MARKET CONDUCT EXAMINATION REPORT
PROMPT PAY

of

AMERIHEALTH HMO, INC.

as of

June 30, 2006

I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

AMERIHEALTH HMO, INC.
PROMPT PAY

is a true and correct copy of the document filed with this Department.

ATTEST BY: _____

DATE: 21 AUGUST 2007

In Witness Whereof, I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 21ST DAY OF AUGUST 2007.

_____
Insurance Commissioner

REPORT ON MARKET CONDUCT PROMPT PAY EXAMINATION

OF THE

AMERIHEALTH HMO, INC.

AS OF

JUNE 30, 2006

The above captioned Report was completed by examiners of the Delaware Insurance Department.

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.

MATTHEW DENN
INSURANCE COMMISSIONER

DATED this 21ST day of AUGUST, 2007.

*Items A-G were not addressed on this examination.

May 3, 2007

Honorable Matthew Denn
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.728, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

AMERIHEALTH HMO, INC.

hereinafter referred to as the "Company." The Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

This report is as of June 30, 2006 and it covers the period of January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

EXECUTIVE SUMMARY

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the seven (7) examination standards authorized by Certificate of Examination Authority Number 06.728. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80].

The principal focus for this examination was compliance with the Delaware insurance laws related to prompt, fair and equitable settlement of claims for health care services. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310, relating to the timely, fair, and equitable payment of clean claims. The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

Prompt Payment Standards 1-7: The examiners found one (1) area of concern resulting in failure of the Company to comply with Standard 3. The issue identified was:

- In some cases, clean claims were not processed within 30 calendar days of receipt, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1-.4.

HISTORY AND PROFILE

AmeriHealth HMO, Inc. is a federally qualified Health Maintenance Organization (HMO) under Title XII of the Public Health Service Act. The Company writes HMO plans in the states of Delaware, Pennsylvania, and New Jersey.

The Company is domiciled in the Commonwealth of Pennsylvania. The registered address of the Company is 1901 Market Street, Philadelphia, PA 19103.

The Company is a wholly owned subsidiary of Independence Blue Cross under the following ownership structure: Independence Blue Cross owns AmeriHealth, Inc., which owns AmeriHealth Integrated Benefits, Inc., which owns the Company.

The Company was initially organized on March 1, 1976 under the name of Greater Delaware Valley Health Care, Inc. Independence Blue Cross acquired Greater Delaware Valley Health Care, Inc. on December 23, 1986. The Company's name was change to Delaware Valley HMO, Inc. On July 1, 1995, Delaware Valley HMO, Inc.'s name was changed to AmeriHealth HMO, Inc.

The management structure of the Company has remained stable throughout the period of examination.

METHODOLOGY

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC methodology.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were evaluated using tests designed to adequately determine how the Company met each standard. Each standard tested is described and the result of testing is provided under the

appropriate standard. Only standards tested are shown in this report of the limited scope examination.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

The following sections are covered in a full scope market conduct examination. They are listed here to clarify that this exam was limited to the claims area only.

A. COMPANY OPERATIONS/MANAGEMENT- not addressed on this exam

B. COMPLAINTS/GRIEVANCES-not addressed on this exam

C. MARKETING AND SALES- not addressed on this exam

D. NETWORK ADEQUACY- not addressed on this exam

E. PRODUCER LICENSING-not addressed on this exam

F. POLICYHOLDER SERVICE-not addressed on this exam

G. UNDERWRITING AND RATING-not addressed on this exam

H. CLAIMS

Comments: The examiners reviewed seven (7) separate claims samples. Five (5) of the samples selected were random samples of specific populations and two (2) of the samples consisted of the entire population of claims. The seven (7) samples selected for review are as follows:

- Sample 1. One hundred claims from a population of 22,496 adjudicated by the Company within the examination period.

- Sample 2. Fifty claims from a population of 196 claims adjudicated by the Company in excess of 30 days from the date of receipt.

- Sample 3. Fifty behavioral health claims from a population of 605 adjudicated by Magellan Behavioral Health Systems, LLC. (Magellan) within the examination period.

- Sample 4. The single behavioral health claim adjudicated by Magellan in excess of 30 days from the date of receipt.

- Sample 5. Ten (10) claims from a population of 94 behavioral health claims adjudicated by Magellan for members under Delaware contracts residing in other states. During the data reconciliation process for the Company's behavioral health claims, it was determined that the data provided by Magellan was incomplete. Claims for members under Delaware contracts residing in other states were not included. The examination team selected an additional proportionate sample form the additional population identified.

- Sample 6. Fifty claims from a population of 493 vision claims adjudicated with payment by Davis Vision within the examination period.

- Sample 7. The entire population of eight (8) vision claims adjudicated without payment by Davis Vision within the examination period. This sample of claims without payment resulted from the fact that during the data reconciliation process for the Company's vision claims, it was determined that the data provided by Davis Vision was incomplete. The original data provided did not include any claims adjudicated without payment. The examination team reviewed the entire population of claims that had initially been excluded from the data provided.

The evaluation of standards in this business area is based on Company responses to information requested by the examiners, discussions with the Company's staff, electronic testing of claim databases, and the review of claim files. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules, and regulations.

Services provided to the subscribers of the Company do not typically result in a claim by the recipient of care as is usually seen in an indemnity scenario. Claims to the Company usually arise from the provider who delivers services to a subscriber of the Company

The following Standards were developed to test compliance with Delaware statutes, rules and regulations.

Prompt Payment Standard 1

The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.

18 Del. Admin. Code 1310 § 4.0

Comments: This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" is in compliance with 18 Del. Admin. Code 1310 § 4.0.

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: PASS

Observation: Reviews, interviews, and testing indicate the Company standards and definitions identifying clean claims are compliant with 18 Del. Admin.Code 1310 § 4.0.

Prompt Payment Standard 2

The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included.

18 Del. Admin. Code 1310 § 4.7

Comments: This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7.

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: PASS

Observation: Reviews, interviews, and testing of claims samples indicate the Company adjudicates claims in a manner that complies with this standard.

Prompt Payment Standard 3

The Company's clean claim processing is timely and in compliance with applicable statutes, rules and regulations. 18 Del. C. § 2304, 18 Del. Admin. Code 1310 § 6.0 and 7.0

Comments: This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0 et al which requires adjudication within 30 days and 18 Del. Admin. Code 1310 § 7.0, which

states "Within a 36 month period, three instances of a carrier's failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304."

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: FAIL

Observation: Review of the selected samples indicated that 37 claims out of 50 tested from Sample 2 (claims adjudicated by the Company in excess of 30 days) were clean claims and adjudicated in an untimely manner. In addition, the one (1) claim from Sample 4 (claim adjudicated by Magellan in excess of 30 days) was a clean claim and adjudicated in an untimely manner. No errors were revealed in the review of Samples 1, 3, 5, 6 or 7.

The 38 instances of non-compliance found in the claims samples for the Company and Magellan that were processed in access of 30 days form the date of receipt exceed the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304

***Recommendations*: It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department.**

Prompt Payment Standard 4

Proper payment is made on clean claims. 18 Del. Admin. Code 1310 § 6.1.1and 6.1.2

Comments: This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin.Code 1310 § 6.1.1 and 6.1.2.

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: PASS

Observation: Reviews, interviews, and testing of claims samples indicate the Company adjudicates claims in a manner that complies with this standard.

Prompt Payment Standard 5

The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.
18 Del. Admin.Code 1310 § 6.1.2 and 6.1.3

Comments: This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin.Code 1310 § 6.1.2 and 6.1.3.

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: PASS

Observation: Review of the selected samples indicate the Company is sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

Prompt Payment Standard 6

The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules. 18 Del. Admin.Code 1310 § 6.1.4, 6.2 and 6.3

Comments: This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 § 6.1.4 states "if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim." 18 Del. Admin.Code1310 § 6.2 states in part, "A carrier who requests information under this subsection shall take action… within 15 days of receiving properly requested information." 18 Del. Admin.Code1310 § 6.3 limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, Magellan and Davis Vision. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel. Phone interviews were held with Magellan and Davis Vision claims personnel.

Results: PASS (with comments below)

Observation: Based on reviews, interviews, and testing of claims samples the Company appears to adjudicate claims in a manner that materially complies with this standard.

When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. The following is a list of several methods a provider has to supply additional information regarding claims to AmeriHealth:

- Mailing the additional information to AmeriHealth at the PO Box established and communicated by AmeriHealth to the providers for adjustments: AmeriHealth AR P.O. Box is 6645, Wayne PA, 19087. Additional information submitted to this location will result in the adjustment of the original claim.

- Calling the provider service line and sending the service representative the additional information. The call is logged into the call tracking system and the additional information provided is sent to the AmeriHealth Adjustment area for processing.
- Contrary to procedures included with the Company's request for additional information, providers occasionally send the additional information to the original claim submission address. If this occurs, the Company generally does not have a way to identify the claim as a response to an information request and therefore, the claim is processed as a clean claim, within 30 days of receipt.

If a claim is adjusted using the first two methods it will be copied to a new claim number and processed within 15 days of receipt. The original and the new claim numbers are linked by comments within the claims processing screens.

To assist the provider in sending the information necessary to adjust the claim, the statement of remittance contains information regarding the information needed. In addition, if the provider calls the provider service line, they will be informed of the additional information that is needed to adjust the claim.

Prompt Payment Standard 7

The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations. 18 Del. Admin. Code 1310 § 8.0

Comments: This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

Results: PASS

Observation: No interest payments on claims have been ordered to date.

SUMMARY

The Company is a Delaware domiciled health insurer that provides health care coverage in the commercial and individual markets.

This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

Recommendations have been made to address the areas of concern noted during the examination. These are summarized below.

LIST OF RECOMMENDATIONS

It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department.

CONCLUSION

The examination was conducted by the undersigned and respectfully submitted,

Market Conduct Examiner-in-Charge
Delaware Insurance Department