

# **OHIO DEPARTMENT OF INSURANCE**

**A**

**MARKET CONDUCT EXAMINATION**

**OF**

**SUMMA INSURANCE COMPANY, INC.**

**NAIC # 10649**

**And**

**SUMMACARE, INC.**

**NAIC # 95202**

**As Of**

**October 31, 2011**



**ODI**  
Ohio Department  
of Insurance

John R. Kasich, Governor  
Mary Taylor, Lt. Governor/Director

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Honorable Mary Taylor  
Lt. Governor / Director  
Ohio Department of Insurance  
50 West Town Street  
Third Floor – Suite 300  
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

Summa Insurance Company, Inc. - NAIC # 10649

And

SummaCare Inc. – NAIC # 95202

The examination was conducted at the Company's statutory home office at:

10 North Main Street  
Akron, Ohio 44308

A report of the examination is enclosed.

Angela Dingus, MCM, AIC, AINS  
Chief, Market Conduct Division  
Office of Risk Assessment

10/17/2013

Date

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## **FOREWORD**

This examination was conducted under authority provided under Ohio Revised Code (“ORC”) 3901.011.

## **SCOPE OF EXAMINATION**

On November 3, 2011, the Market Conduct Division of the Ohio Department of Insurance (“Department”) opened an examination into the non-financial business practices of Summa Insurance Company, Inc. (“SICI”) and SummaCare Inc. (“SCI”) (collectively referred to as the “Companies”) by sending the Companies a call letter and initial request for information. On January 30, 2012, the on-site portion of the examination began in Akron, Ohio, at the statutory home office for the Companies.

The examination was restricted to a review of the Companies’ activities for the prompt payment of Ohio health insurance claims for the period from November 1, 2010 through October 31, 2011. The examination report is by test and was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (“NAIC”) and the state of Ohio’s applicable statutes and rules.

Accordingly, the examination included the following areas of the Companies’ operations:

- A. Company History
- B. Company Operations
- C. Claims

## **METHODOLOGY**

As part of the examination, the Department’s examiners reviewed the Companies’ claims department procedures and claim files for paper and electronic paid and denied claims. This information was supplemented by interviewing the Companies’ managers and with written inquiries requesting clarification and/or additional information.

Only Ohio policyholders’ files were reviewed. A series of tests was designed and applied to these files to determine the Companies’ level of compliance with Ohio’s prompt pay insurance statutes and rules. These tests are described and the results noted in this report.

The examiners used the NAIC’s standard of:

7% error ratio on claim files (93% compliance rate)

to determine whether an apparent pattern or practice of non-compliance existed for any given test. The results of each test applied to a particular sample are reported separately. Each test is expressed as a “yes/no” question. A “yes” response indicates compliance and a “no” response indicates a failure to comply.

In any instance where errors were noted, the examiners described the apparent error and asked the Companies for an explanation. The Companies responded to the examiners and either:

- Concurred with the findings,
- Had additional information for the examiners to consider,
- Disagreed with the findings, and/or
- Proposed remedial action(s) to correct the apparent deficiency.

If applicable, the examiners' recommendations are included in this report.

### **SAMPLING**

Upon request, the Companies supplied reports of policy and claim data in file formats which could be used on IBM compatible personal computers. Except as otherwise noted, all tests were conducted on a sample of files randomly selected from a given report. The samples were pulled from populations consisting of Ohio policies and were selected using a standard business database application that provides a true random sample given that it supplies a random starting point from which to select the sample.

### **COMPANY HISTORY – SUMMACARE, INC (“SCI”)**

SCI originated in 1990 as a product offering to large self-funded employers in the Akron, Ohio area. As a result of its success with self-funded programs, the Company began receiving a growing number of inquiries by smaller, local employers to develop similar products on a fully-insured basis. In response, SCI was incorporated in October 1992 and received its Certificate of Authority (“COA”) in March 1993 from the Department to operate as a fully licensed Health Insuring Corporation (“HIC”) in the state of Ohio.

In 1993, SCI began marketing fully-insured HIC products to local employers in a seven county service area. Over the next several years, the commercial managed care marketplace evolved, and the Company developed a series of Point-of-Service (“POS”) managed care products to meet the changing needs of its commercial clients. During 1995, the Company applied and was successfully selected by the Ohio Department of Human Services (now known as the Ohio Department of Job and Family Services) as a managed care option for residents in Summit County covered by Medicaid for Dependent Children. The Company quickly grew to be the largest Medicaid HIC provider in Summit County, serving 70% of the Medicaid-eligible population. As a result of the subsequent consolidation in the Medicaid managed care industry and the increasing competition from national and regional organizations, the Company elected to transition its Medicaid members to Buckeye Community Health Plan in May 2005.

In 1996, SCI successfully completed its application to the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services) to become a managed care option for the Medicare recipients covered under Medicare Advantage plans. The Company enrolled its first Medicare HIC member in July 1996 and today is the largest Medicare HIC in Summit County. The Company's Medicare Advantage network spans 18 counties in the state of Ohio.

Effective January 1, 2000, SCI formally changed ownership from Akron City Health System, a not-for-profit joint venture between Summa Health System (“SHS”) and physicians, to Summa Insurance Company, Inc. (“SCIC”), a licensed for-profit property & casualty insurance company domiciled in Ohio. While viewed as a formal change in ownership, effective control and governance remain consistent with the original hospital and physician owners.

In August 2001, Apex Benefit Services, LLC (“APEX”), a licensed third party administrator (“TPA”) providing administrative services to self-funded employers, was created. APEX is a full service TPA that offers an array of services including claims re-pricing and adjudication, customer service, medical management, utilization review, disease management, stop loss services,

membership billing and eligibility, ancillary benefits, client reporting, actuarial services, Accountable Care Organization “ACO” administration services and benefit consultative services.

Since its inception, SCI has had growth in all of its lines of business. Total membership is currently over 225,000 lives and the service area has been expanded to include 19 counties for commercial Preferred Provider Organizations (“PPO”) products.

### **COMPANY HISTORY – SUMMA INSURANCE COMPANY, INC. (“SICI”)**

SICI was organized in August 1995 and received its COA in November 1995. SICI is a for-profit, licensed property and casualty insurance company domiciled in Ohio. The Company is jointly owned by SHS and physicians.

SICI owns 100% of the shares of common stock of SCI and SHS holds 100% of preferred, non-voting shares of SCI. SICI is the sole owner of APEX and Summa Insurance Agency.

SICI was created to respond to the marketplace need for PPO. SICI’s evolution originated with the creation of SCI.

### **COMPANY OPERATIONS**

The COAs issued by the Department authorize the Companies to engage in the business of accident & health and group accident & health insurance. The Companies are domiciled in the state of Ohio and are licensed only in their state of domicile.

The products currently offered through the Companies include commercial HIC, PPO and POS products for both large and small groups, individual products and government administered plans for the Medicare program. All products are supported by providers through contractual arrangements with the Summa Health Network, the Cleveland Health Network and other direct provider contracts. The HIC plan is a closed panel product offered by SCI. The PPO plan offers an open-panel option, which allows its members to receive health care services from either network or non-network providers. As part of the PPO product design, members incur lower deductibles, copayments, coinsurance and overall out-of-pocket expenses when care is received from network providers. The Companies jointly offer the POS product, a multi-benefits product with the indemnity level benefits underwritten by SICI.

The commercial PPO products are sold in Ashtabula, Carroll, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, Mahoning, Medina, Ottawa, Portage, Sandusky, Stark, Summit, Trumbull and Wayne counties in Ohio. The individual Medicare products are sold in Ashtabula, Carroll, Columbiana, Cuyahoga, Erie, Geauga, Huron, Lake, Lorain, Mahoning, Medina, Portage, Sandusky, Stark, Summit, Trumbull, Tuscarawas and Wayne counties in Ohio.

The commercial products are promoted through direct sales representatives and brokers. The Medicare products are solicited through direct sales representatives.

For calendar year 2010, SCI reported total net premium income of \$270,374,805 and incurred losses of \$226,991,004. SCI’s year-end 2010 premium and loss information from its annual financial statement is as follows:

**2010 Accident & Health Insurance**

<b>Line of Business</b>	<b>Ohio Premiums</b>	<b>Ohio Incurred Claims Losses</b>
Comprehensive (Hospital & Medical)	\$23,249,119	\$22,348,203
Medicare Supplement	\$0	\$4,494
Title XVIII Medicare	\$247,125,686	\$204,685,377
Federal Employees Health Benefit Plan	\$0	(\$47,070)

For calendar year 2010, SICI reported total net premium income of \$153,995,227 and incurred losses of \$136,176,713. SICI's year-end 2010 premium and loss information from its annual financial statement is as follows:

**2010 Accident & Health Insurance**

<b>Line of Business</b>	<b>Ohio Premiums</b>	<b>Ohio Incurred Claims Losses</b>
Comprehensive (Hospital & Medical)	\$153,909,243	\$136,132,681
Medicare Supplement	\$72,392	\$38,032
Title XVIII Medicare	\$13,592	\$6,000

**CERTIFICATE OF AUTHORITY**

The Companies operate under COA's issued by the Department which permits them to transact appropriate business thereunder as defined by the ORC. In the course of the examination, the examiners determined that the Companies' operations were in compliance with the COAs.

**COMPLIANCE**

The Vice President of Corporate Services, who is the Companies' Compliance Officer, oversees all aspects of the corporate compliance program (training, internal audit, Medicare compliance), legal services, human resources, and risk management activities. The Vice President of Corporate Services also serves as the Privacy Officer and directs policy development and activities related to privacy and other Health Insurance Portability and Accountability Act ("HIPAA") requirements.

The Medicare Compliance Manager supports the Compliance Officer in effective management of Medicare compliance.

The Companies' Compliance & Legal Departments are responsible for maintaining current knowledge of all federal and state laws and standards that regulate the commercial and Medicare products. The Legal Department conducts research and tracks legislative changes that apply to the health insurance industry. In addition to receiving up-to-date information about current and pending laws from professional organizations including the Health Lawyers Association, the American Bar Association, the Ohio State Bar Association, and the Ohio Association of Health Plans ("OAHP"), the Companies routinely check on-line sources. The legal & compliance staffs are active members of the OAHP's Regulatory Committee that meets monthly to review pertinent legislative and Department updates that affect the Companies' business.

The Companies indicate that their legal & compliance staffs take advantage of external training and education programs that enhance their knowledge base. The Companies disseminate this information via pertinent committees, individual department meetings, and specially designed

training programs that are administered either in person to small groups or through electronic training.

The Internal Audit Department, which is housed within the Compliance Department, routinely audits processes and policies to ensure they correspond with all regulatory requirements. The Manager of Internal Audit manages and guides activities of the auditing and investigative staff. In addition, the Manager of Internal Audit implements, administers, and monitors new and existing internal auditing and fraud and abuse initiatives to ensure compliance with the Companies' policies and procedures and regulatory guidelines. Deficiencies are addressed through corrective action plans and routine monitoring.

## **CLAIMS FILE AUDIT PROCESS**

### **Claim Quality Audits – Accuracy Review**

The Companies monitor the accuracy of manually adjudicated claims processing through both pre-payment and post-payment audit programs. Additionally, these audit programs identify areas where guidance and/or training may be necessary.

### **Procedures**

The majority of routine health claims received by the Companies are auto-adjudicated. However, more complex hospital, physician, dental, and medical equipment claims are processed manually by adjusters. These claims are closely reviewed and included within scheduled claims audits.

Pharmacy claims are generally processed through the Companies' delegated pharmacy vendor, which also audits claims per the Companies' delegation agreement.

The abovementioned claims are categorized according to the following factors to determine the percentage of review or auditing:

- Dollar amount to be released;
- Manually priced (Yes/No);
- Experience level of claims processor

The claims are audited for both financial accuracy (i.e. were the dollars paid correctly) and procedural accuracy (i.e. did the claim pay against the correct benefit and accurately depict the service provided).

The Companies' audit process focuses on every applicable field in each claim reviewed, depending upon the type of claim, the claim format (electronic or paper) and whether the claim includes modifiers or coordination of benefits.

The claims processors are responsible for the following:

- Eligibility – This includes, but is not limited to, the verification of correct member, date of birth, gender review and coordination of benefits.
- Provider – This is comprised of, but not limited to, the correct selection of individual versus group coverage, affiliation selection, and verification of payment address.
- Service Line Data Elements – This consists of entries (or omission of entries) affecting the processing and reporting of claims. This includes the remarks to enable an accurate review of duplicate and/or possible duplicate claims submissions, clean

date processing, re-pricing, and Ohio Department of Job and Family Services reimbursement processing.

- Financial – This includes entries (or omission of entries) affecting payment of the claim. This consists of modifiers, the correct order of modifiers, number of units, anesthesia time, etc.
- Procedural – This encompasses the entries (or omission of entries) which have no financial impact on the claim.

### **Percentages Audited**

Quality audits are performed on each staff member at a rate of one claim per week. An adjustment may be made to this number when deemed necessary due to amount of overall work or when particular staff members are identified as falling below the Companies' standard. Either the Director of Claims or the Claims Manager may request this adjustment.

In addition to this one claim per week random audit, a 100% audit will be performed for all claims greater than \$4,000 with a status 12 service line, which indicates a manually priced line. These audits will be included in the processor's results. There will also be a 100% review of all claims that:

- Exceed \$20,000, which will be reviewed by the Senior Processor prior to release.
- Exceed \$75,000, which will be approved by the Companies' management prior to release.
- Are processed by the Companies' staff outside the Claims Department with security assignments that allow write access to claims. These will be audited by the Internal Audit Department.

The dollar reviews are pre-disbursement. The quality audits (used for quality improvement purposes) are post-disbursement.

### **Reporting & Results**

Once selected for review, the turnaround goal for quality audits is to be within one month current, or within two weeks for trainees.

To calculate individual financial quality, once the correct payment is determined, the absolute error is subtracted. This amount is divided by the correct payment to equal the average financial percentage.

To determine the percentage of claims a processor handles with financial correctness, the total number of claims financially correct is divided by the total number of claims audited.

The results of the audit are reported at the individual employee level on a weekly basis to provide detailed feedback to each claims processor. When an immediate need for training is identified through the audit process, a summary of the issue and the recommended actions are transmitted in writing to the employee's supervisor for review. Monthly audit scores are provided as a summary.

### **Performance Feedback**

When a week's auditing is complete, the auditing staff notifies the claims processors and managers via e-mail. The audit spreadsheets are electronically stored and are secured so only the managers and the specific processors have access to view the results. The processors will be responsible for reviewing their audit results and any feedback provided.

### **GENERAL CLAIMS PRACTICES**

#### **Overview of Claims Department responsibilities, staffing and reporting structures**

The Fully Insured/Medicare claims area is under separate direction from the Self Funded line of business. Both Directors report to the Vice President of Client Services.

The document management team reports to the Director of Self Funded Claims and provides support to all lines of business. This team opens mail, scans the documents and vertexes the images that are then loaded into the Companies' Claim Processing System (Amisys).

The Fully Insured claims processing is managed by a Claims Supervisor and a Team Lead, who have responsibility for ensuring prompt payment requirements are met by managing the claims payment process. They are assisted by eight Senior Claims Processors and one Claims Processor. One Senior Claims Processor has oversight for electronic claims and another has oversight for paper claims. This team works in conjunction with all other areas within the Companies with responsibility for pending claim resolution. The other areas within the Companies are notified weekly by the Claims Department of the claims that need to be resolved for the week's payable run. Paper claims are monitored and worked daily. The Claims Processors are also responsible for the necessary investigation and adjustments received via Contract Service Forms and reports from other areas of the Companies.

The Claims Recovery area reports to the same Director as the Fully Insured/Medicare area but provides support to all lines of business. Its responsibilities include recovery of overpayments, processing the related claims adjustments and take backs, and oversight for the subrogation and workers' compensation vendors.

#### **Payment of Claims Submitted Electronically**

ORC 3901.381(F) provides that a third party payer shall transmit electronically any payment with respect to claims that the third party payer receives electronically and pays to a contracted provider under this section and under ORC sections 3901.383, 3901.384, and 3901.386. If a company issues a non-electronic payment in response to an electronically submitted claim, the Companies must provide documented proof of a good faith effort to obtain electronic funds transfer (EFT) information from the provider or evidence of the provider's refusal to provide EFT information.

The Companies provided the Department with a copy of the July 1, 2010 EFT Announcement letter that was sent to providers that submit claims electronically. This mailing requested that providers complete and submit an EFT form to initiate the electronic claims payment process.

In addition, the Companies provided the Department with a copy of Third and Fourth Quarter 2010 Provider Press news letters that contained information regarding EFT and instructions for providers.

After the fourth quarter 2010, the Companies began to distribute the EFT enrollment letter and form to providers as part of the contracting process. Any forms completed and returned to the Companies are processed for electronic payment.

### **Anti-Fraud Initiatives**

In 1998, HCFA issued a mandate requiring Medicare+Choice Plans to implement compliance programs to detect and reduce the risk of fraud and abuse. In response to this mandate, the Companies established a corporate-wide compliance department in June of 1999 to increase compliance in all areas of the organization.

Fundamentally, compliance efforts are designed to establish a culture within an organization that promotes prevention, detection and resolution of instances of conduct that do not conform to Federal and State law and Federal health care program requirements, as well as ethical and business policies. As a demonstration of the Companies' commitment to compliance, the Compliance Department implemented a Corporate Compliance Program as well as a Fraud and Abuse Program, that provides detail on how the organization prevents, detects, investigates and reduces the risk of fraud, waste, and abuse.

### **General Claims Practices/Procedures**

The examiners found that a complete chronological reconstruction of the Companies' claims activities was extremely difficult. This difficulty was due to the Companies' use of designated and labeled data fields within their claims processing system (Amisys) for dissimilar information and calculations. For example, the "paid date" field is utilized for documenting the date the claim was paid. However, this same data field is used to capture the "denied date" and to document the date the Companies requested additional information from external sources such as providers and/or members.

Additionally, it was discovered during the review of claims files that numerous claims were initially denied for a lack of information instead of being placed in a "pend" status followed by a subsequent request for information.

The Companies' policies and procedures for pended claims stipulate "If a claim is received with incomplete information, the claim is pended and sent to the appropriate department for review through Maccess queues and work flows." The denial of claims for the lack of information appears to be a breach of the Companies' policies and fails to comply with Ohio Administrative Code ("OAC") 3901-8-11 and ORC 3901.381. The Companies' interpretation of this code does not count the days between the date information is requested and the date information is received as part of the aggregate total of processing days, if the request for information is not made within 30 days. Ohio's Prompt Pay Law states that the accrual of "countable" days continues without interruption if the additional request for supporting documentation is made outside of the 30-day period after the claim is received.

**Examiner Recommendation:** The Companies shall employ revised procedures to ensure that each claim file is documented to allow a complete chronological reconstruction of the third party payer's activities in accordance with OAC 3901-8-11(G). Furthermore, the Companies must develop and enforce a policy that ensures in instances where supporting documentation is necessary, the Companies notify all relevant external sources within the legal time frame in compliance with ORC 3901.381(B)(2)(a) and OAC 3901-8-11.

## **SPECIFIC CLAIMS PRACTICES**

### **GENERAL TEST METHODOLOGY**

- The examiners reviewed the Companies' Claim Department Procedure Manual as part of the exam process.
- The review also included tests to assure that the Companies' claim practices and procedures were in compliance with the ORC and the OAC.
- The claims files were reviewed to verify dates in the claims settlement process.
- A claim was considered to be an exception if it did not contain adequate documentation.
- A claim file was considered to be an exception if the documentation did not include the date of each activity or communication.

### **SEGMENTED EXAMINATION PERIOD CLARIFICATION**

Throughout the course of the examination it was discovered that the Companies were in the midst of training, implementing and testing new claims procedures throughout the first two months of the examination period (November and December of 2010). This became evident when assessing the compliance of the claims files throughout this period. In lieu of excluding November and December 2010 from the examination entirely, the Department agreed to present the findings of each test in a segmented manner displaying the Companies' compliance during the first two months of the exam period (11-1-10 through 12-31-10) and the Company's compliance for the remaining ten months of the examination period (1-1-11 through 10-31-11).

Additionally, the results of each claim test are displayed in a table format. Each table displays population and sample values that reflect the removal of duplicate claims and claims received by the company prior to November 1, 2010. All compliance ratings have been calculated based on 100% of the revised sample size.

## **PAID CLAIMS**

### **Timeliness of Requests for Information: All Paid Claims With Additional Information Requested**

**Test Methodology:** The examiners requested and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814 that were closed and paid during the examination period, where additional information was requested after the claim was received.

- A claim was considered to be an exception if the request for additional information for the claim was not made within 30 days for electronically submitted claims or 15 days for non-electronically submitted claims.

**Standard:** The initial contact by the third-party payer with the claimant is within the required time frame.

**Test 1:** If additional information is needed for a paper claim, was a notification of all items, statements, and forms, if any, made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-07(C)(5)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	110	15	10	5	93%	67%
Summa Ins.	01-01-11 to 10-31-11	302	41	27	14	93%	66%
SummaCare	11-1-10 to 12-31-10	12	12	10	2	93%	83%
SummaCare	01-01-11 to 10-31-11	3	3	3	0	95%	100%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in three of the four above noted segments.

**Examiner Recommendation:** In situations where additional documentation is necessary, the Companies should develop a corrective action plan and enhance procedures to ensure that a notification of all items, statement, and forms, if any is made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-07(C)(5).

**Test 2:** If additional information is needed for an electronic claim, did the third-party payer notify the relevant external sources that supporting documentation is needed within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(2)(a)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	790	22	18	4	93%	82%
Summa Ins.	01-01-11 to 10-31-11	1,729	31	28	3	93%	90%
SummaCare	11-1-10 to 12-31-10	27	14	14	0	93%	100%
SummaCare	01-01-11 to 10-31-11	54	12	9	3	93%	75%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in three of the four above noted segments.

**Examiner Recommendation:** In situations where additional documentation is necessary, the Companies should develop a corrective action plan and enhance procedures to ensure that relevant external sources are notified that supporting documentation is needed within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(2)(a).

**Timeliness of Claim Payments: All Paid Claims With No Additional Information Requested**

**Test Methodology:** The examiners requested and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814 that were closed and paid during the examination period, where no additional information was requested after the claim was received.

- A claim was considered to be an exception if the claim was not paid within 30 days when no additional information was requested for electronically submitted claims or 21 days from receipt of a properly executed proof of loss for non-electronically submitted claims.

**Standard:** A third-party payer shall settle health claims in a timely manner.

**Test 1:** Was the paper claim paid within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standar	Compliance
Summa Ins.	11-1-10 to 12-31-10	7,247	14	12	2	93%	86%
Summa Ins.	01-01-11 to 10-31-11	31,143	79	74	5	93%	94%
SummaCare	11-1-10 to 12-31-10	544	23	19	4	93%	83%
SummaCare	01-01-11 to 10-31-11	522	19	14	5	93%	74%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in three of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with OAC 3901-1-07(C)(12).

**Test 2:** Was the electronic claim paid within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(1)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	60,069	26	26	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	279,761	160	158	2	93%	99%
SummaCare	11-1-10 to 12-31-10	8,206	46	46	0	93%	100%
SummaCare	01-01-11 to 10-31-11	6,187	42	41	1	93%	98%

The standard for compliance is 93%. The Companies' claims practices are above the compliance standard.

**Timeliness of Claim Payments: All Paid Claims With Additional Information Requested**

**Test Methodology:** The examiners requested, and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, that were closed and paid during the examination period, where additional information was requested after the claim was received.

- A claim was considered to be an exception if the claim was not paid within 45 processing days when additional information had been requested for electronically submitted claims or 21 days from receipt of a properly executed proof of loss for non-electronically submitted claims.

**Standard:** A third-party payer shall settle health claims in a timely manner.

**Test 1:** Was the paper claim paid within 21 days following the receipt of requested supporting documentation in accordance with OAC 3901-1-07(C)(12)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	110	15	14	1	93%	93%
Summa Ins.	01-01-11 to 10-31-11	302	41	32	9	93%	78%
SummaCare	11-1-10 to 12-31-10	12	12	10	2	93%	83%
SummaCare	01-01-11 to 10-31-11	3	3	3	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in two of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with OAC 3901-1-07(C)(12).

**Test 2:** Was the electronic claim paid within 45 days following the receipt of requested supporting documentation in accordance with ORC 3901.381(B)(2)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	790	22	18	4	93%	82%
Summa Ins.	01-01-11 to 10-31-11	1,729	31	27	4	93%	87%
SummaCare	11-1-10 to 12-31-10	27	14	14	0	93%	100%
SummaCare	01-01-11 to 10-31-11	54	12	6	6	93%	50%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in three of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with ORC 3901.381(B)(2).

**Interest on Claim Payments: All Claims Paid Over 30 Days With No Additional Information Requested**

**Test Methodology:** The examiners requested, and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, which were paid in excess of the required time frame of 30 days with no additional information requested.

- An electronically submitted claim was considered to be an exception if no interest was paid where required or interest was not properly calculated.
- Non-electronically submitted claims were excluded from the test because the law applies only to electronically submitted claims.

**Standard:** Any third-party payer who fails to make claim payments in compliance with Ohio statutes and rules shall be liable for claim interest payments. The process for payment of interest on late health claims shall be in compliance with Ohio statutes and rules.

**Test 1:** Was the interest calculated correctly as required by ORC 3901.389?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	60,069	26	26	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	279,761	160	160	0	93%	100%
SummaCare	11-1-10 to 12-31-10	8,206	46	46	0	93%	100%
SummaCare	01-01-11 to 10-31-11	6,187	42	42	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are above the compliance standard.

**Interest on Claim Payments: All Claims Paid Over 45 Days With Additional Information Requested**

**Test Methodology:** The examiners requested, and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, where additional information was requested and the total processing time was greater than 45 days.

- An electronically submitted claim was considered to be an exception if no interest was paid where required or interest was not properly calculated.
- Non-electronically submitted claims were excluded from the test because the law only applies to electronically submitted claims.

**Standard:** Any third-party payer who fails to make claim payments in compliance with Ohio statutes and rules shall be liable for claim interest payments. The process for payment of interest on late health claims shall be in compliance with Ohio statutes and rules.

**Test 1:** Was the interest calculated correctly as required by ORC 3901.389?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	790	22	19	3	93%	86%
Summa Ins.	01-01-11 to 10-31-11	1,729	31	29	2	93%	94%
SummaCare	11-1-10 to 12-31-10	27	14	13	1	93%	93%
SummaCare	01-01-11 to 10-31-11	54	12	9	3	93%	75%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in two of the four above noted segments.

**Examiner Recommendation:** Most of the exceptions noted above stem from miscalculations of interest. The Companies' interpretation of this portion of the ORC excluded the calculation and payment of interest between the request and receipt date of missing information when the request for information was made more than 30 days after the initial receipt of the claim. The Companies should develop a corrective action plan and enhance procedures to ensure that interest is calculated and paid in accordance with ORC 3901.389.

## DENIED CLAIMS

### Timeliness of Requests for Information: All Denied Claims With Additional Information Requested

**Test Methodology:** The examiners requested and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, where additional information was requested and the claim was denied.

- A claim was considered to be an exception if the request for additional information for the claim was not made within 30 days for electronically submitted claims or 15 days for non-electronically submitted claims.

**Standard:** The initial contact by the third-party payer with the claimant is within the required time frame.

**Test 1:** If additional information is needed for a paper claim, was a notification of all items, statements, and forms, if any, made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-07(C)(5)?

#### **Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	101	9	7	2	93%	78%
Summa Ins.	01-01-11 to 10-31-11	209	31	28	3	93%	90%
SummaCare	11-1-10 to 12-31-10	6	6	6	0	93%	100%
SummaCare	01-01-11 to 10-31-11	8	8	8	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in two of the four above noted segments.

**Examiner Recommendation:** In situations where additional documentation is necessary, the Companies should develop a corrective action plan and enhance procedures to ensure that a notification of all items, statements, and forms, is made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-07(C)(5).

**Test 2:** If additional information is needed for an electronic claim, did the third-party payer notify the relevant external sources that supporting documentation is needed within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(2)(a)?

#### **Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	532	14	14	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	1,194	36	35	1	93%	97%
SummaCare	11-1-10 to 12-31-10	46	17	17	0	93%	100%
SummaCare	01-01-11 to 10-31-11	21	7	7	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are above the compliance standard.

**Timeliness of Claims Denials: All Denied Claims With No Additional Information Requested**

**Test Methodology:** The examiners requested and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, where no additional information was requested and the claims were denied.

- A claim was considered to be an exception if the claim was not denied within 30 processing days when no additional information was requested for electronically submitted claims or 21 days from receipt of a properly executed proof of loss for non-electronically submitted claims.

**Standard:** A third-party payer shall notify the provider and beneficiary of denial of a claim in a timely manner and give reason(s) upon which the denial is based.

**Test 1:** Was the paper claim denied within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	2,203	18	16	2	93%	89%
Summa Ins.	01-01-11 to 10-31-11	9,712	73	70	3	93%	96%
SummaCare	11-1-10 to 12-31-10	204	19	16	3	93%	84%
SummaCare	01-01-11 to 10-31-11	405	30	24	6	93%	80%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in three of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with OAC 3901-1-07(C)(12).

**Test 2:** Was the electronic claim denied within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(1)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	9,973	17	17	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	50,235	77	76	1	93%	99%
SummaCare	11-1-10 to 12-31-10	1,474	41	41	0	93%	100%
SummaCare	01-01-11 to 10-31-11	1,467	53	53	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are above the compliance standard.

**Timeliness of Claim Denials: All Denied Claims With Additional Information Requested**

**Test Methodology:** The examiners requested and the Companies supplied, a report of all Ohio health claims, not excluded by ORC 3901.3814, where additional information was requested and the claim was denied.

- A claim was considered to be an exception if the claim was not denied within 45 processing days when additional information had been requested for electronically submitted claims or 21 days from receipt of a properly executed proof of loss for non-electronically submitted claims.

**Standard:** A third-party payer shall notify the provider and beneficiary of denial of a claim in a timely manner and give reason(s) upon which the denial is based.

**Test 1:** Was the paper claim denied within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	101	9	9	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	209	31	29	2	93%	94%
SummaCare	11-1-10 to 12-31-10	6	6	4	2	93%	67%
SummaCare	01-01-11 to 10-31-11	8	8	8	0	93%	100%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in one of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with OAC 3901-1-07(C)(12).

**Test 2:** Was the electronic claim denied within 45 days following the receipt of requested supporting documentation in accordance with ORC 3901.381(B)(2)?

**Findings:**

Company	Exam Period:	Population	Sample	Yes	No	Standard	Compliance
Summa Ins.	11-1-10 to 12-31-10	532	14	14	0	93%	100%
Summa Ins.	01-01-11 to 10-31-11	1,194	36	34	2	93%	94%
SummaCare	11-1-10 to 12-31-10	46	17	17	0	93%	100%
SummaCare	01-01-11 to 10-31-11	21	7	5	2	93%	71%

The standard for compliance is 93%. The Companies' claims practices are below the compliance standard in one of the four above noted segments.

**Examiner Recommendation:** The Companies should develop a corrective action plan and enhance procedures to ensure that all health claims are settled in a timely manner in accordance with ORC 3901.381(B)(2)?

## **COMPANY COOPERATION**

Throughout the course of this examination, the level of cooperation offered by the Companies was polite and courteous. Each e-mail exchange with the Companies was professional and timely. However, there were instances where the Companies failed to respond to the examiners' telephone requests in a timely fashion. The overall cooperation by the Companies was acceptable.

## SummaCare, Inc. and Summa Insurance Company Summary

(Note: The standard for compliance is 93% for every test performed throughout this examination)

<u>Areas of Review</u>	<b>Summa Ins. Co. Compliance Rate</b>	<b>SummaCare Compliance Rate</b>
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### PAID CLAIM PRACTICES

#### **Paid Claims – WITH Additional Information Requested**

##### **Timeliness of Requests for Information:**

If additional information is needed for a paper claim, was a notification of all items, statements, and forms, if any, made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-07(C)(5)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>67%</b>	<b>83%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>66%</b>	<b>100%</b>

If additional information is needed for an electronic claim, did the third-party payer notify the relevant external sources that supporting documentation is needed within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(2)(a)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>82%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>90%</b>	<b>75%</b>

#### **Paid Claims – WITH NO Additional Information Requested**

##### **Timeliness of Claim Payments:**

Was the paper claim paid within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>86%</b>	<b>83%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>94%</b>	<b>74%</b>

Was the electronic claim paid within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(1)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>99%</b>	<b>98%</b>

(Note: The standard for compliance is 93% for every test performed throughout this examination)

<u>Areas of Review</u>	<b>Summa Ins. Co. Compliance Rate</b>	<b>SummaCare Compliance Rate</b>
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**Paid Claims – WITH Additional Information Requested**

**Timeliness of Claim Payments:**

Was the paper claim paid within 21 days following the receipt of requested supporting documentation in accordance with OAC 3901-1-07(C)(12)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>93%</b>	<b>83%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>78%</b>	<b>100%</b>

Was the electronic claim paid within 45 days following receipt of requested supporting documentation in accordance with ORC 3901.381(B)(2)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>82%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>87%</b>	<b>50%</b>

**Paid Claims – WITH NO Additional Information Requested**

**Interest on (electronic) Claim Payments Beyond 30-days:**

Was the interest calculated correctly as required by ORC 3901.389?

<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>100%</b>	<b>100%</b>

**Paid Claims – WITH Additional Information Requested**

**Interest on (electronic) Claim Payments Beyond 45-days:**

Was the interest calculated correctly as required by ORC 3901.389?

<b>November 1, 2010 thru December 31, 2010</b>	<b>86%</b>	<b>93%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>94%</b>	<b>75%</b>

**DENIED CLAIM PRACTICES**

**Denied Claims – WITH Additional Information Requested**

**Timeliness of Requests for Information:**

If additional information is needed for a paper claim, was a notification of all items, statements, and forms, if any, made within 15 days of receiving notice of the claim in accordance with OAC 3901-1-7(C)(5)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>78%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>90%</b>	<b>100%</b>

(Note: The standard for compliance is 93% for every test performed throughout this examination)

<u>Areas of Review</u>	<b>Summa Ins. Co. Compliance Rate</b>	<b>SummaCare Compliance Rate</b>
If additional information is needed on an electronic claim, did the third party payer notify the relevant external sources that supporting documentation is needed within 30-days after receipt of the claim in accordance with ORC 3901.381(B)(2)(a)?		
<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>97%</b>	<b>100%</b>

**Denied Claims – WITH NO Additional Information Requested**

**Timeliness of Claim Denials:**

Was the paper claim denied within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>89%</b>	<b>84%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>96%</b>	<b>80%</b>

Was the electronic claim denied within 30 days after receipt of the claim in accordance with ORC 3901.381(B)(1)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>99%</b>	<b>100%</b>

**Denied Claims – WITH Additional Information Requested**

**Timeliness of Claim Denials:**

Was the paper claim denied within 21 days after receipt by the insurer of a properly executed proof of loss in accordance with OAC 3901-1-07(C)(12)?

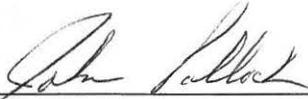
<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>67%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>94%</b>	<b>100%</b>

Was the electronic claim denied within 45 days following the receipt of requested supporting documentation in accordance with ORC 3901.381(B)(2)?

<b>November 1, 2010 thru December 31, 2010</b>	<b>100%</b>	<b>100%</b>
<b>January 1, 2011 thru October 31, 2011</b>	<b>94%</b>	<b>71%</b>

**CONCLUSION**

This concludes the report of the Market Conduct Examination of Summa Insurance Company, Inc., and SummaCare, Inc. The examiners, John Pollock, Ben Hauck, Laura Price, and Robert Baker would like to acknowledge the assistance provided by the management and the employees of the Companies.



\_\_\_\_\_  
John Pollock  
Examiner-in-Charge



\_\_\_\_\_  
Date



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October 3, 2013

Ms. Angela Dingus, Chief, Market Conduct Division  
Ohio Department of Insurance  
50 West Town Street  
Columbus, Ohio 43215

Dear Ms. Dingus,

We have received your report dated May 22, 2013, related to the Ohio Department of Insurance Market Conduct Examination of Summa Insurance Company, Inc. and SummaCare, Inc. Summa Insurance Company, Inc. and SummaCare, Inc. have prepared the following comments to the findings noted in the examination.

Electronically Submitted Health Claims

Per ORC 3901.381(B)(2), if additional information is needed to establish the third-party payer's responsibility to make payment on electronically submitted health claims, the request for information must be made within 30 days of receipt of the claim and the claim must be paid within 45 total processing days. The time between the request for information and the receipt of the information is not counted towards the 45 total processing days. This is applicable to both paid and denied claims.

If a claim is paid in violation of 3901.381(B)(2), interest is required to be paid for the time outside of the statutory required time frames and at the time of the claim payment per ORC 3901.389. The rate of interest is 18%.

**Company Response**

***Summa Insurance Company, Inc. and SummaCare, Inc. are in the process of modifying the programming logic for the calculation of the 45 day processing time as well as the interest calculation in accordance with ORC 3901.381(B)(2) and 3901.389. The modification addresses the findings noted as part of the examination.***

Non-Electronically Submitted (Paper) Health Claims

Per OAC 3901-1-07 (C)(12), non-electronically submitted health claims must be processed within 21 days of receipt of a properly executed proof of loss. If additional information is needed, the request for information must be made within 15 days of receipt of the claim, per OAC 3901-1-04 (C)(5). If information was requested, the claim must be processed within 21 days of receipt of the information. This is applicable to both paid and denied claims.

### Company Response

*While Summa Insurance Company, Inc. and SummaCare, Inc. did not meet the 93% standard for compliance, significant improvements have been noted in the processing of paper health claims. Summa Insurance Company, Inc. and SummaCare, Inc. will continue weekly inventory and prompt pay monitoring of paper claims adjusting workflows and processes as needed to expedite throughput.*

*On June 17, 2013, Summa Insurance Company, Inc. and SummaCare, Inc. upgraded the current document management/imaging system in an effort to increase the efficiency and effectiveness of the processing of all paper documentation including claims.*

*Summa Insurance Company, Inc. and SummaCare, Inc. will also continue to collaborate with providers submitting paper claims to transition to electronic format.*

### Requests for Information

Per OAC 3901-1-07, if additional information is needed for a paper claim, the request must be made within 15 days of receiving notice of the claim. Per 3901.38, if additional information is needed for an electronic claim, the request must be made within 30 of receiving notice of the claim. Requests for information are to be sent for each claim and are not to be part of a notice of a claim denial.

### Company Response

*Summa Insurance Company, Inc. and SummaCare, Inc. noted that the findings related to the requests for information were primarily attributable to situations involving considerations for pre-existing condition or coordination of benefits.*

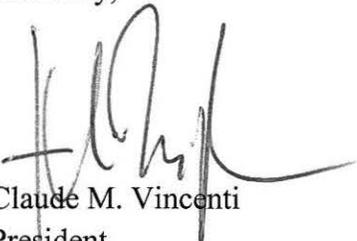
*Summa Insurance Company, Inc. and SummaCare, Inc. have modified the pre-existing process whereby each individual claim pending for response to a pre-existing questionnaire will not deny until 30 days have elapsed. Summa Insurance Company, Inc. and SummaCare, Inc. also send a status letter to the member and the servicing provider advising them of the information being requested in order to make a determination on the payment or denial of the claim.*

*Summa Insurance Company, Inc. and SummaCare, Inc. have also modified the coordination of benefits process. As consistent with the changes made to the pre-existing process, each individual claim pending for response to a*

*coordination of benefits questionnaire remains in a pended status for 30 days. Summa Insurance Company, Inc. and SummaCare, Inc. also send a status letter to the member and the servicing provider advising them of the information being requested in order to make a determination on the payment or denial of the claim.*

Thank you for your consideration of our response to your findings. Please do not hesitate to contact SummaCare with any additional questions, comments, or concerns.

Sincerely,



Claude M. Vincenti  
President