RDA 2996

Confidential Legal Citation: TCAs 56-32-125, 56-32-135, 56-51-150, and 71-5-142

§ 56-32-125. Confidentiality

(a) Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from the person or from any provider by any HMO shall be held in confidence by the HMO and shall not be disclosed by the HMO to any person, except upon any one (1) of the following circumstances:
(1) To the extent that it may be necessary to carry out the purposes of this chapter;
(2) Upon the express consent of the enrollee or applicant;
(3) In the event of a claim or litigation between an enrollee or applicant and the HMO wherein the data or information is pertinent;
(4) To implement the purposes of title 71, chapter 5; or
(5) When the data or information is required to be disclosed by the authority of another statute.
(b) Nothing in this section shall be construed to amend § 63-1-150 regarding confidentiality of records and statements relating to quality improvement committees of the HMO that shall remain privileged and not subject to subpoena or discovery.

§ 56-32-135. Confidential information and documentation

Any information and documentation obtained by the department pursuant to § 56-32-117(c) or § 56-32-132, shall be considered confidential, unless the commissioner in the commissioner's sole discretion determines to disclose the information or documentation.

§ 56-51-150. Confidentiality

(a) Any information pertaining to the diagnosis, treatment, or health of any enrollee of a prepaid limited health service organization is confidential and exempt from § 10-7-503, and shall only be available pursuant to specific written consent of the enrollee, or as otherwise provided by law. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.
(b) Any proprietary financial information contained in contracts entered into with providers by prepaid limited health service organizations is confidential and exempt from § 10-7-503.
(c) Any information obtained or produced by the department pursuant to an examination or investigation is confidential and exempt from § 10-7-503 until the examination report has been filed and adopted by the commissioner or until the time, if ever, the information is used in litigation by the commissioner or in a contested case. Except for active criminal intelligence or criminal investigative information; personal financial and medical information; information that would defame or cause unwarranted damage to the good name or reputation of an individual; information that would impair the safety and financial soundness of the licensee or affiliated party; proprietary financial information; or information that would reveal the identity of a confidential source, all information obtained by the

department pursuant to an examination shall be available after the examination report has been filed.

§ 71-5-142. Proprietary information; confidentiality

(a) All proprietary information, including but not limited to, provider reimbursement information provided either to the Tennessee department of commerce and insurance or to the TennCare bureau, or any successor entity operated by the state of Tennessee for the purpose of administering the TennCare program, or any successor program shall be deemed confidential and not subject to disclosure under the Tennessee Public Records Act, compiled in title 10, chapter 7. Nothing contained in this section shall be construed to conflict with or obviate §§ 56-9-202(b) and 56-9-504(f).
(b) This section shall not apply to disclosures to the medicaid fraud unit of the Tennessee bureau of investigation for law enforcement activities authorized by federal or state law.
(c) Nothing in this section shall be construed to limit access to, or use of, these records by governmental agencies performing official functions.

Legal Citation: TCAs 56-6-404; 56-32-115, 126, 131, 132, 134; 56-51-132, 136,146, 150

§ 56-6-404. Records

(a) Every administrator shall maintain at its principal administrative office, for the duration of the written agreement referred to in § 56-6-402 and five (5) years thereafter, adequate books and records of all transactions between it, insurers and insured persons. The books and records shall be maintained in accordance with prudent standards of insurance record keeping. The commissioner shall have access to the books and records for the purpose of examination, audit and inspection.
(b) Any trade secrets contained in the books and records, including, but not limited to, the identity and addresses of policyholders and certificate holders, shall be confidential, except the commissioner may use the information in any proceedings instituted against the administrator.
(c) The insurer shall retain the right to continuing access to the books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator concerning the proprietary rights of the parties in the books and records.
(d) The commissioner shall collect the proper charges incurred in the examination in accordance with § 56-1-413.

§ 56-32-115. Certificates of authority; assurance of financial viability

(a) The commissioner of commerce and insurance, in cooperation with the commissioner of health, shall coordinate the regulation of any HMO holding a certificate of authority to ensure the financial viability of the HMO and that the HMO is currently providing and shall in the future provide health care services efficiently, effectively and economically. The commissioner of commerce and insurance and the commissioner of health shall develop an interdepartmental agreement to coordinate the functions necessary for the proper administration of this section.
(b) The commissioner of commerce and insurance may make an examination of the affairs of any HMO and any providers with whom the HMO has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. The examinations of HMOs shall occur not less frequently than once every five (5) years. The commissioner of commerce and insurance may also contract, at reasonable fees for work

performed, with qualified, impartial outside sources to perform audits or examinations, or portions of audits or examinations, pertaining to the qualification of an entity for issuance for a certificate of authority to operate as an HMO or to determine the continued compliance of any operating HMO. Any contracted assistance shall be under the direct supervision of the commissioner of commerce and insurance. The results of any contracted assistance shall be subject to the review of, and approval, disapproval, or modification by, the commissioner of commerce and insurance.
(c) The commissioner of health or the commissioner's designee may make an examination concerning an HMO's capability to provide health care services efficiently, effectively and economically, and any providers with whom the HMO has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. The examinations of HMOs shall occur not less frequently than once every three (3) years. The commissioner of health shall report findings to the commissioner of commerce and insurance, who may then suspend or revoke a certificate of authority issued to the HMO as provided in § 56-32-116.
(d) Every HMO shall submit its books and records for the examinations and in every way facilitate the completion of the examinations. For the purpose of examinations, the commissioner of commerce and insurance and the commissioner of health may administer oaths to, and examine, officers and agents of the HMO.
(e) The expenses of examinations of HMOs under this section shall be assessed against the HMO being examined and remitted to the commissioner for whom the examination is being conducted.
(f) In lieu of the examinations, the commissioner of commerce and insurance or the commissioner of health may accept the report of an examination made by the commissioner of insurance or the commissioner of health of another state.

§ 56-32-126. Health maintenance organizations; prompt payment of claims; requirements

(a) HMOs shall be subject to the same requirements regarding prompt payment of claims, and the additional liability for bad faith failure to pay claims promptly, as are applicable to insurance companies under § 56-7-105.
(b) This subsection (b) is intended to ensure the prompt and accurate payment of all provider claims for services delivered to an enrollee in the TennCare program that are submitted to an HMO involved in a TennCare line of business or a subcontractor of that HMO. Accordingly, each such HMO or subcontractor must establish and implement the following procedures for the processing of provider claims and the resolution of any disputes regarding the payment of claims:
(1) The HMO shall ensure that ninety percent (90%) of claims for payment for services delivered to a TennCare enrollee, for which no further written information or substantiation is required in order to make payment, are processed, and, if appropriate, paid within thirty (30) calendar days of the receipt of the claims. The HMO shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine and one half percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program. If a provider agreement requires the HMO to pay a provider a capitated payment each month, the payment shall be made by the time specified in the contract between the provider and the HMO. If the contract between the provider and HMO does not specify a payment schedule, payment shall be made by the tenth day of each calendar month. Disputed capitated provider payments are subject to independent review;
(A) "Pay" means that the HMO shall either send the provider cash or 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 HMO;
(B) "Process" means the HMO must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim has been paid or informing the provider that a claim has been either partially or totally denied and specify all known

reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all the information and documentation;
(2)(A) If a provider's claim is partially or totally denied in a remittance advice or other appropriate written or electronic notice from an HMO, or a provider's previously allowed claim is subsequently partially or totally denied by an HMO by an appropriate written or electronic notice, then the provider may file a written request to the commissioner to submit the claim denial to an independent reviewer as provided in subdivision (b)(3). In the event the provider receives no remittance advice or other appropriate written or electronic notice from an HMO either partially or totally denying a claim within sixty (60) calendar days of the HMO's receipt of the claim, then the provider may file a written request to the commissioner to submit the claim to an independent reviewer as provided in subdivision (b)(3). However, prior to sending this request, the provider must send a written request for reconsideration to the HMO that identifies the claim or claims in dispute, the reasons for the dispute and any documentation supporting the provider's position or request by the HMO. The HMO must respond to the reconsideration request within thirty (30) calendar days after receipt of the request. The response may be a letter acknowledging the receipt of the reconsideration request with an estimated time frame in which the HMO will complete its investigation and provide a complete response to the provider. If the HMO determines that it needs longer than thirty (30) calendar days to completely respond to the provider, the HMO's reconsideration decision shall be issued within sixty (60) calendar days after receipt of the reconsideration request, unless a longer time to completely respond is agreed upon in writing by the provider and the HMO. If the HMO continues to deny the provider's claims or the HMO does not respond to the reconsideration request within the time frames allowed in this subdivision (b)(2)(A), then the provider may file a written request with the commissioner to submit the claims to an independent reviewer as provided in subdivision (b)(3);
(B) The provider must include a copy of the written request for reconsideration with the request for an independent review. If the provider does not have a written contract with the HMO that denied the claim on the date the request is filed with the commissioner, then the provider must also send the commissioner payment satisfactory to the commissioner to cover the fees incurred by the independent reviewer. This payment shall be refunded to the provider if the provider is not ultimately required to pay the independent reviewer. Otherwise, the payment shall be used to reimburse any entity that paid the independent reviewer. The provider shall also furnish the commissioner any other information needed by the commissioner to process the provider's request;
(C) The provider must file a request for independent review within three hundred sixty-five (365) calendar days after the HMO denies the claim for the first time or recoups the claims payment;
(D) Claims payment disputes involved in litigation, arbitration or not associated with a TennCare member are not eligible for independent review;
(3) Each HMO operating a TennCare line of business must contract with independent reviewers selected in accordance with subdivision (b)(4), and implement the following procedures to resolve disputed provider claims:
(A) The commissioner shall use best efforts to refer an equal proportion of the total disputed claims to each independent reviewer. A provider may request, and the commissioner may allow, the claims of a provider involving the same HMO to be aggregated and submitted for simultaneous review by an independent reviewer when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law. The mere fact that a claim is not paid does not create a common substantive question of fact or law, unless the provider has received no remittance advice or other appropriate written or electronic notice from an HMO, either partially or totally denying a claim, within sixty (60) calendar days of the HMO's receipt of the claim and the claims regard a common substantive question of fact or law. The reviewer shall, within fourteen (14) calendar days of receipt of the disputed claim or claims, request in writing that both the provider and the HMO provide the reviewer any and all information and documentation regarding the disputed claim or claims. The reviewer shall request the provider and HMO to identify all information and documentation that has been submitted by the provider to the HMO regarding the disputed claim or

claims, and advise that the reviewer will not consider any information or documentation not received within thirty (30) calendar days of receipt of the reviewer's request unless the HMO or provider requests the independent reviewer for additional time to complete the investigation of independent review requests when a provider elected to aggregate their claims. Thereupon, the reviewer may grant the HMO or provider an additional thirty (30) calendar days. The reviewer shall then examine all materials submitted and render a decision on the dispute within sixty (60) calendar days of the receipt of the disputed claim or claims, unless either the reviewer requests guidance on a medical issue from the TennCare appeals unit, or the reviewer requests and receives an extension of time from the commissioner to resolve the dispute. In reaching a decision, the reviewer shall not consider any information or documentation from the provider that the provider did not submit to the HMO during that organization's review of the provider's disputed claim or claims;
(B) Should the reviewer need assistance on a medical issue connected with the disputed claim or claims, then the reviewer shall refer this specific issue for review and response to the person in charge of the TennCare appeals unit within the TennCare bureau, unless the department in writing designates a different contact. Medical issues requiring referral may include whether a medical benefit is a covered service under the TennCare contract. The TennCare appeals unit may respond to the request, refer the request to an independent contractor, or refer the request to the TennCare bureau for review. A request to determine whether a service received was medically necessary must be responded to by a physician licensed by one (1) or more states in the United States. The appeals unit shall provide a concise response to the request within ninety (90) calendar days after receipt. If the appeals unit seeks the guidance of the TennCare bureau on whether a benefit is a covered service, then the bureau must respond to that request in writing in sufficient time to allow the appeals unit to timely respond to the reviewer. The reviewer shall make a final decision within thirty (30) calendar days of receipt of the appeals unit's response;
(C) The reviewer shall send the HMO, the provider, and the TennCare division of the department of commerce and insurance a copy of the decision. Once the reviewer makes a decision requiring an HMO to pay any claims or portion of the claims, then the HMO must send the payment in full to the provider within twenty (20) calendar days of receipt of the reviewer's decision;
(D) Within sixty (60) calendar days of a reviewer's decision, either party to the dispute may file suit in any court having jurisdiction to review the reviewer's decision and to recover any funds awarded by the reviewer to the other party. Any claim concerning a reviewer's decision not brought within sixty (60) calendar days of the reviewer's decision will be forever barred. Suits filed pursuant to this section will be conducted in accordance with the Tennessee Rules of Civil Procedure, and the review by the court will be *de novo* without regard to the reviewer's decision. The reviewer, or any person assisting the reviewer in reaching a decision, shall be prohibited from testifying at the court proceeding considering the reviewer's decision. Unless the contract between the parties specifies otherwise, venue and jurisdiction will be in accordance with Tennessee law. If the dispute between the parties is not fully resolved prior to the entry of a final decision by the court initially hearing the dispute, then the prevailing party shall be entitled to an award of reasonable attorney's fees and expenses from the nonprevailing party. "Reasonable attorney's fees" means the number of hours reasonably expended on the dispute multiplied by a reasonable hourly rate, and shall not exceed ten percent (10%) of the total monetary amount in dispute or five hundred dollars ($500), whichever amount is greater;
(E) In lieu of requesting independent review, a provider may pursue any appropriate legal or contractual remedy available to the provider to contest the partial or total denial of the claim. For all claims filed on or after October 1, 1999, the state may not mandate that the provider and HMO resolve the claims payment dispute through arbitration;
(F) Providers who are owned by state or local governmental entities shall retain the statutory right of setoff if available. Judicial review of a reviewer's decision regarding a state or local governmental provider shall be in the chancery court of Davidson County, and not in the Tennessee claims commission, unless the provider and HMO have agreed to another appropriate venue and jurisdiction by contract. The Prompt Pay Act, compiled in title 12, chapter 4, part 7, does not impact any claim of sovereign immunity that a state or local governmental provider may possess, although

the provider will be responsible for paying any appropriate attorney's fees and expenses awarded under subdivision (b)(3)(D);
(G) All costs associated with implementing these procedures shall be paid by the applicable HMO. However, the provider shall reimburse the HMO the independent reviewer's fee within twenty (20) calendar days of receipt of the reviewer's decision, if the reviewer finds that the HMO properly denied the claim being reviewed. If a provider fails to properly reimburse the HMO, the TennCare division of the department of commerce and insurance may prohibit that provider from future participation in the independent review process;
(H) The HMO shall compensate the independent reviewer pursuant to their written agreement within thirty (30) calendar days of the HMO's receipt of the independent reviewer's bill for services rendered. If the HMO fails to pay the bill for the independent reviewer's services, then the independent reviewer may request payment directly from the state from any funds held by the state that are payable to the HMO; and
(I) The procedures in subdivisions (b)(3)(A)-(H) shall not apply to any claims filed with the HMO before October 1, 1999, even if that claim is refiled after that date;
(4) The commissioner shall appoint a panel of five (5) persons, known as the selection panel for TennCare reviewers. The panel shall consist of two (2) provider representatives, one (1) representative from each of the two (2) HMOs with the largest number of TennCare enrollees, and the commissioner or the commissioner's duly designated representative. The panel shall select a chairperson, and all decisions of the panel shall be made by a majority vote of the members of the panel. The panel shall select and identify an appropriate number of independent reviewers to be retained by each HMO under subdivision (b)(3). The panel shall negotiate the rate of compensation for each reviewer, and the rate of compensation shall be the same for each reviewer. Each HMO engaged in a TennCare line of business, as a condition of participating in this contract or in the TennCare program, shall contract with each reviewer and agree to pay the rate of compensation negotiated by the panel. The members of the panel shall not be paid. The panel shall meet at least twice a year;
(5) By no later than May 1 of each year, the commissioner shall report to the department of health and to the fiscal review committee the number of requests for TennCare claims review filed for each HMO operating a TennCare line of business during the prior calendar year. The commissioner shall also generally report the outcome of these independent review requests for each HMO. In addition, the commissioner shall report the name of any provider whose claim denial is upheld in more than fifty percent (50%) of the independent review requests, as well as the number of claim reviews with the claims denial upheld;
(6) All claims for services furnished to a TennCare enrollee filed with an HMO must be processed by either the HMO or by a single subcontractor retained by the organization for the purpose of processing claims. However, another single entity can process claims related to each of the following: pharmacy, vision, dental or mental health benefits or durable medical equipment;
(7) The HMO shall ensure all its subcontractors processing TennCare claims follow the same claims processing and resolution procedures required by the Prompt Pay Act, compiled in title 12, chapter 4, part 7. TennCare claims processed by a subcontractor are subject to the prompt payment requirements of this statute. Claims denied by a subcontractor are subject to independent review. If a provider requests independent review of a claim denied by a subcontractor, the HMO contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the HMO the reviewer's fee. If the independent reviewer finds for the provider, the HMO contracted with the subcontractor must pay the provider within twenty (20) calendar days of the reviewer's decision;
(8) An HMO that subcontracts with another entity to obtain services for TennCare enrollees shall guarantee and assure the payment of all contracted amounts agreed to be paid to the providers by that entity or that entity's agent. This does not preclude the HMO from seeking reimbursement from the subcontractor for any amounts paid. Nor does this prevent the HMO from asserting any legal defenses to the payment of a provider's claims that were available to the subcontractor. Claims filed with a subcontractor are subject to the prompt payment requirements of this statute. Claims denied

by a subcontractor are subject to independent review. If a provider requests independent review of a claim denied by a subcontractor, the HMO contracted with that subcontractor must initially pay the independent reviewer's fee. If the independent reviewer upholds the subcontractor's denial, the provider must reimburse the HMO the reviewer's fee. If the independent reviewer finds for the provider, the HMO contracted with the subcontractor must pay the provider within twenty (20) calendar days of the reviewer's decision; and
(9) Any HMO found by the commissioner to be in violation of this subsection (b) shall be subject to revocation or suspension of its certificate of authority under § 56-32-116 or, in the alternative, the imposition of the penalties and other remedies set forth at § 56-32-120.

§ 56-32-131. Health benefits delivery; verification procedure

(a) It is the intent of this section to establish a procedure to verify that the HMOs and behavioral health organizations participating by contract in the TennCare program are delivering the health benefits required under their TennCare contracts with the state. This procedure shall also assure that each of these entities have adequate provider networks to ensure the effective and efficient delivery of health care services to TennCare enrollees.
(b) The commissioner, with the advice and consent of the office of the comptroller of the treasury, shall contract with an entity independent of the state of Tennessee to conduct annual reviews of organizations contracting with the state in the TennCare program. The contract shall be entered into in accordance with appropriate state procedures. The purpose of this contract shall be to verify, on an annual basis, that each HMO and behavioral health organization contracting with the state of Tennessee in the TennCare program is delivering health care services in conformity with the TennCare contract and applicable statutory authority. This annual review shall include verifying that each of these organizations maintains an adequate network. The standards for network adequacy are defined by the TennCare contract and applicable statutes and regulations. Nothing in this subsection (b) precludes the expansion of the state's current contract with its External Quality Review Organization (EQRO) to include having the EQRO conduct this review. The contractor shall submit all findings for each organization in writing to the commissioner, the comptroller of the treasury and the director of the TennCare bureau.
(c) The department of commerce and insurance is authorized to conduct a survey of persons disenrolled by the TennCare program to determine if the persons were able to procure health insurance in the private market, or otherwise had access to healthcare benefits. The survey will not commence until a survey form is developed with the assistance of the TennCare bureau of the department of finance and administration, adopted by the commissioner of commerce and insurance, and approved by the state comptroller of the treasury. The survey will be conducted of persons who were disenrolled during the period from January 1, 2002, to December 31, 2002.

§ 56-32-132. Department of commerce and insurance; examination and investigation

For the purposes of regulation and oversight of HMOs that participate in the TennCare program under Title XIX of the federal Social Security Act (42 U.S.C. § 1396 et seq.), or any successor to the TennCare program, and in addition to the powers and duties set forth in this title, the department of commerce and insurance has the power to examine and investigate the affairs of every person, entity, HMO, an affiliate of the parent of the HMO, or an affiliate of the HMO, in order to determine whether the person, entity, HMO, anaffiliate of the parent of the HMO, or an affiliate of the HMO, is operating in accordance with this chapter and title 71, chapter 5.

§ 56-32-134. Audit and verification

(a) As used in this section, "affiliate" has the same meaning as defined in § 56-32-102.
(b)(1) For verification and audit purposes, each managed care organization that participates in the TennCare program shall provide to the department of commerce and insurance the following information for its organization:
(A) The names and addresses of all persons required to file a disclosure with the commissioner of health under § 71-5-137(a) and (b);
(B) An explanation of the interest in or connection with the managed care organization, or an affiliate of the organization, in accordance with § 71-5-137(a), of each person required to file a disclosure under subdivision (b)(1)(A); and
(C) A listing of all compensation of any form paid to each person required to file a disclosure under subdivision (b)(1)(A) related to the person's interest in or connection with the managed care organization, or an affiliate of the organization, in accordance with § 71-5-137(a).
(2) The information shall be provided on or before January 15 of each year for the preceding calendar year.

§ 56-51-132. Examination by the department

The department shall examine the affairs, transactions, accounts, business records, and assets of any prepaid limited health service organization, in the same manner and subject to the same terms and conditions that apply to health maintenance organizations under § 56-32-115.

§ 56-51-136. Minimum net worth and working capital requirements

(a) Except as set forth in subsection (c), each prepaid limited health service organization must at all times maintain a minimum net worth and working capital as required pursuant to § 56-32-112.
(b) Except as set forth in subsection (c), the department may not issue a certificate of authority unless the prepaid limited health service organization is in compliance with § 56-32-112.
(c) Notwithstanding subsections (a) and (b), the department is authorized to promulgate rules and regulations pursuant to the Uniform Administrative Procedures Act, compiled at title 4, chapter 5 that set forth minimum net worth and working capital requirements for any prepaid limited health service organization that limits the services it offers to services rendered by professionals licensed to practice the healing arts and regulated by a single health related board pursuant to title 63.

§ 56-51-146. Investigative power of department

The department has the power to examine and investigate the affairs of every person, entity, or prepaid limited health service organization in order to determine whether the person, entity, or prepaid limited health service organization is operating in accordance with this chapter, or has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by §§ 56-8-103 and 56-8-104. The department also has the powers enumerated in chapter 8 of this title.

§ 56-51-150. Confidentiality

(a) Any information pertaining to the diagnosis, treatment, or health of any enrollee of a prepaid limited health service organization is confidential and exempt from § 10-7-503, and shall only be available pursuant to specific written consent of the enrollee, or as otherwise provided by law. With respect to any information pertaining to the diagnosis, treatment, or health of any enrollee or applicant, a prepaid limited health service organization is entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the prepaid limited health service organization is entitled to claim.
(b) Any proprietary financial information contained in contracts entered into with providers by prepaid limited health service organizations is confidential and exempt from § 10-7-503.
(c) Any information obtained or produced by the department pursuant to an examination or investigation is confidential and exempt from § 10-7-503 until the examination report has been filed and adopted by the commissioner or until the time, if ever, the information is used in litigation by the commissioner or in a contested case. Except for active criminal intelligence or criminal investigative information; personal financial and medical information; information that would defame or cause unwarranted damage to the good name or reputation of an individual; information that would impair the safety and financial soundness of the licensee or affiliated party; proprietary financial information; or information that would reveal the identity of a confidential source, all information obtained by the department pursuant to an examination shall be available after the examination report has been filed.