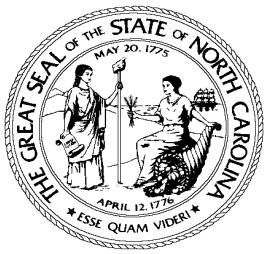

REPORT ON

MARKET CONDUCT EXAMINATION

of

COMPBENEFITS INSURANCE COMPANY (VISION PPO)
Houston, Texas

BY REPRESENTATIVES OF THE

NORTH CAROLINA DEPARTMENT OF INSURANCE

as of

June 9, 2011

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Raleigh, North Carolina
June 9, 2011

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
State of North Carolina
Dobbs Building
430 N. Salisbury Street
Raleigh, North Carolina 27603

Office of Commissioner of Insurance
State of Texas
333 Guadalupe Street
Austin, Texas 78701

Honorable Ralph T. Hudgens
Commissioner of Insurance
State of Georgia
2 Martin Luther King Drive
704 West Tower
Atlanta, Georgia 30334

Honorable Commissioners:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a target examination has been made of the market conduct activities of the Vision Preferred Provider Organization (VPPO)

COMPBENEFITS INSURANCE COMPANY
(NAIC #60984)
NAIC Exam Tracking System Exam Number: NC170-M98
Roswell, Georgia

hereinafter generally referred to as the Company, at the North Carolina Department of Insurance (Department) office located at 11 South Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

FOREWORD

This examination reflects the North Carolina insurance activities of CompBenefits Insurance Company (Vision PPO). The examination is, in general, a report by exception. Therefore, much of the material reviewed will not be contained in this written report, as reference to any practices, procedures, or files that manifested no improprieties were omitted.

SCOPE OF EXAMINATION

This examination commenced on August 23, 2010 and covered the period of January 1, 2007 through December 31, 2008, with analyses of certain operations of the Company being conducted through June 6, 2011. All comments made in this report reflect conditions observed during the period of the examination.

The examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners (NAIC) Market Regulation Handbook procedures, including analyses of Company operations and accordingly included tests of provider relations and delivery system, claims practices, policyholder treatment and delegated oversight.

It is the Department's practice to cite companies in apparent violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for utilization review determinations, grievances (including quality of care), sales and advertising, producers who were not appointed and/or licensed, the use of contract forms that were neither filed with nor approved by the Department, the listing of a provider/facility in the provider/facility directory prior to being fully credentialed and use of unapproved underwriting methodology and factors; 7.0 percent for claims practices, provider and facility credentialing, and the content of quality management and utilization management review notification letters; and 10.0 percent for all other areas reviewed. When errors are detected in a sample, but the error rate is below the applicable threshold for citing an apparent violation, the Department issues a reminder to the Company.

EXECUTIVE SUMMARY

This target examination revealed concerns with Company procedures and practices in the following areas:

General Administration -- failure to submit the managed care annual filing data to the Department by the established due date for data years 2007 and 2008.

Provider Relations and Delivery System -- failure to provide a copy of the 2007 and 2008 printed provider directories; written policies and procedures failed to state that monitoring of provider availability will occur at least annually or reference another policy with respect to this requirement; failure to conduct provider accessibility monitoring during the examination period as required by the regulation; failure to receive prior approval from the Department before utilizing a provider agreement form.

Claims Practices -- failure to establish a claims processing timeliness standard which complies with all of the statutory requirements; failure to process paid claims correctly and/or failure to include sufficient documentation to demonstrate proper handling of the claim. As a result of the Department's review of the paid claims sample, the Company reprocessed 4 claims, which resulted in a total of $136.00 in additional benefits paid and an additional total of $90.37 in interest payments to the applicable claimants.

All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance web site www.ncdoi.com by clicking "NCDOI DIVISIONS" then "Legislative Services".

In the course of an examination, various non-compliant practices may be identified, some of which may extend to other jurisdictions. In such cases, the Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify or criticize improper or non-compliant business practices in North Carolina or in other jurisdictions does not constitute acceptance of such practices. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company's practices and ensure consumer protection.

COMPANY OVERVIEW

History and Profile

CompBenefits Insurance Company became a part of the Humana Inc. holding company system when Humana Inc. acquired CompBenefits Corporation, an Atlanta, Georgia-based dental and vision benefits company, in the fourth quarter of 2007. CompBenefits Insurance Company is domiciled with its statutory address in Houston, Texas. It is licensed in 31 states as a Life and Health insurer and in 7 states as a Third Party Administrator and offers vision and dental plans in these jurisdictions. It has been licensed as a Life and Health insurer in North Carolina since October 1, 2002.

GENERAL ADMINISTRATION

The Company's general administration activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The Company failed to submit the managed care annual filing data for data years 2007 and 2008 to the Department by the established due date and was deemed to be in apparent violation of the provisions of NCGS 58-3-191(a).

PROVIDER RELATIONS AND DELIVERY SYSTEM

The Company's provider relations and delivery system activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Provider Directories

The Company's provider directories are updated continuously through the Company's web site and reprinted on demand. Members may access updated listings of providers on the Company's web site or they may call the Customer Care line and request a printed copy.

The Company could not provide a copy of its 2007 and 2008 printed provider directories. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC

19.0102 and 19.0106. The Company was also educated on the provisions of NCGS 58-3-245 regarding the requirements for printed directories.

Network Availability and Accessibility Standards

The Company has established provider availability standards via a ratio of 1 vision provider to 1,000 members in accordance with the provisions of 11 NCAC 20.0301(1).

The Company has established provider accessibility standards in accordance with the provisions of 11 NCAC 20.0302(4). The plan covers routine vision care only.

The Company's written policies and procedures (Policy VNSD 3.0 and VNSD 4.0) do not state that monitoring of provider availability will occur at least annually or reference another policy with respect to this requirement. Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0304. The Department further noted that the Company did not conduct appointment accessibility monitoring in 2007. In 2008, the Company only conducted appointment accessibility monitoring upon request by the employer group and therefore did not conduct accessibility monitoring for all members across the entire network. In addition, the monitoring which occurred in 2008 did not directly address/monitor the established 4 week standard for scheduling a routine appointment, as the survey question only asked if the member was "satisfied with his/her ability to schedule an appointment in a reasonable amount of time." Therefore, the Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0304 as it did not conduct provider accessibility monitoring during the examination period as required by the regulation.

The Company failed to adequately document the time frame during which it had monitored provider availability and accessibility standards in 2007, as the Company's geo-access report for the 2007 time period was dated January 2008. Therefore, the Company was reminded of the provisions of 11 NCAC 20.0304.

It was also noted that the Company could not consistently provide signed policies and procedures with respect to provider availability and accessibility. Therefore, the Department was unable to ascertain the effective date for each iteration of the policies.

Provider Contracts

During the examination period, the Company utilized a provider agreement form (VISPROV (06/07)) which had not been approved by the Department and was deemed to be in apparent violation of the provisions of 11 NCAC 20.0201.

CLAIMS PRACTICES

The Company's claims practices were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. The Company has executed a policy which generally reflects the North Carolina Prompt Pay Law in accordance with the provisions of NCGS 58-3-225.

The Company's "North Carolina Prompt Pay" policy (CL065-01) utilized during the examination period states that it is applicable to members residing in North Carolina; however, the policy must apply to all contracts situsedin North Carolina, including members who live and/or work in the state.

Claims Standards and Performance

The Claims Department receives records and processes all claims for services incurred by members. The Company's established standards and actual performance during the examination period are outlined in the following chart:

Performance Measure	Standard	2007 Actual	2008 Actual
Claims processed within 15 business days (%)	85.0	85.4	93.0
Processing accuracy (%)	95.0	97.7	98.7
Claim payment accuracy (%)	98.0	99.9	98.3
Financial accuracy (%)	99.0	99.5	99.7

The Company has established a standard for claims processing timeliness of 85.0 percent within 15 business days, which does not meet the requirements of NCGS 58-3-225 which state

that within 30 days of receiving all claims, an insurer must perform an action, including sending either payment; notice of denial; notice that the claim is officially pended, requiring additional information; or pended based on nonpayment of fees or premiums. Therefore, the Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as its current standard does not comply with the statutory requirements.

Paid Claims Sample Review

The Department reviewed a random sample of 50 paid claims from a population of 1,198 to determine the Company's accuracy and timeliness of payments. The review revealed that 5 claims (10.0 percent error ratio) were not processed correctly and/or contained insufficient documentation. Therefore, the Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 and/or 11 NCAC 19.0102 and 19.0105.

- Three claims (6.0 percent error ratio) included a processing error which resulted in incorrect payments to the claimants. One of these claims included an overpayment for contact lenses, as the billed charges were less than the allowed amount, but the claims processor paid the allowed amount. Upon reviewing this claim, the Department further noted that the allowed benefit amount for this service was incorrectly loaded into the claims adjudication system for this group. This resulted in underpayments for 3 additional claims outside of the original sample. At the Department's request, the Company reprocessed these claims, which resulted in a total of $135.00 in additional benefits paid and an additional total of $89.64 in interest payments to the applicable claimants. Two claims from the sample included processing errors which required 1 of the claims to be reprocessed, resulting in a total of $1.00 in additional benefits paid, plus an additional payment of $0.73 in applicable interest.

- Two claims (4.0 percent error ratio) failed to include sufficient documentation to demonstrate proper handling of the claim.

In addition, the review revealed that 3 claims (6.0 percent error ratio) were processed in excess of 30 days from receipt and included the applicable interest in accordance with the provisions of NCGS 58-3-225.

The average service time to process a paid claim was 21 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	8	16.0
8 - 14	26	52.0
15 - 21	6	12.0
22 - 30	7	14.0
31 - 60	2	4.0
Over 60	1	2.0
Total	**50**	**100.0**

Denied Claims Sample Review

The Company did not have any denied claims during the examination period. Providers are required to complete and submit a "Vision Pass" to verify eligibility and benefits prior to rendering services.

Rescissions

The Company's application process does not include medical information and therefore the Company did not have any policy rescissions/reformations during the examination period.

POLICYHOLDER TREATMENT

The Company's policyholder treatment activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

The Company operates a call center which accepts member and provider telephone calls through a toll-free telephone line. The Customer Care Department is available 5 days a week from 8:00 AM to 6:00 PM, Eastern Standard Time. After normal business hours and during holidays, a recorded message informs callers that the office is closed and provides them with the hours of operation for the Customer Care line so they can call back during that time. Providers are given the option of using the self-service phone service to check member eligibility and/or the status of a claim.

The Customer Care Department has established telephone service standards and monitors actual performance. Review of the telephone reports revealed that the Customer Care Department has not met its established standards throughout the examination period as outlined in the following chart:

Performance Measure	Standard	2007 Actual	2008 Actual
Calls answered within 60 seconds (%)	70.0	60.6	63.6
Abandonment rate (%)	≤ 5.0	6.5	4.9

Member Grievances

The Company received 3 member grievances during the examination period which were handled in accordance with the Company's written policies and procedures.

The average service time to process a member grievance was 22 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	33.3
22 - 30	2	66.7
Total	**3**	**100.0**

DELEGATED OVERSIGHT

During the examination period, the Company did not delegate any functions which were reviewed as part of this examination.

SUMMARY

The target examination revealed the following:

1. General Administration

    a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-191(a) as it failed to submit the managed care annual filing data to the Department by the established due date for data years 2007 and 2008.

2. Provider Relations and Delivery System

    a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0102 and 19.0106 as it could not provide a copy of its 2007 and 2008 printed provider directories.

    b. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0304 as its written policies and procedures do not state that monitoring of provider availability will occur at least annually or reference another policy with respect to this requirement.

    c. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0304 as it did not conduct provider accessibility monitoring during the examination period as required by the regulation.

    d. The Company was reminded of the provisions of 11 NCAC 20.0304 as it failed to adequately document the time frame during which it monitored provider availability and accessibility standards in 2007, as the Company's geo-access report for the 2007 time period was dated January 2008.

    e. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 20.0201 as it utilized a provider agreement form which had not been approved by the Department.

3. Claims Practices

    a. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 as its claims processing timeliness standard did not comply with the statutory requirements.

    b. The Company was deemed to be in apparent violation of the provisions of NCGS 58-3-225 and/or 11 NCAC 19.0102 and 19.0105 as 10.0 percent of paid claims were not processed correctly and/or failed to include sufficient documentation to demonstrate proper handling of the claim.

4. Additional Issues Noted During the Examination

    a. The Company could not consistently provide signed policies and procedures with respect to provider availability and accessibility. Therefore, the Department was unable to ascertain the effective date for each iteration of the policies.

b. The Company's "North Carolina Prompt Pay" policy utilized during the examination period states that it is applicable to members residing in North Carolina; however, the policy must apply to all contracts sitused in North Carolina, including members who live and/or work in the state.

c. The Company failed to meet its established telephone standard for calls answered within 60 seconds during the examination period and failed to meet the abandonment rate standard in 2007.

TABLE OF STATUTES AND RULES

Statute/Rule	Title
NCGS 58-2-131	Examinations to be made; authority, scope, scheduling, and conduct of examinations.
NCGS 58-2-132	Examination reports.
NCGS 58-2-133	Conflict of interest; cost of examinations; immunity from liability.
NCGS 58-2-134	Cost of certain examinations.
NCGS 58-3-191	Managed care reporting and disclosure requirements.
NCGS 58-3-225	Prompt claim payments under health benefit plans.
NCGS 58-3-245	Provider directories.
NCGS 58-67-100	Examinations.
11 NCAC 19.0102	Maintenance of Records.
11 NCAC 19.0105	Claim Records.
11 NCAC 19.0106	Records Required for Examination.
11 NCAC 20.0201	Written Contracts.
11 NCAC 20.0301	Provider Availability Standards.
11 NCAC 20.0302	Provider Accessibility Standards.
11 NCAC 20.0304	Monitoring Activities.

CONCLUSION

A target examination has been conducted on the market conduct affairs of CompBenefits Insurance Company (Vision PPO) for the period of January 1, 2007 through December 31, 2008 with analysis of certain operations of the Company being conducted through June 6, 2011. The Company's response to this report, if any, is available upon request.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of general administration, provider relations and delivery system, claims practices, policyholder treatment and delegated oversight.

Respectfully submitted,

Jill H. Dale

Jill H. Dale, PAHM, MHP, HIA
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Tracy M. Biehn

Tracy M. Biehn, LPCS, MBA
Deputy Commissioner
Market Regulation Division
State of North Carolina