a) Non-hospital, residential alcohol treatment services which are included as a covered benefit 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.

CONCLUSIONS OF LAW

- 4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:
 - (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

- (b) Respondent's violations of Sections 2166(A) and (B) of Act 68 (40 P.S. § 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.
- (c) Section 5(c) 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.
- (d) Respondent's violations of Section 3 of the Accident and Health Filing Reform Act, No. 159 (40 P.S. § 3803) are punishable as detailed in the Report of Examination 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.
- (e) Respondent's violations of Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 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.
- (f) 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).

(g) Respondent's violations of Title 31, Pennsylvania Code, Section 89.612 are punishable under Section 354 of the Insurance Company Law (40 P.S. § 477b) by suspension or revocation of the license(s) of Respondent; refusal, for a period not to exceed one year thereafter, to issue a new license to Respondent; or imposition of a fine of not more than one \$1,000.00 for each act in violation of the Act.

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 Forty-Five Thousand Dollars (\$45,000.00) 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, Bureau of Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120.
 Payment must be made no later than thirty (30) days after the date of this Order.
- 6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, <u>supra</u>, 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, <u>supra</u>, 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: CAPITAL ADVANTAGE INSURANCE COMPANY, 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 Capital Advantage Insurance Company; hereafter referred to as "Company," at the Company's office located in Harrisburg, Pennsylvania, February 23, 2009, through March 20, 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 Market Conduct Division Chief

Frank 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).

Frank W. Kyazze, MCM, AIE, ALHC, FLMI

[Examiner in Charge]

Sworn to and Subscribed Before me

This 22 Day of July

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, 2007, through December 31, 2007, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The target examination focused on the Company's 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 subcategories by line of insurance or Company administration. These specific subcategories, 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

Capital Advantage Insurance Company ("CAIC") was originally incorporated as a wholly owned subsidiary of Pennsylvania Blue Shield under the name of "Camp Hill Insurance Company." The Articles of Agreement (which was the form required at the time for corporate articles of incorporation) for Camp Hill Insurance Company was signed on February 5, 1980, and eventually approved by the Pennsylvania Secretary of State on May 6, 1981, which is the date deemed to be CAIC's "Incorporated/Organized" date for statutory reporting purposes. Accordingly, the date of May 6, 1981, appears on CAIC's Annual Statement as the "Incorporated/Organized" date.

On August 3, 1982, Capital BlueCross acquired 50% of the stock of Camp Hill Insurance Company. On May 15, 1992, Capital BlueCross acquired 100% of Camp Hill Insurance Company's stock. On November 11, 1992, Capital Hill Insurance Company was renamed Capital Health Insurance Company. On May 26, 1993, Capital Health Insurance Company was renamed Capital Advantage Insurance Company.

Capital Advantage Insurance Company is a Pennsylvania stock casualty insurance Company. A wholly owned subsidiary of Capital BlueCross, Capital Advantage Insurance Company offers health coverages, including:

- Traditional Medical Surgical and Major Medical Benefits
- Short-Term Major Medical
- Comprehensive
- Preferred Provider Organization (PPO)
- Point of Service (POS)
- Prescription Drug
- Senior Blue PPO (A Medicare Advantage Plan)
- Senior (Medicare Complementary Coverage)

Capital Advantage Insurance Company's total Pennsylvania health premiums earned, as reported in their 2007 Annual Statement, was 1,158,678,475. The total annual member months were 4,160,366.

IV. FORMS

The Company was requested to provide a list and copies of all individual and group policy/certificate forms and conversion contracts used during the experience period of in Pennsylvania. The forms provided were reviewed to ensure compliance with pertinent state insurance laws and regulations including, but not limited to: Insurance Company Law, Section 354; Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Warning Notice; 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. In addition, contracts were reviewed for inclusion of the following state mandated coverages:

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

The following violation was noted:

1 Violation - Accident and Health Filing Reform Act, No. 159, Section 3(A) (40 P.S. §3803)

Each insurer (including PPOs) and HMO shall file with the Pennsylvania Insurance Department (the Department) any policy form which it proposes to issue in the Commonwealth, except for forms of a type or kind which, in the opinion of the Commissioner, do not require filing.

Verification of Department form filing and approval could not be established for the form noted.

Form	Form #
Application	CAIC-APP (9/2001)

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 used in handling alcohol and substance abuse and mental illness claims during the experience period. The Company provided the following documentation for review:

- 1. Facets Claims Manual 3,742-page CD
- 2. Substance Abuse Treatment Processes Followed by Magellan Behavioral Health, Inc. Narrative
- 3. Magellan Behavioral Health, Inc. Contract

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 3 areas:

- A. Alcohol & Drug Claims Denied
- B. Alcohol & Drug Services Denied
- C. Mental Illness Claims Denied

All claim files were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171); Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options; Title 31, Pennsylvania Code, Section 89.612, Minimum covered services; Section 635.1 of the Insurance Company Law (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Alcohol & Drug Claims Denied

The Company was requested to provide a list of all denied claims finalized during the experience period of January 1, 2007 to December 31, 2007. The Company provided a universe of 490 alcohol and drug claims denied. From the original universe of 490 claims, the Department utilizing an audit program, extracted claims that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied claims was 84 claims. From the new universe, a random sample of 35 claim files was requested, received and reviewed.

The following table displays the universe and sample for each denial reason reviewed.

Denial Reason	Universe	Sample
No Preauthorization/Need Medical Records	35	7
Not A Covered Service	35	0
Benefit Day Maximum - Substance Abuse	35	11
Out-of-Network Services Not Covered	35	17

The files were reviewed to ensure that the Company's claims adjudication process was adhering to contract provisions, as well as complying with alcohol and substance abuse mandated laws and regulations. The following violations were noted:

11 Violations - Title 31, Pennsylvania Code §89.612 Minimum covered services.

- (a) Non-hospital, residential alcohol treatment services which are included as a covered benefit under Article VI-A of the act (40 P. S. § § 908-1—908-8) shall be covered for a minimum of 30 days per year. The minimum of 30 days per year may not be exchanged for outpatient alcohol treatment services.
- (b) Outpatient alcohol treatment services which are included as a covered benefit under Article VI-A of the act shall be covered for a minimum of 30 outpatient, full-session visits or equivalent partial visits per year. The minimum 30 sessions per year may not be exchanged for non-hospital residential alcohol treatment services.
- (c) Thirty outpatient, full-session visits or equivalent partial visits, which may be exchanged on a two-for-one basis for up to 15 non-hospital residential alcohol treatment days, shall be available in addition to the minimum required in subsections (a) and (b).
- (d) Treatment services provided in subsections (a) (c) may be subject to a lifetime limit, for a covered individual, of 90 days of non-hospital, residential alcohol treatment services and 120 outpatient, full session visits or equivalent partial visits.

The mandated benefit provides for 30 outpatient sessions. The benefit also provides for an additional 30 outpatient sessions that can be exchanged for up to 15 non-hospital residential alcohol treatment days.

The 11 noted claims for outpatient services were denied as meeting or exceeding the 30 visits for outpatient service. In order for the claimant to obtain coverage for the outpatient sessions over the initial 30 days, the Company required the claimant to sign and return an authorization form to evoke the use of the additional 30 outpatient days. In the absence of the authorization form, the noted claims for outpatient services remained denied. The denial of mandated benefits for the lack of an authorization form is not in compliance.

11 Violations - Act 205, Section 5 (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 11 outpatient claims noted was not justified. The claim practice for denial of additional outpatient benefits for the lack of an authorization form is inconsistent with contract provisions and mandated benefit laws and regulations.

11 Violations - Insurance Company Law, Section 2166 (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 11 clean claims noted were not paid within 45 days of receipt.

11 Violations - Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider 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 was not paid on the 11 claims noted.

B. Alcohol & Drug Services Denied

The Company was requested to provide a list of all services denied during the experience period of January 1, 2007 to December 31, 2007, for alcohol and drug rehabilitative services. The Company identified a universe of 4 denied services. All 4 denied service files were requested, received and reviewed. The files were reviewed to ensure that the alcohol and drug service requests were being appropriately administered by the Company's claim process relative to the provisions of the policy contract, as well as complying with alcohol and drug mandated laws and regulations. No violations were noted.

C. Mental Illness Claims Denied

The Company was requested to provide all claims denied during the experience period of January 1, 2007 to December 31, 2007, for mental illness services. The Company identified a universe of 8,547 mental illness denied claims. A random sample of 50 claim files was requested, received, and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to contract provisions, as well as complying with mental illness mandated laws and regulations. The following violation was noted:

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

- (c) Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet, at a minimum, the following standards:
- (1) Coverage for serious mental illnesses shall include at least thirty (30) inpatient and sixty (60) outpatient days annually;
- (2) a person covered under such policies shall be able to convert coverage of inpatient days to outpatient days on a one-for- two basis;
- (3) There shall be no difference in either the annual or lifetime dollar limits in coverage for serious mental illnesses and any other illnesses.

The denial of the serious mental illness claim was not justified. The claimant should not be held responsible for a claim processing error.

VI. RECOMMENDATIONS

The recommendation made below identifies 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 requirements Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.
- 2. The company must review internal control procedures to ensure compliance with prompt and fair claim settlement practices requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).
- 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 internal 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). Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.
- 5. The Company must review internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. §764g)
- 6. Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of payment on the claims noted in the examination and all other claims identified by the Company for the improper denial of outpatient mandated benefits due to the lack of an authorization form.

VII. COMPANY RESPONSE



Michael B. Wolfe Senior Counsel (717) 541-6366 (717) 651-4075 Fax Michael.Wolfe@capbluecross.com

August 28, 2009

Daniel A. Stemcosky, AIE, FLMI, MCM Market Conduct Division Chief Pennsylvania Insurance Department 1227 Strawberry Square Harrisburg, PA 17120 Via Electronic Mail and U.S. Mail delivery

RE: Examination Warrant Number: 08-M25-024

Response to Report of Examination of Capital Advantage Insurance Company

Dear Mr. Stemcosky:

On behalf of Capital Advantage Insurance Company ("CAIC"), please allow this letter to serve as our response to the Report of Market Conduct Examination Warrant Number 08-M25-024 (the "Report"), which was received with your cover letter dated July 30, 2009. We have reviewed the Report and respectfully submit this response.

Our responses, addressing the Department's six recommendations on page 16 of the Report, follow:

1. 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.

CAIC accepts this recommendation. CAIC understands the Department's concerns, but CAIC believes the procedures in effect at the time complied with the law and better preserved the availability of potential future in-patient treatment for our Members. CAIC has, however, modified its internal control procedures to comply with the Department's guidance.

2. The Company must review internal control procedures to ensure compliance with prompt and fair settlement practice requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).

CAIC accepts this recommendation. CAIC understands the Department's concerns, but CAIC believes the procedures in effect at the time complied with the law and better preserved the availability of potential future in-patient treatment days for our Members. CAIC has, however, modified its internal control procedures to comply with the Department's guidance.

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.

CAIC accepts this recommendation. CAIC has a well-earned reputation for prompt and accurate processing and payment of provider claims. Nevertheless, we continue to strive for improvements and will review and, if necessary, modify our claims procedures with regard to the cited statute.

4. The Company must review internal 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). Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claims noted in the examination.

CAIC accepts this recommendation. CAIC has a well-earned reputation for prompt and accurate processing and payment of provider claims, and the payment of interest, when required. Nevertheless, we continue to strive for improvements and will review and, if necessary, modify our claims procedures with regard to the cited statute. Within sixty days of the Report issue date, CAIC will provide proof of interest payment on the claims at issue.

5. The Company must review and revise internal control procedures to ensure compliance with the coverage for serious mental illnesses mandated benefit as required by Section 5 of the Insurance Company Law of 1921, No. 150 (40 P.S. §764g).

CAIC accepts this recommendation and has modified its internal control procedures to ensure compliance with the cited regulation.

6. Within 60 days of the Report issue date, the Company must provide to the Insurance Department proof of payment on the claims noted in the examination and all other claims identified by the Company for the

Daniel A. Stemcosky Page 3 August 28, 2009

improper denial of outpatient mandated benefits due to the lack of an authorization form.

CAIC accepts this recommendation. Within sixty days of the Report issue date CAIC will provide proof of payment on the claims at issue.

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Thank you for your consideration of this matter and for providing us with this opportunity to respond to the Report. Thank you, too, for the courtesies extended by Mr. Kyazze and the other examiners throughout the course of this examination.

Sincerely,

Michael B. Wolfe