STATE OF MISSOURI

# DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

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|---|---|---|
| In re: | ) | |
| | ) | Examination No. 0612-61-TGT |
| HMO Missouri, Inc. f/k/a BlueChoice (NAIC #95358) | ) | |

## ORDER OF THE DIRECTOR

NOW, on this 6th day of November, 2012, Director John M. Huff, after consideration and review of the market conduct examination report of HMO Missouri, Inc. f/k/a BlueChoice (NAIC #95358), (hereafter referred to as "the Company") report numbered 0612-61-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement ("Stipulation"), does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2011), is in the public interest.

IT IS THEREFORE ORDERED that, the Company and the Division of Insurance Market Regulation having agreed to the Stipulation, the Director does hereby approve and agree to the Stipulation.

IT IS FURTHER ORDERED that the Company shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place the Company in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those correctiveactions at all times.

IT IS FURTHER ORDERED that the Company shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $5,000, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 6TH day of NOVEMBER, 2012.

John M. Huff
Director

TO: Office of the President
Anthem Blue Cross Blue Shield
1831 Chestnut St.
St. Louis, MO 63103-2275

RE: Missouri Market Conduct Examination 0612-61-TGT
HMO Missouri, Inc. f/k/a BlueChoice (NAIC #95358)

**STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE**

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and HMO Missouri, Inc. formerly known as BlueChoice, (hereafter referred to as the "Company"), as follows:

WHEREAS, John M. Huff is the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereafter referred to as "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, the Company has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of the Company and prepared report number 0612-61-TGT; and

WHEREAS, the Department determined in its report of the Market Conduct Examination

that:

1. In some instances, the Company improperly denied Pap smear claims, in violation of §§376.1199.1(1) and 376.1250.1(1), RSMo.

2. In some instances, the Company improperly denied mammography claims, in violation of §§376.1199.1(1) and 376.782, RSMo.

3. In some instances, the Company improperly denied PSA claims, in violation of §376.1250.1(2), RSMo.

4. In some instances, the Company failed to pay ambulance / ER and cancer screening claims within 45 days after receipt of the claim and improperly calculated the amount of interest due on the claims, in violation of §§376.383 and 376.384, RSMo.

5. In some instances, the Company failed to have an adequate process in place to monitor whether or not providers that collect copayments from members in excess of 50% of the cost of any single service make the necessary refunds to those members. In such instances, the Company reimbursed the excess copayment to the provider. However, the examiners could not readily ascertain whether the necessary refunds were ever made by the provider to the member, and if so, when they were made and in what amount, thereby violating 20 CSR 100-8.040(2).

6. In some instances, the Company failed to acknowledge claims within 10 working days from the date it received the initial grievance communication from the insured member, in violation of §375.1007(2), RSMo, and 20 CSR 100-1.030(2).

WHEREAS, the Company does not admit any fault or wrongdoing with respect to the factual and legal issues and disputes that were the subject of the examination; and

WHEREAS, the Company and the Department desire to resolve and settle all such issues and disputes;

WHEREAS, the Company hereby agrees to take the following actions to bring it into compliance with the statutes and regulations of Missouri and agrees to maintain those corrective actions at all times:

1. The Company agrees to take corrective action to assure that the alleged errors noted in the above-referenced market conduct examination report do not occur in the future;

2. The Company agrees to make all remedial payments required by this Stipulation of Settlement and Voluntary Forfeiture within 90 days of the entry of a final Order closing this examination, and agrees to file documentation of such payments as well as all remedial actions taken by it to implement compliance with the terms of this Stipulation of Settlement and Voluntary Forfeiture, including explaining the steps taken and the results of such actions, with the Director within 120 days of the entry of a final Order closing this examination, except as noted below;

3. The Company agrees to review and pay all of its denied Pap smear claims denoted as errors within the market conduct examination report, bearing in mind that for electronic claims, an additional payment of one percent (1%) per month from the date 45 days after receipt of the claim to the date of payment will be due in accordance with §376.383.5, RSMo (Supp. 2009); and for paper claims, all interest accrued from the date of claim submission through the date of payment will be due at a rate of nine per cent (9%) per annum pursuant to §408.020, RSMo, on those late payments. A letter should be included with the refund payments indicating that the payments are being made "as a result of a Missouri Market Conduct examination;" and

4. The Company agrees to review and pay all of its denied mammography claims denoted as errors within the market conduct examination report, bearing in mind that for electronic claims, an additional payment of one percent (1%) per month from the date 45 days after receipt of the claim to the date of payment will be due in accordance with §376.383.5, RSMo (Supp. 2009); and for paper claims, all interest accrued from the date of claim submission through the date of payment will be due at a rate of nine per cent (9%) per annum pursuant to §408.020, RSMo, on those late payments. A letter should be included with the refund payments indicating that the payments are being made "as a result of a Missouri Market Conduct examination;" and

5. The Company agrees to review and pay all of its denied PSA claims denoted as errors within the market conduct examination report, bearing in mind that for electronic claims, an additional payment of one percent (1%) per month from the date 45 days after receipt of the claim to the date of payment will be due in accordance with §376.383.5, RSMo (Supp. 2009); and for paper claims, all interest accrued from the date of claim submission through the date of payment will be due at a rate of nine per cent (9%) per annum pursuant to §408.020, RSMo, on those late payments. A letter should be included with the refund payments indicating that the payments are being made "as a result of a Missouri Market Conduct examination;" and

6. The Company agrees to review all of its ambulance/ER and cancer screening claims administered on the Company's Central Region Facets claims system that were received from July 1, 2006, through December 31, 2010, and paid after 45 days from the date of receipt and send interest payments to the claimants with a letter stating that the interest payments are being paid "as a result of a Missouri Market Conduct examination;" and

7. The Company agrees to review all of its claims administered on the Company's Central Region Facets claims system that were received on or after July 1, 2006, and paid prior to November 1, 2012, to identify all instances where the scheduled co-payment charged to a member for a single service exceeded 50% of the total cost of providing that single service. In those instances where the aggregate amount of co-payments in excess of 50% applicable to a member is equal to or exceeds $5.00, the Company will refund the excess amount of the co-payment directly to the member. All such payments will include all interest accrued from the date of the claim through the date of payment at the statutory rate of 9% per annum in accordance with §408.020, RSMo. The Company will include a letter with the co-payment refunds indicating that the payments are being made "as a result of a Missouri Market Conduct examination;" and

8. The Company agrees, on and after November 1, 2012, to make refunds directly to members of any copayments collected in excess of the 50% limitation set forth in 20 CSR 400-7.100 and to maintain sufficient documentation of these refunds to allow audits of the process in future market conduct examinations in compliance with 20 CSR 100-8.040(2). The Company agrees to submit a written report outlining the details of this auditable process for making refunds within 90 days after the Director enters a final Order closing this examination.

WHEREAS, the Company is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, the Company, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, which may have otherwise applied to the above referenced Market Conduct Examination; and

WHEREAS, the Company hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0612-61-TGT and further agrees, voluntarily and knowingly, to surrender and forfeit the sum of $5,000.

NOW, THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of the Company to transact the business of insurance in the State of Missouri or the imposition of other sanctions, the Company does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of $5,000, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 10/29/12

President
Anthem Blue Cross Blue Shield
HMO Missouri, Inc. f/k/a BlueChoice

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April 27, 2010

**CONFIDENTIAL - TRADE SECRET**
**NON-PUBLIC RECORD**

Carolyn H. Kerr
Senior Counsel, Market Conduct Section
Department of Insurance
Financial Institutions and Professional Registration
301 West High Street, Room 530
P.O. Box 690
Jefferson City, MO 65102-0690

**Re: Response to Report on Missouri Market Conduct Examination #0612-61-TGT HMO Missouri, Inc. d/b/a BlueChoice (NAIC #95358)**

Dear Ms. Kerr:

This letter is in response to the report on Missouri Market Conduct Examination #0612-61-TGT for HMO Missouri, Inc., d/b/a BlueChoice (company). Below are our responses to the errors and violations identified in the report.

1. *The Company wrongfully denied 16 Pap-smear claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding pelvic and Pap-smear examinations. Said denial reasons are in violation of Section 376.1250.1(1), RSMo.*(Note: Item identified as #1 on the Executive Summary and A.1. in the Claims Practices section.)
   a. Disagree.

   This criticism assessed that we denied claims for not paying for pelvic examination and PAP smear for any nonsymptomatic woman covered under such policy or contract. Based upon our review we respectfully disagree with such finding.

   Under the policy, it states that services must be provided by a network provider. The benefits also state that the services must be provided for routine care. However, the treatment of obesity is an exclusion. In Attachment A, we have included a copy of our certificates that state these benefits. We have found that these claims were denied for either an out of network provider or for an excluded diagnosis. Attachment B contains a spreadsheet listing the explanation for each of the claims in question.

   Even assuming the Draft Report is correct and these claims were denied incorrectly, as stated in the Draft Report, this sample had an Error Ratio of 2.96%, which by the Department's own standards, does not constitute a business practice. As this Error Ratio is below the NAIC Benchmark of 7%,

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the Company believes that these files are an anomaly and, the Company respectfully requests that this finding be removed from the final report and not be reference in the order.

2. *The company wrongfully denied 29 mammogram claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding mammogram coverage. Said denial reasons are in violation of Section 376.782, RSMo.* (Note: Item identified as #2 on the Executive Summary and A.3. in the Claims Practices section. There is no "A.2." identified on the report.)
   a. Disagree.

   The claims have been denied due to services being provided by a non-network provider. Under the policy, services must be provided by a network provider. If the service is not provided by a network provider, the claim will reject either for non referral from PCP or routine care by provider not covered, again since the provider was not a network provider. Attachment C contains copies of the HMO certificates stating these benefits.

   Even assuming the Draft Report is correct and these claims were denied incorrectly, as stated in the Draft Report, this sample had an Error Ratio of 3.20%, which by the Department's own standards, does not constitute a business practice. As this Error Ratio is below the NAIC Benchmark of 7%, the Company believes that these files are an anomaly and, the Company respectfully requests that this finding be removed from the final report and not be reference in the order.

3. *The company wrongfully denied 16 PSA claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding prostate examinations and laboratory tests for cancer on any non-symptomatic male. Said denial reasons are in violation of Section 176.1250.1(2), RSMo.* (Note: Item identified as #3 on the Executive Summary and A.4. in the Claims Practices section.)
   a. Disagree.

   This criticism assessed that we denied claims for not paying for a prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under such policy or contract.

   The claims have been denied correctly based on the group contract. Under the policy, it states that services must be provided by a network provider. The benefits also state that the services must be provided for routine care. However, the treatment of sexual dysfunction care is an exclusion. Attachment D contains a copy of our group contract that states these benefits. We have found that these claims were denied for either an out of network provider or for an excluded diagnosis. Attachment E contains a spreadsheet listing the explanation for each of the claims in question.

   Even assuming the Draft Report is correct and these claims were denied incorrectly, as stated in the Draft Report, this sample had an Error Ratio of 4.53%, which by the Department's own standards, does not constitute a business practice. As this Error Ratio is below the NAIC Benchmark of 7%, the Company believes that these files are an anomaly and, the Company respectfully requests that this finding be removed from the final report and not be reference in the order.

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4. *The Company failed to pay four claim files in a timely manner. The failure to pay within 45 calendar days of the claim receipt date violates Sections 376.383.2, and 376.383.5, RSMo.* (Note: Item identified as #4 on the Executive Summary and A.5--A.6. in the Claims Practices section.)

   a. Disagree.

   Claim No: 042112636601: Our records indicate that on July 29, 2004 our company received a claim for $66.44. We denied the claim on August 04, 2004. On February 2, 2005, we adjusted the claim and paid $37.00. We do not believe interest was due on the claim because the claim was adjusted within 45 days from the date the exception was made. When HMO Missouri, INC, receives information that impacts a claim that was previously processed correctly, it is treated like a new claim. See Attachment F for further documentation.

   Claim No: 052151696800: This finding asserts that $16.75 interest is owed on an additional payment of $335.00 made on 2/15/06 related to a claim received on 8/3/05 for which the Company denied the claim for no referral submitted on 8/17/05. The referral was submitted on 10/24/05 and additional payment was made on 2/15/06.

   - Based on the prompt pay regulations, we paid interest in the amount of $7.60. Under the prompt pay statute in this case, we originally processed the claim correctly, within the appropriate time frames. Subsequent to that correct processing new information was received on 10/25/05. With the new information this is now treated as a new claim and we processed the claim in 114 days therefore interest was due for a total of 69 days.
   - See Attachment G_1 and G_2 for further documentation.

   Claim No: 051373737901: This claim was received on May 17, 2005 and $18,153.93 was paid on May 25, 2005. On August 24, 2005, we adjusted the claims and paid an additional $514.00 that was approved for another day of care. $1.35 (check #321577) in interest was paid on 10/13/05. No additional interest is due on this claim. See Attachment H for further documentation.

   Claim No: 050532258601: Our records indicate that on February 22, 2005 our company received a claim for $1423.45; we denied the claim on March 16, 2005 for no referral. On April 20, 2005, a referral was received and the claim was adjusted and paid on April 20, 2005. We do not believe interest was due on the claim because the claim was adjusted within 45 days from the receipt of new information.

   - Based on the prompt pay regulations, interest is not owed on the additional payment. Under the prompt pay statute in this case, we originally processed the claim correctly, within the appropriate time frames. Subsequent to that correct processing new information was received; this new information is then treated like a new claim, which was then processed within appropriate time frames. Accordingly, we have discharged our obligation under the prompt pay statute and interest would not apply to the additional payment. We have previously forward our 2005 procedure on how interest is determined.
   - We received an Order to Cure the violations from the Department of Insurance that some of the claims adjusted did not follow the regulation. A business decision was made to pay interest on all claims adjusted from January 1, 2002 – April 20, 2005.
   - See Attachment I for further documentation.

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Even assuming the Draft Report is correct and these claims were denied incorrectly, as stated in the Draft Report, these two samples had an Error Ratio of .28% for the Ambulance/Emergency Room Claims and .79% for the Cancer Claims, which by the Department's own standards, does not constitute a business practice. As this Error Ratio is below the NAIC Benchmark of 7%, the Company believes that these files are an anomaly and, the Company respectfully requests that this finding be removed from the final report and not be reference in the order.

5. *The Company's claim handling procedures and records do not allow the examiners to readily ascertain and adequately determine if, when, how, and in what amounts its agents, the participating providers, are refunding to the enrollees on amounts which were paid in excess of the percentages allowed by 20 CSR 400-7.100.* (Note: Item identified as #5 on the Executive Summary and Section B under General Handling Practices.)
   a. Disagree

   This criticism assessed that we do not maintain any "auditable" procedure to assure that providers are actually refunding excess copayment charges back to members.

   The Company believes the process as described below complies with the requirements of 20 CSR 400-7.100. Nothing in this regulation requires Health Plans to maintain an "auditable" procedure as implied in the draft report. As noted in the responses provided in March and November of 2008 to the request for a description of how refunds of co-payment amounts that exceed 50% of the total cost of providing any single service to an enrollee are to be addressed, the network manual (which has also been available to providers and others on the company's website) provides detailed information on collection of co-payments from HMO members and how the 50% co-payment rule is applied to claims submitted for HMO members. The manual also instructs providers regarding refunding the appropriate amount to members when the provider has collected a co-payment that exceeds 50% of the total cost of providing any single service to an enrollee. For your convenience, we have provided below certain information from the network operations manual:

   50% CoPay Rule
   An HMO member's copay cannot be more than 50% of the cost of services.
   When you submit a claim to BlueCHOICE, we determine if 50 percent of the allowed amount for the service(s) provided is less than the copay amount. If so, we adjust the member's copay to be 50 percent of the allowed amount for the service(s).We then pay you up to the remaining allowed amount.

   Your Remittance Advice will indicate if an adjustment was made to the member's copay due to the copayment normally charged to the member being more than 50 percent of the allowed amount for the service(s) provided. If we adjust the copay, you owe the member the difference between the normally charged copay amount and the adjusted copay amount.

   50% CoPay Rule Example
   A member receives care at the office of Dr. Smith, a specialist. The office calculates the billed charge for this service as $20, accepts the member's $15 specialist copay as indicated on the ID card, and submits billed charged to BlueCHOICE. Upon adjudication, BlueCHOICE determines the allowed amount for this service to be $18. Since 50 percent of the allowed

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amount ($18) is $9 and is less than the copay ($15), BlueCHOICE will adjust the member's copay to be $9, and will reimburse Dr. Smith up to the remaining allowed amount ($9). Dr. Smith owes the member a refund of $6 ($15 minus $9 equals $6).

Additionally, the Explanation of Benefits (EOB) and remittance advice serve as a monitoring mechanism for both the provider and member to identify if the provider has collected a copayment in excess of the 50% limit. The provider remittance highlights the copayment due from the member for the services. When the provider reviews the remittance information for a specific claim and prepares to post the related claim, they are prompted to follow the procedures in the network operations manual if excess copayment has been collected. The member's EOB for a claim also highlights the copayment that was due for a particular service. As such, if the provider collected a copayment in excess of the amount indicated on the claim, the provider and member would be aware that a refund is due to the member from the provider who collected the copayment.

To further clarify why we do not directly refund excess copayments back to our members, providers deal personally with the member at the time of service and the providers are obligated to comply with the 50% rule as discussed above. Because only the providers deal with the member at that point, the company cannot and does not know whether the provider actually received a copayment from the member or what copayment amount, if any, was received by the provider at that time. As such, the provider must make the determination as to any refund amount, if any, based on the copayment knowledge that is known only to the provider. In addition, the company likewise cannot know who, if anyone, paid the copayment amount at that time. For example, a copayment might be paid by a divorced father pursuant to a court order rather than the member. Likewise, a dependent might pay a copayment rather than a subscriber. Only the provider could know whether, and to whom, any refund might be owed.

We therefore believe this process as described complies with the requirements of 20 CSR 400-7.100. The Company respectfully requests that this finding be removed from the final report and not be referenced in the order.

6. *Five complaints involving claims were not acknowledged by the Company within 10 working days of the date from receiving the initial grievance communication from the insured member. Reference: Section 375.1007 (2), RSMo, and 20 CSR 100-1.030(2)* (Note: This item was not referenced in the Executive Summary and was identified in Section III under Complaints.)
   a. Disagree

   The Company acknowledges that the files suggest that the grievances were not acknowledged timely. It is often difficult to route grievances to the correct unit immediately because of variances in the way they are received. Even though instructions on the correct method for filing grievances are clear in member and provider communications, correspondence is often received at a wrong address, and/or it is not clearly marked as a grievance on the envelope, which delays receipt in the correct department. Because of that, the Company does not believe that any perceived deficiency should be considered a general business practice.

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The Company also notes that it has taken steps to improve both the initial identification of correspondence as grievances and in processing those grievances in a timely manner, once they are identified. We continuously work with our mailroom vendor to identify issues such as these, and to put corrective actions in place to improve the service level of quality.

The Company believes that these files are an anomaly and, the Company respectfully requests that this finding be removed from the final report and not be referenced in the order.

The Company offers our sincere gratitude to the Department and to the professionalism extended to us throughout the course of the examination. Open communication was evident at all times between the examiners and the Company making the examination run smoothly and efficiently.

We appreciate the opportunity to respond to the findings in the examiners report. Please review our responses and let us know if you have any further comments or questions regarding the information we have provided.

Sincerely,

Elizabeth A. Cox
Compliance Director, Anthem BCBS

cc: Dennis Matheis, President and GM, Anthem BCBS, Missouri
Joseph P. Murray, Senior Managing Counsel
David A. Smith, Government Affairs Director, Anthem BCBS
Amy Philipps, Project Director

Attachments:

A: Non-group Membership Certificate

HMO
Exam_Attachment A

B: Spreadsheet for 16 Pap-smear claims

HMO
Exam_Attachment B.

C: Non-group Membership Certificate

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HMO
Exam_Attachment C

D: Group Contract

HMO
Exam_Attachment D

E: Spreadsheet for 16 PSA Claims

HMO
Exam_Attachment E.

F: Prompt Pay Documentation

HMO
Exam_Attachment F.

G: Prompt Pay Documentation

\HMO Exam_Attach G_1.doc

HMO Exam_Attach G_2 .pdf

H: Prompt Pay Documentation

HMO
Exam_Attachment H.

I: Prompt Pay Documentation

HMO
Exam_Attachment I.

# STATE OF MISSOURI
# DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

FINAL MARKET CONDUCT EXAMINATION REPORT
**Of the Health Business of**

**HMO MISSOURI, INC. d/b/a BlueChoice**
**NAIC # 95358**

MISSOURI EXAMINATION # 0612-61-TGT

**NAIC EXAM TRACKING SYSTEM # MO 268-M25**

October 30, 2012

**Home Office**
**1831 Chestnut**
**St. Louis, MO 63103-2275**

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## FOREWORD

This is a targeted market conduct examination report of HMO Missouri, Inc. d/b/a Blue Choice, (NAIC Code # 95358). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the Department of Insurance, Financial Institutions and Professional Registration (DIFP).

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:
"Company" or "HMO MO;" refers to HMO Missouri, Inc. d/b/a BlueChoice;
"CSR" refers to Code of State Regulations;
"Department" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
"NAIC" refers to the National Association of Insurance Commissioners; and
"RSMo" refers to the Revised Statutes of Missouri.

## SCOPE OF THE EXAMINATION

The authority of the Department to perform this examination includes, but is not limited to, §§ 354.190, 374.110, 374.190, 374.205, 375.445, 375.938, 375.1009, and 376.384, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statues, DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2003, through December 31, 2005, unless otherwise noted. However, errors discovered outside of this time period may also be included in the report.

This examination was a targeted examination involving the following business functions and lines of business:

- Claims – Denied Cancer
- Claims – Denied Child Immunization
- Claims – Denied Emergency/Ambulance
- Claims – Denied Mammograms
- Claims – Denied Pap (Papanicolaou Test)
- Claims – Denied PSA (Prostrate-Specific Antigen)
- Complaints, Grievances and Appeals

This examination was conducted in accordance with the standards established in the NAIC *Market Regulation Handbook.* As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews. The NAIC benchmark error rate for claims practices is seven percent (7%), five percent (5%) for prompt pay reviews of health claims and ten percent (10%) for all other trade practices. Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

In performing this examination, the examiners only reviewed a sample of the Company's practices, procedures, products and files. Therefore, some noncompliant practices, procedures, products and files may not have been discovered. As such, this report may not fully reflect all of the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

## EXECUTIVE SUMMARY

The Department conducted a targeted market conduct examination of HMO Missouri Inc. d/b/a Blue Choice. The contents of the examination report reflect the errors and violations that the examiners discovered during their review of the Company's records. The principal issues of concern found in this examination are as follows:

1. The Company wrongfully denied 16 Pap-smear claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding pelvic and Pap-smear examinations. Said denial reasons are in violation of §§375.1007(12), 376.1199.1(1) and 376.1250.1(1), RSMo.

2. The Company wrongfully denied 27 mammogram claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding mammogram coverage. Said denial reasons are in violation of §§375.1007(12), 376.1199.1(1) and 376.782, RSMo.

3. The Company wrongfully denied 13 PSA claims. The denial reasons used by HMO MO on these claims were not suitable exceptions to the Missouri mandate regarding prostate examinations and laboratory tests for cancer on any non-symptomatic male. Said denial reasons are in violation of §§ 375.1007(12) and 376.1250.1(2), RSMo.

4. The Company failed to pay three claim files in a timely manner. The failure to pay interest on claims when the claims are not paid within 45 calendar days of the claim receipt date violates § 376.383.5, RSMo.

5. The Company's claim handling procedures and records do not allow the examiners to readily ascertain and adequately determine if, when, how, and in what amounts its agents, the participating providers, are refunding to the enrollees on amounts which were paid in excess of the percentages allowed by 20 CSR 400-7.100, in violation of § 374.205 and 20 CSR 300.2.200 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08].

## EXAMINATION FINDINGS

## I. COMPANY AUTHORIZATION

Missouri law determines which companies may sell insurance and the lines of insurance these companies may sell by requiring that each obtain the appropriate authority to transact the business of insurance. To protect the consumer, Missouri enacted laws and regulations to ensure that companies provide fair and equal treatment in its business dealings with Missouri citizens. An insurance company receives a Certificate of Authority that allows it to operate within the state only after it complies with certain application requirements regulated by the Department.

HMO Missouri, Inc. d/b/a BlueChoice, a Missouri corporation, has current authority to transact business in Missouri as a HMO carrier identified under §§ 354.400-354.636, RSMo.

## II. CLAIMS PRACTICES

This section of the report is designed to provide a review of the Company's claims handling practices. Examiners reviewed how the Company handled claims to determine the accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners restricted the claim review process to only those claims denied by the Company. The review consisted of Missouri claims denied by the Company with a closing date of from January 2004 through December 2005.

A claim file is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g; §§ 375.1000 – 375.1018, and 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%) and five percent (5%) for electronically submitted health claims per §376.384.3,

RSMo. Error rates in excess of the NAIC or statutory benchmark error rates are presumed to indicate a general business practice contrary to the law.

Errors indicating a failure to comply with laws that do not apply to the general business practice standard are separately noted as errors and are not included in the error rates.

For purposes of this targeted report, a claim error will include, but not be limited to, any of the following:

- An unreasonable or wrongful denial of a claim.
- A failure to calculate claim benefits correctly.
- A failure to comply with Missouri law regarding claim settlement practices.

Missouri statutes require the Company to disclose to first-party claimants all pertinent benefits, coverage or other provisions of an insurance policy under which a claim is presented. Claim denials must be given to the claimant in writing, and the Company must maintain a copy in its claim files.

## A. Unfair Settlement of Claims

The examiners reviewed the Company's claim handling processes to determine compliance with contract provisions and adherence to unfair claims statutes and regulations. Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited the Company for noncompliance.

The results of this review are as follows:

1. Denied Pap-Smear Claims

| | |
|---|---|
| Field Size: | 540 |
| Sample Size: | 540 |
| Type of Sample: | Census |
| Number of Errors: | 16 |
| Error Ratio: | 2.96% |

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following 16 pap-smear claims. The denial reasons given to the examination staff were not suitable exceptions to the Missouri mandate regarding pelvic and pap-smear examination coverage. Furthermore, the Company failed to provide a reasonable and accurate explanation of the basis or reasons for its denials.

Reference: §§ 375.1007(12), 376.1199.1(1) and 376.1250.1(1), RSMo.

| Claim Number | Date Claim Incurred | Company Denial Reason |
|---|---|---|
| 050060077800 | 12/22/2004 | Non-referral from primary care physician. |
| 050660131100 | 02/24/2005 | Non-referral from primary care physician. |
| 051020375800 | 02/01/2005 | Non-referral from primary care physician. |
| 051095436400 | 04/07/2005 | Non-referral from primary care physician. |
| 050600328001 | 02/11/2005 | Non-referral from primary care physician. |
| 051222875400 | 04/29/2005 | Non-referral from primary care physician. |
| 051390358300 | 05/09/2005 | Non-referral from primary care physician. |
| 051443614100 | 04/29/2005 | Non-referral from primary care physician. |
| 051600645200 | 05/25/2005 | Non-referral from primary care physician. |
| 052200367500 | 07/22/2005 | Care for obesity not covered. |
| 052240583700 | 07/18/2005 | Non-referral from primary care physician. |
| 052300680800 | 08/04/2005 | Non-referral from primary care physician. |
| 052310600500 | 08/05/2005 | Non-referral from primary care physician. |
| 052580475500 | 08/31/2005 | Non-referral from primary care physician. |
| 052583583000 | 09/14/2005 | Non-referral from primary care physician. |
| 052700755200 | 09/12/2005 | Non-referral from primary care physician. |

2. Denied Mammogram Claims

| | |
|---|---|
| Field Size: | 905 |
| Sample Size: | 905 |
| Type of Sample: | Census |
| Number of Errors: | 27 |
| Error Ratio: | 2.98 % |

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following 29 mammogram claims. The denial reasons given to the examination staff were not suitable exceptions to the Missouri mandate regarding mammogram coverage. Furthermore, the Company failed to provide a reasonable and accurate explanation of the basis or reasons for its denials.

Reference: §§ 375.1007(12), 376.1199.1(1) and 376.782, RSMo.

| Claim Number | Date Claim Incurred | Company Denial Reason |
|---|---|---|
| 43490548000 | 12/01/2004 | Non-referral from primary care physician. |
| 43622617400 | 12/13/2004 | Non-referral from primary care physician. |
| 50560627700 | 02/15/2005 | Non-referral from primary care physician. |
| 50565569800 | 02/17/2005 | Non-referral from primary care physician. |
| 51184593700 | 04/18/2005 | Non-referral from primary care physician. |
| 51950433600 | 07/01/2005 | Non-referral from primary care physician. |
| 52410104500 | 08/17/2005 | Non-referral from primary care physician. |
| 52580403600 | 08/29/2005 | Non-referral from primary care physician. |
| 52972776100 | 10/10/2005 | Non-referral from primary care physician. |
| 51612949700 | 06/03/2005 | Non-referral from primary care physician. |
| 51573299600 | 05/17/2005 | Non-referral from primary care physician. |
| 52492225200 | 08/17/2005 | Routine care by provider not covered. |
| 52973573000 | 10/10/2005 | Routine care by provider not covered. |
| 52762243900 | 09/24/2005 | Routine care by provider not covered. |
| 52693723100 | 09/01/2005 | Routine care by provider not covered. |

| Claim Number | Date Claim Incurred | Company Denial Reason |
|---|---|---|
| 52633240600 | 09/12/2005 | Routine care by provider not covered. |
| 52503886100 | 08/25/2005 | Routine care by provider not covered. |
| 52384070600 | 08/10/2005 | Routine care by provider not covered. |
| 51543655200 | 05/17/2005 | Routine care by provider not covered. |
| 51164174000 | 04/18/2005 | Routine care by provider not covered. |
| 50780660600 | 01/04/2005 | Routine care by provider not covered. |
| 50544242900 | 02/15/2005 | Routine care by provider not covered. |
| 50341728700 | 01/27/2005 | Routine care by provider not covered. |
| 50322434400 | 01/24/2005 | Routine care by provider not covered. |
| 50135622500 | 12/13/2004 | Routine care by provider not covered. |
| 50043427000 | 11/17/2004 | Routine care by provider not covered. |
| 53074301800 | 10/25/2005 | Failure to obtain preauthorization. |

3. Denied PSA (Prostate-Specific Antigen) Claims

| | |
|---|---|
| Field Size: | 353 |
| Sample Size: | 353 |
| Type of Sample: | Census |
| Number of Errors: | 13 |
| Error Ratio: | 3.7% |

The following errors were cited in this review:

Claim documentation indicates that the Company wrongfully denied the following 13 PSA claims. The denial reasons given to the examination staff were not suitable exceptions to the Missouri mandate regarding prostate examinations and laboratory tests for cancer on any non-symptomatic covered male. Furthermore, the Company failed to provide a reasonable and accurate explanation of the basis or reasons for its denials.

Reference: §§ 375.1007(12) and 376.1250.1(2), RSMo.

| Claim Number | Date Claim Incurred | Company Denial Reason |
|---|---|---|
| 051590423600 | 05/26/2005 | Non-referral from primary care physician. |
| 051167008701 | 04/19/2005 | Not a covered service. |
| 051790566700 | 06/20/2005 | Non-referral from primary care physician. |
| 051870553200 | 06/28/2005 | Non-referral from primary care physician. |
| 052083138600 | 07/20/2005 | Non-referral from primary care physician. |
| 052100472800 | 07/19/2005 | Non-referral from primary care physician. |
| 052272732100 | 08/09/2005 | Non-referral from primary care physician. |
| 052373338600 | 08/12/2005 | Not a covered service. |
| 052760499100 | 09/16/2005 | Not a covered service. |
| 052914142100 | 01/05/2005 | Not a covered service. |
| 052914148900 | 10/05/2005 | Not a covered service. |
| 053013151600 | 10/19/2005 | Non-referral from primary care physician. |
| 053210600200 | 11/10/2005 | Non-referral from primary care physician. |

4. Ambulance/Emergency Room Claims Not Paid Within 45 Days

| | |
|---|---|
| Field Size: | 360 |
| Sample Size: | 360 |
| Type of Sample: | Census |
| Number of Errors: | 1 |
| Error Ratio: | .28% |

The following error was cited in this review:

Claim item 042112636601 was not paid within 45 calendar days of the date the claim was received. The failure in not making a timely payment resulted in the Company owing an additional $2.39 of interest on this claim that was received by BlueChoice on 07/29/04 and not paid until 02/02/05. (Interest owed = the claim benefit amount of $37.00 x .046 = $1.70)

Reference: § 376.383.5, RSMo.

5. Cancer Claims Not Paid Within 45 Days

| | |
|---|---|
| Field Size: | 379 |
| Sample Size: | 379 |
| Type of Sample: | Census |
| Number of Errors: | 3 |
| Error Ratio: | .79% |

The following errors were cited in this review:

(a) Claim item 052151696800 was not paid within 45 calendar days of the date the claim was received. The failure in not making a timely payment resulted in the Company owing an additional $16.75 of interest on this claim that was received by BlueChoice on 08/03/05 and not paid until 02/15/06. (Interest owed = the claim benefit amount of $335.00 x .049 = $16.42)

Reference: § 376.383.5, RSMo.

(b) Claim item 051373737901 was not paid within 45 calendar days of the date the claim was received. The failure in not making a timely payment resulted in the Company owing an additional $7.80 of interest on this claim that was received by BlueChoice on 05/17/05 and not paid until 08/24/05. (Interest owed = the claim benefit amount of $514.00 x .01733 - $1.35 of interest paid by the Company = $7.56)

Reference: § 376.383.5, RSMo.

(c) Claim item 050532258601 was not paid within 45 calendar days of the date the claim was received. The failure in not making a timely payment resulted in the Company owing an additional $55.66 of interest on this claim that was received by BlueChoice on 02/22/05 and not paid until 04/20/05. (Interest owed = the claim benefit amount of $1,423.45 x .004333 = $6.17)

Reference: § 376.383.5, RSMo.

## B. General Handling Practices

Apart from the review of determining those claims that were improperly denied, reduced or delayed by the Company, the examination staff reviewed the carrier's procedures for maintaining proper control over the usage of Coordination of Benefits (COB), deductible and coinsurance provisions.
The results of this review are as follows:

The examination team discovered that HMO MO does not maintain any auditable procedure to assure that excess copayment charges (amounts in excess of 50%) are actually being refunded back to insured members. The examiners found that the Company's claim files lacked any documentation that would verify any monitoring by HMO MO to make certain that medical providers were reimbursing members for any excessive co-payments collected.

The Company provided the following explanation when asked by the examiners how it dealt with the excess copayment issue: "Providers participating in our HMO network have access to the Company's website www.bcbsmo.com; where the network operations manual can be found. This manual provides detailed information on collecting co-payments from HMO members and how the 50% co-payment rule is applied to claims submitted for HMO members. The member's co-payment section of the manual also instructs the provider to refund members when the office has collected a co-payment in an amount greater than 50% of the allowed amount for the service(s) billed."

HMO's are responsible for complying with provisions 20 CSR 400-7.100, dealing with co-payments to be paid by its enrollees for the cost of health care services. HMO Missouri has made its participating providers agents for handling these co-payments and making sure that the enrollees do not pay co-payments that are in excess of the percentages set forth in that regulation. The Company's claim handling procedures and records do not allow the examiners to readily ascertain and adequately determine if,

when, how, and in what amounts its agents, the participating providers, are refunding to the enrollees on amounts which were paid in excess of the percentages allowed by 20 CSR 400-7.100.

Reference: § 374.205, RSMo, and 20 CSR 300-2.200(2) [as replaced by, 20 CSR 100-8.040(2), eff. 07/30/08].

## III. COMPLAINTS

This section of the report is designed to provide a review of the Company's complaint handling practices. Examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

Section 375.936(3), RSMo, requires companies to maintain a registry of all written complaints received for the last three years. The registry must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company.

The examiners verified the Company's complaint registry, dated January 1, 2003, through December 31, 2005. The registry contained a total of 223 complaints. They reviewed all 79 complaints that went through DIFP and all 144 complaints that did not come through the Department, but went directly to the Company.

The review consisted of an evaluation of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint as required by § 375.936(3), RSMo, and 20 CSR 300-2.200(3)(D) (as replaced by 20 CSR 100-8.040, effective 7/30/08).

The examiners noted the following exceptions during their review:

The following five complaints involving claims were not acknowledged by the Company within 10 working days of the date from receiving the initial grievance communication from the insured member.

Reference: § 375.1007 (2), RSMo, and 20 CSR 100-1.030(2)

| Claim Number | Notification Date | Acknowledgement Date | Number of Working Days |
|---|---|---|---|
| 0202941194 | 06/03/2005 | 07/14/2005 | 28 |
| 0203028735 | 06/24/2005 | 08/18/2005 | 38 |
| 0510083350 | 03/10/2005 | 04/01/2005 | 16 |
| 0202123852 | 12/13/2004 | 01/27/2005 | 31 |
| 0202786584 | 05/09/2005 | 06/24/2005 | 33 |

## IV. CRITICISM AND FORMAL REQUEST TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri law requires companies to respond to criticisms and formal requests within 10 calendar days. Please note that in the event an extension was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examination team. If the response was not received within that time period, the response was not considered timely.

The amount of time taken by the Company to respond is noted below.

### A. Criticism Time Study

| Calendar Days | Number of Criticisms | Percentage |
|---|---|---|
| Received within time limit, including any extensions. | 7 | 100.0% |
| Received outside time-limit, including any extensions. | 0 | 0% |
| No Response: | 0 | 0% |
| Total: | 7 | 100% |

In this review, the Company responded to all criticisms within a timely manner.

Reference: § 374.205.2(2), RSMo, and 20 CSR 100-8.040

### B. Formal Request Time Study

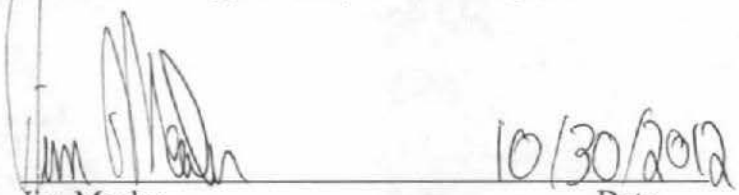
| Calendar Days | Number of Criticisms | Percentage |
|---|---|---|
| Received within time limit, including any extensions. | 10 | 100.0% |
| Received outside time-limit, including any extensions. | 0 | 0% |
| No Response: | 0 | 0% |
| Total: | 10 | 100% |

In this review, the Company responded to all formal requests within a timely manner.

Reference: § 374.205.2(2), RSMo, and 20 CSR 100-8.040

## EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of HMO Missouri, Inc. d/b/a BlueChoice (NAIC #95358), Examination Number 0612-61-TGT. This examination was conducted by David Pierce, John Clubb, and Jack Baldwin. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated March 17, 2010. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.



Jim Mealer — Date
Chief Market Conduct Examiner