RECEIVED
NOV 2 2 2005
Dept. Of Commerce & Insurance
Company Examinations

Report on

Prompt Pay Examination

of the

CARITEN INSURANCE COMPANY
(NAIC #82740, GROUP CODE #1253)
1420 Centerpoint Blvd.
Knoxville, Tennessee 37932

as of

December 31, 2004

THE DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF TENNESSEE
Nashville, Tennessee

EXHIBIT
tabbies
A

TABLE OF CONTENTS

Salutation	1
Forward	1
Scope of Examination	1
Profile Facts	2
Executive Summary	3
Previous Examination Findings	4
Pertinent Factual Findings	4
Summarization	8
Conclusion	9
Affidavit	10

November 18, 2005

The Honorable Paula A. Flowers
Commissioner of Commerce and Insurance
State of Tennessee
500 James Robertson Parkway, 5th Floor
Nashville, Tennessee 37243

Dear Commissioner Flowers:

Pursuant to your instructions and in accordance with Tennessee insurance laws and regulations, and resolutions adopted by the National Association of Insurance Commissioners ("NAIC"), an examination has been made of the prompt payment of claims of

CARITEN INSURANCE COMPANY
(NAIC #82740, GROUP CODE #1253)

(hereinafter and generally referred to as "the Company") at its principal offices at 1420 Centerpoint Boulevard, Knoxville, Tennessee 37932. The report thereon is hereby respectfully submitted.

FORWARD

This report is written primarily by test, wherein each test applied during the examination is stated and the results are reported. Exceptions are noted as part of the comments for the applicable test.

SCOPE OF EXAMINATION

This is the initial prompt payment examination of the Company by the Tennessee Department of Commerce and Insurance ("Tennessee Department"). The examination commenced on June 6,

2005, and covers the period January 1, 2004, through December 31, 2004, including relevant subsequent events. The examination was made pursuant to Tenn. Code Ann. § 56-7-109, and conducted by representatives of the Tennessee Department and accordingly included tests of prompt payment of claims.

Testing performed during the review provided a credible basis for the findings and recommendations contained in this report.

PROFILE FACTS

The Company was incorporated as the National Burial Insurance Company, Memphis, Tennessee, on August 28, 1964, under the laws of the State of Tennessee. On September 12, 1977, the Company was purchased by Southern Affiliated Services, Inc., Knoxville, Tennessee, a Tennessee corporation. Following the purchase of the National Burial Insurance Company, the Company's name and principal office were changed to The Bankers' Service Life Insurance Company, Knoxville, Tennessee. Southern Affiliated Services, Inc., subsequently changed its name to Bankers' Affiliated Services, Inc. on October 13, 1977. In 1984, Bankers' Affiliated Services, Inc. changed its name to Financial Technology Corporation.

On April 19, 1989, Millard Oakley and Somerset Holdings, Inc. purchased the Company and changed the principal office location to Nashville, Tennessee.

On February 17, 1994, Methodist Medical Center of Oak Ridge, Inc. and Fort Sanders Alliance, Inc. purchased the Company and changed the Company's name from The Bankers' Service Life

Insurance Company to Future Health Insurance Company of America. On May 6, 1994, the Company's principal office was moved to Knoxville, Tennessee.

On November 20, 1996, the Company changed its name to Cariten Insurance Company.

The Company is authorized to write and issue all types of insurance policy contracts insuring the lives of individuals from all types of injuries, sickness, accidents, hospitalization, hazards of any nature, and death including, but not limited to, those classes of insurance generally referred to as life, health, accident, sickness, hospitalization, disability, annuity and endowment contracts and all forms of insurance written on the lives of individuals.

EXECUTIVE SUMMARY

The Tennessee Department conducted a prompt payment of claims examination of Cariten Insurance Company.

The Company is licensed to transact business in Tennessee and is engaged in the sale of commercial health insurance products, including preferred provider organization and point of service products primarily in east Tennessee.

The focus of the examination was a review of the Company's prompt payment of claims including compliance with Tennessee laws.

The Company is in compliance with Tenn. Code Ann. § 56-7-109.

PREVIOUS EXAMINATION FINDINGS

This is the initial prompt payment examination of the Company. However, the subject matter of this examination was considered during the Financial Examination conducted by the Tennessee Department as of December 31, 2001.

That examination reported that 80.5% of claims were paid in a timely manner in accordance with Tenn. Code Ann. § 56-7-109. This statute requires that 95% of clean claims submitted be paid within 30 days of receipt for paper claims and within 21 days of receipt for electronic claims.

The review of the timeliness of claim payments was hampered because the Company's claims handling system did not save the necessary data to prove compliance. The system did not save the date that additional information was provided to correct a previously submitted claim. Therefore, the results of the examination procedures were based on the original date that the claim was received, not the date the claim was made a "clean" claim.

PERTINENT FACTUAL FINDINGS

The tests of prompt payment of claims were conducted in accordance with Tenn. Code Ann. :

Tenn. Code Ann. § 56-7-109 (a)(A): specifies that:

> "Clean claim" means a claim received by a health insurance entity for adjudication, and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health

insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section.

Tenn. Code Ann. § 56-7-109 (a)(4): specifies that:

"Pay" means that the health insurance entity shall either send the provider cash or a cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health insurance entity. Payment shall occur on the date when the cash, cash equivalent or notice of credit is mailed or otherwise sent to the provider, and.

Tenn. Code Ann. § 56-7-109 (a)(5): specifies that:

"Submitted" means that the provider either mails or otherwise sends a claim to the health insurance entity. Submission shall occur on the date the claim is mailed or otherwise sent to the health insurance entity.

Tenn. Code Ann. § 56-7-109 (b) specifies that:

Not later than thirty (30) calendar days after the date that a health insurance entity actually receives a claim submitted on paper from a provider, a health insurance entity shall:

i. If the claim is clean, pay the total covered amount of the claim;

ii. Pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or

iii. Notify the provider in writing of all reasons why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean.

Not later than twenty-one (21) calendar days receiving a claim by electronic submission, a health insurance entity shall:

i. If the claim is clean, pay the total covered amount of the claim;

ii. Pay the portion of the claim that is clean and not in dispute and notify the provider in writing why the remaining portion of the claim will not be paid; or

iii. Notify the provider of the reason why the claim is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim.

Tenn. Code Ann. § 56-7-109 (c)(2): specifies that:

If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay ninety-five percent (95%) of all clean claims received from all providers during that year in accordance with this section, the commissioner may levy an aggregate penalty up to ten thousand dollars ($10,000). If the commissioner finds a health insurance entity has failed during any calendar year to properly process and pay eighty-five percent (85%) of all clean claims received from all providers during that year in accordance with this section, the commissioner may levy an aggregate penalty in an amount of not less than ten thousand dollars ($10,000) nor more than one hundred thousand dollars ($100,000), if reasonable notice in writing is given of the intent to levy the penalty. If the commissioner finds a health insurance entity has failed during any

> calendar year to properly process and pay sixty percent (60%) of all clean claims received from all providers during that year in accordance with this section, the commissioner may levy an aggregate penalty in an amount of not less than one hundred thousand dollars ($100,000) nor more than two hundred thousand dollars ($200,000)...

In order to test for the prompt payment of claims, a data download of claims data was received from the Company's information technology department. This population of claims data included both paper and electronic claims. The majority of the claims received were electronic claims. For each of the remaining claims, calculations were made to determine the amount of time from the "clean claim" date to the date of claim payment. In accordance with Tennessee Department and NAIC procedures, a sample of 100 claims was then randomly selected to ensure data integrity by verifying that the population data received from the information technology department agreed with the actual claim file. This sample size produced a 95% confidence level. No exceptions were noted.

Tests of prompt payment of claims, in accordance with Tenn. Code Ann. §56-7-109(b), were conducted with the following results:

Total claims	1,308,452	
Claims marked clean	1,031,695	
Claims paid in 21 days or less	993,582	
Claims paid in 21-30 days	27,863	
Claims paid in 31-60 days	7,233	
Claims paid in 61-90 days	704	
Claims paid in 91-120 days	726	
Claims paid in 121+ days/unpaid	1,587	
Claims unpaid/no date in system	6,211	
Claims timely paid	96.3%	**In Compliance**

SUMMARIZATION

Since the last review of the Company's timely payment of claims, the Company made changes to its claims handling system that now allows the Company to report the clean date of a claim. As a result, the Company is now in compliance with Tenn. Code Ann. §56-7-109(b) in regards to timely payment of claims.

CONCLUSION

Customary insurance examination practices and procedures, as promulgated by the NAIC and in accordance with Tennessee insurance laws and regulations, have been followed in connection with the prompt payment of claims examination of the Company for the period January 1, 2004, through December 31, 2004.

The courteous cooperation of the officers and employees of the Company extended during the course of the examination is hereby acknowledged.

Respectfully submitted,

Norman Chandler, CPA, CPCU, ARe, AIAF, ARC
Examiner-in-Charge
TaylorChandler, LLC
On behalf of the State of Tennessee
Southeastern Zone, NAIC

T. Britt Taylor, CPA
Insurance Examiner
TaylorChandler, LLC
On behalf of the State of Tennessee
Southeastern Zone, NAIC

AFFIDAVIT

The undersigned deposes and says that he has duly executed the attached examination report of Cariten Insurance Company dated November 18, 2005, and made as of December 31, 2004, on behalf of "The Department of Commerce and Insurance", State of Tennessee. Deponent further states he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his knowledge, information and belief.

Norman Chandler, CPA, CPCU, ARe, AIAF
Partner
TaylorChandler, LLC
On behalf of the State of Tennessee
Southeastern Zone, NAIC

Subscribed and sworn to before me
this 11th day of November, 2005
Notary Helen M. Dorey
County Davidson
State Tennessee
Commission Expires: 03/25/2006