STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

In re:	)	
	)	Examination No. 0207-02-LAH
Conseco Medical Insurance Company (NAIC #93769)	)	

ORDER OF THE DIRECTOR

NOW, on this 25th day of August, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of Conseco Medical Insurance Company (NAIC #93769), (hereafter referred to as "Conseco Medical") report numbered 0207-02-LAH, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("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. 2006), is in the public interest.

IT IS THEREFORE ORDERED that Conseco Medical and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

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

IT IS FURTHER ORDERED that Conseco Medical shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $75,018.25, 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 25th day of August, 2009.

John M. Huff
Director

STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

TO: Conseco Services, L.L.C.
Office of the President
11815 N. Pennsylvania Street
Carmel, IN 46032

RE: Missouri Market Conduct Examination #0207-02-LAH
Conseco Medical Insurance Company

STIPULATION OF SETTLEMENT
VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, hereinafter referred to as "Director," and Conseco Medical Health Insurance Company, hereinafter referred to as "Conseco Medical," or "the Company" as follows:

WHEREAS, John M. Huff is the Director of the Department of Insurance, Financial Institutions and Professional Registration, 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, Conseco Medical has been granted a certificate(s) of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Director conducted a Market Conduct Examination of Conseco Medical for the general time period of January 1, 2001, through December 31, 2001, and prepared report number 0207-02-LAH; and

WHEREAS, the report of the Market Conduct Examination has revealed that:

1. Conseco Medical was cited for conducting business with an entity that was not licensed as a third party administrator in Missouri, thereby violating §§376.1084, 376.1092, RSMo and 20 CSR 200-9.600.

2. In some instances, Conseco Medical was cited for using marketing brochures that contained incorrect and misleading information by failing to properly and fully disclose all of the benefits of coverage, thereby violating §§376.1215 and 376.1250, RSMo, and 20 CSR 400-5.700(4) and (5).

3. In some instances, Conseco Medical improperly rescinded or denied policies and claims, in violation of §§376.580 and 376.800, RSMo.

4. In some instances, Conseco Medical improperly cancelled its small group health plans and restricted the affected groups' choice of other coverage by failing to give the affected groups the proper notice of its intent to cancel and by failing to make the new plans guaranteed renewable since Conseco Medical did not non-renew all of its health plans offered in Missouri, thereby violating §§379.938, 379.940, and 379.942, RSMo.

5. Conseco Medical was cited for failing to give the Department the proper notice of its intent to cancel its small group health plans, in violation of §379.938, RSMo.

6. In some instances, Conseco Medical failed to maintain adequate documentation in its Small Employer Group policy files for the examiners to be able to ascertain the reason(s) for policy termination, in violation of 20 CSR 300-2.200(2).

7. In some instances, Conseco Medical failed to pay assigned small employer group medical claims within 30 days after receiving all necessary forms to establish the nature and extent of the claims, in violation of §376.427.2, RSMo, and 20 CSR 100-1.300.

8. In some instances, Conseco Medical failed to acknowledge receipt of small group and individual medical claims within 10 working days after receiving notification of the claims, as required by 20 CSR 1.030(1).

9. In some instances, Conseco Medical failed to pay small group medical claims within 45 days after receipt or send notice of receipt and the specific reason why additional time was needed to investigate the claims, thereby violating §376.383, RSMo, and 20 CSR 100-1.050.

10. In some instances, Conseco Medical was cited for improperly denying claims for complications of pregnancy, in violation of §375.995, RSMo.

11. In some instances, Conseco Medical paid incorrect amounts on claims for preventative care, in that it applied incorrect deductibles and coinsurance to those claims, thereby violating §376.1250, RSMo.

12. Conseco Medical was cited for improperly denying or incorrectly paying claims for immunizations by improperly applying deductibles or co-payment limits to the claims, in violation of §§375.1007(3), (4) and (6), and 376.1215, RSMo.

13. In some instances, Conseco Medical improperly denied or incorrectly paid claims for emergency room claims, thereby violating §§376.1250 and 376.1367, RSMo.

14. In some instances, Conseco Medical failed to state on the explanation of benefits notice for its adjudicated out of network claims whether or not the out-of-network deductible or co-payment amount(s) were applied to the claims, thereby violating §§375.1005, 375.1007(10), RSMo, and 20 CSR 100-1.020(1).

15. In some instances, Conseco Medical was cited for failing to sufficiently maintain and provide relevant materials and documentation to allow the examiners to sufficiently ascertain the complaint, grievance, and claims handling practices of the Company, thereby violating §374.205.2(2), RSMo, and 20 CSR 300-2.200(2) and (3).

16. Conseco Medical was cited for failing to conduct any internal or external review of the operations of three third party administrators it uses for its managed care operations, in violation of §376.1084.2 and .3, RSMo.

17. Conseco Medical was cited for employing a medical director to administer its Utilization Review program and review its PPO plan decisions who is not licensed as a physician in Missouri as required by §376.1361.2, RSMo.

18. Conseco Medical was cited for failing to include "other enrollees" in its second level grievance advisory panel, in violation of §376.1385, RSMo.

19. In some instances, Conseco Medical failed to notify its plan enrollees, the enrollee's representative, or the provider acting on behalf of the enrollees of their right to file an appeal, as required by §§376.1382 and 376.1385, RSMo.

20. In some instances, Conseco Medical was cited for failing to take appropriate action in handling certain complaints, including those related to claim underpayments, incorrect handling of claims, and denying claims after it pre-certified them, thereby violating §§376.782, 376.1250, 376.1361.13, RSMo.

21. Conseco Medical was cited for failing to list all of its grievances on its register, as required by §§376.936(3), and 376.1375, RSMo.

22. Conseco Medical was cited for failing to pay the proper amount of interest on the unearned premium it refunded to the policyholder after it canceled a policy upon the policyholder's request, thereby violating §408.020, RSMo.

23. In some instances, Conseco Medical was cited for failing to respond to the examiners' criticisms and formal requests within the required time period of ten (10) days, thereby violating §374.205.2(2), RSMo and 20 CSR 300-2.200(6).

WHEREAS, Conseco Medical neither admits nor denies the above findings; however, on areas that require correction, Conseco Medical hereby agrees to take remedial action bringing Conseco Medical into compliance with the statutes and regulations of the State of Missouri and agrees to maintain those corrective actions at all times, including, but not limited to the following:

1. Conseco Medical agrees to take corrective action to assure that the errors noted in the market conduct examination report do not recur and further agrees to maintain those corrective actions at all times; and

2. The Company shall take any needed steps to assure that no claims are unfairly denied, and that all payable claims are paid accurately and promptly as required by law.

3. Conseco Medical agrees to review all of its rescinded polices dated 1/1/00 through 12/31/07, that had denied claims which were based on a misrepresentation of health history on the applications and provide a report to the Department detailing its procedures used for the review as well as the results of the review, including the total amount refunded to consumers, including applicable interest paid on those claims, within 180 days of the date a final Order concluding this exam is signed by the Director.

4. Conseco Medical agrees to pay to its current and former policyholders 75% of the claimed amounts due for ICD-9 codes the Independent Review Organization determined were complications of pregnancy with the IDC-9 code diagnoses appearing in the claim files referenced in the Examination Report. Conseco Medical shall include with such payments a letter, as approved by the Division, informing the payee / policyholder that such payments are being made as a result of this Market Conduct Examination. Conseco Medical will notify the Department of the amounts paid to such claimants, including applicable interest paid on claims on which the Company receives additional information from the claimant, in accordance with the terms of the letter. An accounting of these payments will be made to the Department within 180 days of the date a final Order concluding this exam is signed by the Director.

5. Conseco Medical agrees to review all emergency room claims which were denied in calendar years 1999 through 2001, and provide a report to the Department detailing its procedures used for the review as well as the results of the review, including the total amount refunded to consumers, including applicable interest paid on those claims, within 180 days of the date a final Order concluding this exam is signed by the Director.

6. Conseco Medical agrees to review all pre-authorized or pre-certified claims processed between 1/1/00 through 12/31/07, and provide a report to the Department detailing its procedures used for the review as well as the results of the review, including the total amount

refunded to consumers, including applicable interest paid on those claims, within 180 days of the date a final Order concluding this exam is signed by the Director.

7. The Company shall take action to ensure that it takes the appropriate and prompt action on all complaints received, as required by law.

8. The Company shall ensure that its books, records, documents, and other business records are in an order such that the insurer's claims handling practices can be readily ascertained by the Department , as required by 20 CSR 100-8.040 (2008).

WHEREAS, Conseco Medical merged into its affiliate Washington National Insurance Company effective July 1, 2003; and

WHEREAS, Conseco Medical, 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, Conseco Medical hereby agrees to the imposition of the ORDER of the Director set forth below and as a result of Market Conduct Examination number 0207-02-LAH further agrees, voluntarily and knowingly to surrender and forfeit the sum of $75,018.25.

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 Conseco Medical to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Conseco Medical 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 $75,018.25, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 6/1/09

PRESIDENT
Washington National Insurance Company

September 19, 2003

Missouri Department of Insurance
Attn: Cynthia M. Amann
Compliance Auditor
Harry S. Truman State Office Bldg.
301 West High
Jefferson City, Missouri 65101

Re: Market Conduct Exam # 0207-02-LAH for Conseco Medical Insurance Company

Dear Ms. Amann:

I am writing in response to the draft exam report that was sent to us on 7/7/03. We greatly appreciate the additional time that you have allowed for us to respond.

We recognize the issues raised in the report that need correction, and appreciate your bringing them to our attention. Please know that we are taking, or have already completed, steps to resolve them. Our goal is to be in full compliance with all requirements, and we are working hard in order to accomplish that. However, we disagree with some of the issues raised in the report. Our response below addresses only those points of disagreement. The sections given in our response below refer directly to those sections in the report, and they are in the same order as found in the report (please note that the Executive Summary has not been specifically addressed here, because the issues in that section are also addressed elsewhere in the report). In all cases of disagreement described below, we respectfully request that the report be appropriately modified.

Marketing Practices – page 2.

With regard to the allegation that the description of preventive care in the Med IV brochure is misleading: the actual limitation to this particular benefit is that it is only available after PPO or RHP coverage has been in force for 12 months. We believe that that limitation is appropriately and accurately described in the brochure in the following manner: "After PPO or RHP coverage is in force for 12 months, various preventive healthcare services...are covered..." (pls see exhibit 1). This description is listed only under the PPO/RHP section of the brochure, and is not included in the covered charges section of the brochure. We do not understand how the description of this limitation could possibly be clearer than what is currently given in the brochure.

It is also alleged that the Classic Choice sales brochure is misleading with regard to the child immunization benefit. However, that brochure was only used with form CM090006MO, titled Significant Variations in Coverage for the Classic Choice policy (pls see exhibit 2). As can be seen, this form explicitly modifies the description of the child immunization benefit, in such a way that the benefit's description complies with Missouri requirements.

Cancellations and Rejections – page 4 to 13

Policy H52135264 was rescinded because of the insured's misrepresentation regarding his herniated disc condition. This condition contributed to the condition for which a claim was made, which was a surgery for a herniated disk. Consequently, we believe that this policy was appropriately rescinded, and that the claims listed under this policy in the report are not payable. We are currently re-examining the remaining claims listed in this section.

Small Employer Group Health Termination – page 13 and 14

Conseco Medical terminated all small employer group health plans in Missouri, and did so by giving a 90 day advance notice, and providing those groups with the option of obtaining new coverage. This was in compliance with the applicable federal law, code 42 USCS 300gg-12(c). Prior approval for this action was obtained from the Health Care Financing Administration. The Missouri state requirements related to this situation differ to some extent from the federal government's. In situations such as this, where applicable laws conflict, code 42 USCS 300gg-23(a)(1) provides that the rules that are more beneficial to the consumer should be followed. In this case, Missouri law prohibits consumers from obtaining coverage from the insurer after their policy has been terminated, while the applicable federal law allows subsequent coverage. With more coverage options, the consumer cannot possibly be worse off than he would be without those options. The federal law is clearly more beneficial for the consumer, because under it he can choose alternate coverages when those are suitable for his particular situation, while the state law prohibits that choice. Our decision to provide the additional coverage option to these consumers was a good faith effort to comply with the legal requirements applicable to this situation.

Incomplete Files – page 15 and 16

It is alleged that, because policy underwriting files did not include documentation showing the reason for policy termination, we violated code 300-2.200 (2). However, that code requires only that insurers maintain "books, records, documents and other business records in a manner so that...practices of the insurer may be readily ascertained...". The code clearly does not require that all information that could be relevant to a policy be kept in one particular file. It requires only that the information be readily available. Our policy records are maintained in multiple files and computer systems. All information is readily available upon request, and in fact it was quickly provided to the examiners upon their request.

Claim Time Studies – page 18 and 19

Delay in Administering Claims Within the Required 30 days after Receipt of All Necessary Information:

Claim FL9829603 – the report indicates that the claim investigation was completed on 4/16/01. However, that is not correct, because the information received up to that point in time would not allow the claim to be paid. We subsequently received a call from the health care provider on 8/16/01 (pls see exhibit 3) that provided us with necessary information, and payment was then made on 8/27/01, which was well within the 30 day time limit.

Claim EV2378804 – The date that the investigation was completed should be 1/1/01, rather than 6/16/01. The date the claim was paid was 2/8/01, rather than 1/1/01. We agree with the number of days cited of 38.

Claim ES9546503 – The report indicates that the investigation for this claim was completed on 4/14/01. However, that is incorrect. This claim was first received on 5/10/00. Due to a delay in being able to obtain PPO pricing, we paid the claim on 6/15/00 using estimated PPO savings. The actual PPO savings was received on 7/14/00 and an additional payment was made on 7/20/00. This PPO pricing actually indicated a PPO allowed amount that was higher than the provider's charge. We sought clarification as to the proper amount to pay and after receiving instruction from the PPO on 5/24/01, we made the final payment on 5/25/01 (pls see exhibit 4).

Claim ET6386402 – The report indicates that this claim investigation was completed on 5/24/00, but that is incorrect. We received this claim on 5/24/00, and sent a denial on 6/20/00. We then received an appeal of this decision on 2/7/01, and after further review, it was paid on 3/14/01 (pls see exhibit 5).

Failure to Deny Claims Within 15 Working Days after Receipt of All Necessary Information – page 21

Claim FE8831801 – The report indicates that the claim investigation was completed on 12/30/00. However, that is incorrect, as the investigation was not completed until receipt of the diagnosis code from the providers office on 1/26/01 (pls see exhibit 6). The claim was then denied on 2/1/01, which was within the mandated time period.

Unfair Settlement – page 24

Failure to Pay Interest on Claims Not Paid Within 45 days of Claim Receipt

Claim EV2378804 – The original, incomplete claim was received on 6/16/00, but the completed claim was not received until all requested records were received on 1/1/01. Payment was made on 2/8/01, within the 45 day period following receipt of the completed claim (pls see exhibit 7).

Claim ES6950902 - The original, incomplete claim was received on 5/8/00, but the completed claim was not received until all requested records were received on 2/23/01. Payment was made on 3/6/01, within the 45 day period following receipt of the completed claim (pls see exhibit 8).

Claim ET6386402 – please know that interest in the amount of $13.14 has been paid, in compliance with code 376.383 5.

Complication of Pregnancy – pages 29 to 37

The report indicates that Conseco Medical "refused to reconsider" claims made for pregnancy related conditions from a group of 190 policies. During the exam, the word "reconsider" was used to refer to claims that were both re-reviewed, and then paid as a result of the additional review. However, we believe the report is misleading when it indicates that we refused to reconsider claims when we were asked to do so, because we did actually re-review all of the claims that the examiners requested of us (please see exhibit 9 for the results of that review). The real disagreement was over our decision to maintain our previous denial decision on claims. We maintain that position because of our conviction that the condition claimed for does not fit the criteria of "complications of pregnancy", as given in the policy.

Upon the examiners request, we reviewed all of the claims in question. We agreed with the examiners on 52 claims. For those policies, the claims were reopened and additional payments made, or an additional amount was credited toward the deductible. For the majority of the claims

in question, our re-review, pursuant to this exam, confirmed the original review that the conditions in question did not meet the necessary criteria, as defined in the policy, to be classified as complications of pregnancy. The report seems to indicate that all ICD-9 codes 630 through 677 (excepting 650) should be considered to be complications of pregnancy. However, a review of the ICD-9 codes will reveal that, with the exception of codes 640 to 648, none of the other codes within the group 630 to 677 are classified by ICD as "Complications Mainly Related to Pregnancy". Thus we believe these allegations in the report are mistaken, because not only do the conditions in question fail to meet the definition of complications of pregnancy in the policy, but the allegations are also directly contradicted by the ICD system, which is the recognized standard authority [it's use is mandated by HIPAA] for the classification of medical conditions.

In addition, this allegation is based on code 375.995, which prohibits treating complications of pregnancy differently from other conditions under the contract. However, code 375.995 applies to contracts, which are defined as "policies, plans or binders", which are issued in Missouri. It does not apply to certificates issued in Missouri that are evidence of coverage under a group policy that was issued in Illinois. The group policy benefits comply with the benefit mandates of the state of Illinois, and were approved as being in compliance by the Illinois Department of Insurance. The Missouri Department, in a 9/6/00 letter to Conseco Medical, confirmed that certificates issued in Missouri, when the group policy was issued outside Missouri, are not subject to the review or approval of the Missouri Department. That letter also listed the particular Missouri state insurance codes that apply to such certificates, and code 375.995 was not on that list.

Immunization Claims – pages 38 and 39

The report alleges that Conseco Medical "chose to ignore" an amendment to the policy that provided immunization benefits to Missouri insureds. However, the policy itself does not allow payment of these claims, and the large majority of insureds with coverage under this policy are not eligible for such claims. The mistake in processing these particular claims was caused by overlooking the policy amendment, which was unintentional. It is also alleged that we have not adopted and implemented reasonable standards for the prompt investigation and settlement of claims. However, that is not true. Enclosed as exhibit 10 are established procedures for the handling of Child Immunization Benefits. While it has always been our goal to minimize mistakes to the lowest level possible, we believe it is unreasonable to expect the company to be in perfect compliance with these standards at all times.

Emergency Room Claims – page 39 to 42

The first allegation is that, in regard to the examination request on 6/28/02 (exhibit 11), we refused to provide paper copies of the claim files and explanations of benefits (EOB's) for the claims for emergency room services that were denied, and for which we maintained the denial decision after further review. Unfortunately, the company personnel who handled this request assumed that the type of documentation provided to the examiners for other types of claim requests, specifically charts and spreadsheets that included claim descriptions, would be sufficient for this request. We apologize for this misunderstanding. However, when the examiner provided his follow-up request on 9/11/02 (exhibit 12), indicating that our previous response was insufficient, we then provided all of the files and EOB's, on 10/9/02 (exhibit 13). Please note exhibit 13 includes a description of our attempts to comply with the original request. We misunderstood the original 6/28 request, but once it was brought to our attention on 9/11, we complied on 10/9/02. We believe the report is very misleading on this issue, because what was actually an honest misunderstanding is inaccurately described as a "refusal" to provide documents. Also, there is no acknowledgement in the report that the requested documents were in

fact provided once we became aware of the problem. Because we did not refuse to provide requested documents, but rather made an insufficient response that was corrected once it became aware of the fact, we do not believe that code 374.205 was violated.

With regard to the 5 claims listed on page 41 of the exam report, and the first one on page 42: we have re-opened these claims as requested, and will forward the results when requested medical records are received and a determination can be made.

Claim EQ3245801 – The enclosed screen print shows the payment amount, process date, and check clearing date (pls see exhibit 14).

Claim FK9099601 – The enclosed screen print shows the payment amount, process date, and check clearing date (pls see exhibit 15).

Claim FL5255201 – The enclosed screen print shows the payment amount, process date, and check clearing date (pls see exhibit 16).

Claim FS6703601 - The enclosed screen print shows that this amount was applied to the policy deductible on 8/21/02 (pls see exhibit 17).

Adjudicated Out of Network Claims – page 42 to 44

It is alleged that, because our EOB's do not specify whether services received were in or out of the network, those EOB's did not "indicate the coverage under which payment is being made", as required by code 375.1007(10), and that it "failed to fully disclose...all pertinent benefits...under which a claim is presented", as required by code 100-1.020(1). As can be seen, these laws do not specify that benefits have to be described as being in or out of the network. The EOB's do specify the specific, relevant factors applicable to each claim, including a description of the services provided, the amount charged, et cetera. The EOB's actually specify all of the effects of receiving services either in or out of the network, such as the deductibles, co-insurance, and co-pay amounts. Consequently, we do not understand the reasons that these EOB's are viewed as not indicating the coverage, or disclosing all pertinent benefits, as required by the code.

Managed Care – page 45

2. We have confirmed that our Medical Director of the Utilization Review program, Dr. David Ricketts-Kingfisher, has a Missouri license as a physician (pls see exhibit 18)

3. Code 376.1385 requires other enrollees to be part of the grievance advisory panel that is to perform a second level review of a grievance. However, including other enrollees in the grievance panel would result in the sharing of an insured's personal health information with other insureds, which would be in violation of HIPAA and state privacy laws. That is, we believe the requirement of 376.1385.1(1) is in conflict with other legal requirements, and that it is superseded by the federal requirements embodied in HIPAA.

Grievances/Complaints – pages 46 to 56

1. We agree with the criticism, but please note that all insureds are provided with a written description of the Grievance Process, which includes an explanation of their right to file a grievance with the Missouri Department of Insurance, along with the toll free phone number and address of the department.

4. It is alleged that the file for this particular complaint was incomplete, in violation of code 300-2.200, because the second page of the consumer's complaint was missing. However, we received this complaint from the Missouri Department of Insurance without the second page. Consequently, our file was complete in that it contained the entire complaint that was filed with us.

5. Three grievances were mistakenly not recorded on the grievance registers. However, we do not believe that is in violation of code 375.936 (3). That code provides that such mistakes are not considered in violation of the code unless they are committed consciously, or so frequently as to be a general business practice. Neither of these conditions holds true in this case, because these were unintentional mistakes, and the vast majority of grievances were recorded in the register. Our general business practice is to record grievances in the grievance register. We also do not believe this is a violation of code 376.1375. This code requires that a grievance register be maintained. Although our register was missing these 3 grievances, we did maintain it, and it included the vast majority of information that was required to be in it.

6. The description in the report of the complaint involving policy H67007251 excludes relevant information that, as a result, makes the report misleading. The application for this policy for family coverage was received without certain necessary information for Sherri Buck. As a result, an amendment excluding Sherri from coverage was mailed to Joseph Buck for his signature, along with the policy. The amendment was to be returned to allow us to activate the coverage. However, 2 days after that mailing, we received a call from our Field Marketing Office indicating that they had received the information from Sherri that was missing from the original application. Consequently, the return of the signed exclusion rider was no longer necessary for us to activate the policy. We then issued a revised policy in which all family members, including Sherri, were covered. The report seems to indicate that, because the original exclusion amendment was not returned, no contract was ever in force and premiums should not have been collected. However, that ignores the fact that the applicant submitted new information, subsequent to the original application. That new information constituted a counteroffer, which we accepted by issuing a revised contract. A complete description of this case was provided during the examination on 4/15/02 (please see exhibit 19). We do not understand why this additional information was left out of the report, as we believe it shows that this case was handled properly. As is noted in the 4/15/02 memo, for whatever reason we did not receive the 3/1/01 faxed request to cancel. We first heard that the insured did not want this policy upon receiving their call on 4/26/01, which was the same day we received the complaint from the insurance department, at which time the refund was sent. Also, a refund of the interest on the unearned premium was sent on 4/16/02 (please see exhibit 20).

7. The practice of withholding refunds for 30 days following a premium payment is criticized on the grounds that those premium payments clear the bank in less than 30 days. We disagree with this criticism, because banks and financial institutions have the legal right to revoke financial transactions performed through electronic funds transfer or by check, for 60 days following the posting of that transaction (please see a copy of standard bank operating guidelines in exhibit 21). In fact, such financial transaction revocations occur on a regular basis (please see a section from our daily return item listing report in exhibit 22). Consequently, we believe this is a prudent policy, and the report does not indicate that it violates any state requirement. Also, please note that we offer insureds the opportunity to have this 30 day time period waived, on the condition that they submit a letter from the financial institution that guarantees payment of the transaction.

8. It is alleged that, because a grievance file did not include complete documentation, we violated code 300-2.200 (2). However, that code requires only that insurers maintain "books, records, documents and other business records in a manner so that...practices of the insurer may be readily ascertained...". The code clearly does not require that all information that could be relevant to a policy be kept in one particular file. It requires only that the information be readily available. Our policy records are maintained in multiple files and computer systems. All information is readily available upon request, and in fact the documentation missing from this file was provided to the examiner upon his request. Also, code 300-2.200 (3)(B) is inapplicable to this case because it applies to claim files, while this criticism involves a grievance file.

9. This criticism pertains to the lack of a notice on the explanation of benefit forms whether or not specific services are in or out of the network. Our comment regarding this is the same as given above to this same criticism that appears on pages 42 to 44.

10. In this case, an insured sent complaints to the preferred provider organization, Healthlink, rather than directly to us. Because Healthlink did not send those complaints on to us, it is alleged that we do not have sufficient procedures in place to ensure responses to complaints. However, we provide all insureds, including this one, with a written Grievance Procedure. The Procedure was not followed by this insured, because it instructs them to send complaints to our address, rather than to the preferred provider's. We maintain regular communication to Healthlink, and they do forward issues, including complaints, to us in the normal course of business. The fact that Healthlink failed to forward the complaints from this one policyowner is not evidence that we did not have effective procedures.

11. through 18. While it is true that, unfortunately, these 10 claims were mishandled, we corrected the mistakes once we became aware of them. We disagree with the characterization in the report that Conseco Medical intentionally mishandled these claims. That is most certainly not the case, and the report provides no basis for making this serious allegation. The fact that the vast majority of claims are properly handled, and that any mistakes are corrected upon coming to light, is evidence that these cases were not intentional or a general business practice, and therefore, not in violation of code 375.1007. Also, code 300-2.200 requires that all relevant records be provided to market conduct examiners upon their request. We in fact provided all relevant records that were requested concerning these 10 claims, so we do not understand the reason we are being cited for violation of this code.

19. In March, 2000, Conseco Medical mailed a notice to over 3,500 insureds that indicated that their network provider had changed from CCN (or Ethix, depending on their residence) to the Private Health Care System (PCHS). There were 49 policyholders who were not included in the March mailing, due to administrative reasons (for example, their premium was in a suspense account, or their address was in the process of being changed, etc.). We subsequently mailed the notice to these 49 insureds in May, 2000. The report indicates that 9 insureds, from 6 different communities in Missouri, submitted complaints that they had not been notified of this change, which caused them to incur uncovered claims from non-network providers. From this, the report concludes that no such mailing to any of our insureds ever took place.

However, the report is in error because one of the complainants cited, Tracey Wiley, did not indicate that she had not received the notice. Her complaint was that the provider's billing department had not used the correct tax ID number, which caused us to consider the claim as non-network (please see exhibit 23). Once the provider's mistake was discovered, we processed the claim as in-network. Also, in contradiction to the report, another complainent, Debbie Williams, specifically indicates on pages 2 and 3 of her complaint (please see exhibit 24) that she had

received the notice of change in the network. To quote Debbie: "I was with the understanding that our network was with Private Health Care Systems, not CNN....On May 1, 2000, Conseco changed their directory to Private HealthCare Systems. At this point in time, I did not have a complete and current directory from Private HealthCare Systems...I received the new directory weeks later....Days later, I received my new insurance cards and directory from Conseco resulting from changing to Private HealthCare Systems". We provided this information to the examiners. We do not understand why, given this insured's statement that she did receive the mailing, the report still alleges: (1) that she did not receive the mailing, and (2) that no mailing to any insured occurred.

Subtracting the 2 complaints noted above, there were actually 7 complaints that occurred in 4 communities. However, as noted, we mailed the notice to over 3,500 insureds. That only 7 out of over 3,500 insureds indicated that they did not receive a mailing should lead to the reasonable conclusion that the mailing did in fact occur. We believe that there are other, more plausible explanations for these complaints, including the fact that these insureds were attempting to obtain payments for medical benefits, that they may have misplaced the mailing, or overlooked it because it's importance was not understood until a claim was denied, et cetera. We also have circumstantial evidence that the mailing occurred. Please see exhibit 25, which includes: 2 pages from the mailing label report that was used to generate labels for the mailing; our agent publication that refers to the mailing; and an internal implementation document that refers to the completion of the mailing.

In addition to the factors cited above, the correspondence from Debbie Williams is itself a strong indication that a mailing occurred, because there would be no reason for her to say she received it if she had not. And if we had not in fact sent notification of a change of this magnitude to our over 3,500 insureds, we would have expected to receive over 3,500 complaints, rather than 7.

We wish to reserve all of our rights with respect to a hearing on the merits of this examination. We sincerely hope that we can work together to resolve any disputed issues on an amicable basis. Thank you for your consideration.

Sincerely,

Mark Burdett

Mark Burdett FLMI, FAHM, ALHC
Senior Manager, Regulatory Compliance

STATE OF MISSOURI

DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION

MARKET CONDUCT

FINAL EXAMINATION REPORT

OF THE

HEALTH INSURANCE BUSINESS

OF

CONSECO MEDICAL INSURANCE COMPANY

NAIC NUMBER: 93769

NAIC GROUP CODE: 0233

11815 N. Pennsylvania St.
P.O. Box 1911
Carmel, IN 46082-1911

STATE OF DOMICILE: ILLINOIS

June 18, 2009

REPORT NUMBER: 0207-02-LAH

TABLE OF CONTENTS

FOREWORD

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Missouri Department of Insurance. In performing this examination, the Missouri Department of Insurance selected a small portion of the Company's operations for review. As such, this report does not reflect a review of all practices and all activities of the Company. The examiners, in writing this report, cited errors made by the Company. The final examination report consists of three parts: the examiners' report, the response of the Company, and administrative actions based on the findings of Director of the Department of Insurance.

Wherever used in this report:

- "CMIC" or "Company" refers to the Conseco Medical Insurance Company;
- "CSR" refers to the Code of State Regulations;
- "DIFP" 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 DIFP to perform this examination includes, but is not limited to, Sections 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, Section 447.572, RSMo grants authority to the DIFP to determine Company compliance with the Uniform Disposition of Unclaimed Property Act.

The Company examined was Conseco Medical Insurance Company.

The time period covered by this examination is primarily from January 1, 2001, through December 31, 2001, unless otherwise noted.

The purpose of this examination is to determine whether the Company complied with Missouri laws and DIFP regulations. In addition, the examiners reviewed the Company operations to determine if they are consistent with the public interest.

While the examiners reported on errors found in individual files, the examination also focused on the general business practices of the Company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a 10% error tolerance ratio to all operations of the Company, with the exception of claims handling. The error tolerance ratio applied to claims matters was seven percent. Any operation with an error ratio in excess of these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business: small employer group medical, association group major medical and individual major medical insurance. The examination included, unless otherwise noted, a review of the following areas of the Company's operations: Sales and Marketing, Cancellations and Rejections, Claims, Utilization Review Procedures, Grievances, Complaints and Unclaimed Property.

This market conduct examination was performed at the administrative office of the Company:

303 North Main Street
Rockford, Illinois 61101

COMPANY HISTORY

Conseco Medical Insurance Company (CMIC) was formerly Connecticut National Life Insurance Company (CNL). CNL became part of the Conseco insurance holding company system on May 30, 1997, through the purchase by Conseco of all the outstanding stock of Pioneer Financial Services, Inc. ("PFS"), a Delaware publicly traded holding company that indirectly owns CMIC (then CNL). The acquisition was approved by the Illinois Insurance Department pursuant to Order dated May 1, 1997. CMIC is a wholly owned subsidiary of Manhattan National Life Insurance Company. CNL changed its name to Conseco Medical Insurance Company effective August 24, 1998, after obtaining approval from the Illinois Department of Insurance.

EXECUTIVE SUMMARY

The main issues of concern found by the examiners are as follows:

- The Company has been using Express Scripts, Inc. as a Third Party Administrator (TPA) in Missouri. Express Scripts does not have a Certificate of Authority to operate as a TPA in Missouri.

- CMIC has failed to perform any internal or external reviews of the operations of the Third Party Administrators (TPA's) it uses.

- The medical director who administers the Utilization Review program for CMIC and oversees the review decisions for the PPO plans covering Missouri residents is not licensed as a physician in Missouri.

- CMIC has failed to include "other enrollees" in its second level grievance advisory panel.

- The 2000 Annual Statement Supplement submitted for Missouri did not contain any information on Small Employer group business, although the Company should have listed 19 Small Employer groups and 89 insured's on the Supplement.

- Prior to October 1, 2000 small employer groups insured with CMIC were enrolled in several different types of small employer health benefit plans. Small Employer health plans in Missouri are required to be guaranteed renewable unless the carrier non-renews all small employer health benefit plans in the State and does not write any new small group health business in Missouri for five years thereafter.

  On October 1, 2000 CMIC cancelled all Small Employer group health plans in Missouri. CMIC then chose to offer one health benefit plan with a 50% rate increase to these groups. If an employer refused to accept this new benefit plan, with the increased cost, it was forced to seek coverage elsewhere. In addition, CMIC failed to give the Director of the DIFP and all affected policyholders the required 180 days notice of its intent to cancel their health plans.

- Thirteen of the 14 policy files provided for the Small Employer group health plans that terminated in *2001* did not contain the required documentation or reason the plans were terminated. Thirty of the 50 policy files sampled for calendar year *2000* did not contain the required documentation or reason the small group health plans were terminated.

- CMIC rescinded 58 policies in 1999, 2000 and 2001. These rescissions were not listed on the Schedule F page of the 1999, 2000 and 2001 Annual Statements. Twenty-eight of the rescissions also included 130 denied claims.

Some of the claims filed under the rescinded coverage's are payable because the illnesses or injuries involved were not related to the medical conditions not disclosed on the applications for coverage.

- A targeted claims review was preformed to determine if Company claims paying procedures were in compliance with Missouri's mandated coverage laws. It was found that the Company failed to properly adjudicate 424 claims for complications of pregnancy, 677 claims for preventive care and 184 claims for childhood immunizations. The claims in question were denied in 1999, 2000 and 2001, but should have been paid in compliance with Missouri's mandated coverage laws.

- CMIC reopened and paid 42 complications of pregnancy claims and maintained its denial of the remaining 382 claims. The examiners requested that CMIC reconsider the balance of the claim denials based on ICD-9 Codes 630 through 677, excluding claims coded 650, which is the code used for normal delivery. CMIC refused to reconsider the remaining denied complication of pregnancy claims.

  As a result of the Company refusal to reconsider these claims the examiners conducted a review of the claims in question. The review was performed using the Certificate definition of complications of pregnancy and the ICD-9 Codes identified above. The examiners concluded that the conditions described in 202 of the claims met the Certificate definition and fell within the respective ICD-9 Codes for Complications of pregnancy.

  When informed of these findings the Company again refused to reconsider these claims. The examiners again recommended that CMIC reconsider these denied claims. Ultimately, CMIC did reopen and allow benefits for an additional 10 previously denied claims and provided documentation to support its position on eight others. CMIC failed to provide documentation to support its continued denial of the remaining 190 complications of pregnancy claims.

  The examiners found that 12 denied complications of pregnancy claims, the examiners had repeatedly asked CMIC to reconsider during the target claims review, were actually paid in 1999 and 2000. This indicates that CMIC did not re-review those 12 claims when repeatedly requested to do so by the examiners.

- CMIC improperly denied eight childhood immunization claims in 2001, even though it had all forms necessary to determine that benefits were payable on the date of receipt. The Company reopened and paid these denied claims at a later date in calendar year 2001. Certificate form GHC-8783 has a Missouri Amendment that complies with the Missouri immunization law, but it appears that CMIC chose to ignore this contract amendment. The foregoing indicates that CMIC knew as early as 2001 that it had been improperly adjudicating Missouri immunization claims.

- As part of the target review the examiners asked CMIC to review all emergency room claims denied in 1999, 2000 and 2001. In Missouri, emergency services necessary to screen and stabilize an enrollee must be treated as any other illness. The examiners requested that CMIC provide a paper copy of the claim file and related explanation of benefits on any claims for which it continued to maintain its denial.

  The Company advised that it reviewed 192 emergency room claims adjudicated in 1999, 2000 and 2001, and maintained its denial of all but one claim. The Company refused to provide paper copies of the claims for which it continued to maintain its denial.

  The examiners found that benefits on five emergency room claims should have been credited to the certificate deductibles.

  After numerous requests by the examiners CMIC agreed to re-review the previously denied emergency room claims. Thirty emergency room claims were reopened and properly adjudicated.

- When CMIC pays out of network claim benefits (e.g. applies penalty co-payments or deductibles) it does not disclose this fact on its Explanation of Benefits.

- CMIC failed to notify nine health plan enrollees of their right to file a grievance appeal.

- Three grievances were not recorded on the Company's grievance register and two grievance files were incomplete.

- CMIC has a business practice of withholding premium refunds for 30 days after they have been requested, on premiums that were paid by electronic funds transfers or by other premium paying methods.

- Nine complaints were filed against CMIC because it changed the health plan network of PPO providers without notifying the plan enrollees of the network changes. This resulted in financial hardship and stress for the claimants and in some cases damage to their credit ratings.

SECTION I

I. SALES AND MARKETING PRACTICES

This section details the examination findings regarding sales and marketing practices. The items reviewed were the Certificate of Authority, licensing records pertaining to sales personnel, and product marketing and advertising materials.

A. Company Authorization

Missouri law limits the entities that may sell insurance and the types of insurance they may sell. These limitations exist to protect consumers and ensure that they receive fair treatment from insurers. After an insurer has submitted an application and complied with all requirements to conduct insurance business in Missouri, the DIFP grants a license called a Certificate of Authority.

During the time period covered by the examination, Conseco Medical Insurance Company had authority to transact business in the following lines of insurance:

- Accident and Health
- Life, Annuities and Endowments

B. Licensing

Missouri law requires insurers to sell insurance products through individuals and entities that have received a license from the DIFP. The purpose of such a license is to help protect the public from incompetent salespersons. The examiners reviewed the Company's licensing practices to determine whether they comply with Missouri law and regulations.

The examiners found one error in the licensing review:

The following Third Party Administrator is and has been operating in Missouri on behalf of CMIC without a Certificate of Authority.

Reference: Section 376.1084, 376.1092, RSMo and 20 CSR 200-9.600

Name of Administrator

Express Scripts, Inc.

C. Marketing Practices

Missouri law requires that an insurer be truthful and provide adequate disclosure when marketing its insurance products. The examiners reviewed Company marketing practices, advertising and agent training materials used during 1999, 2000 and 2001 to determine whether those materials and marketing practices complied with Missouri law.

The examiners found the following errors in the advertising review:

The Med IV sales brochure contains the following statements: "After coverage has been in force 12 months, certain preventive services are covered at 100 percent up to $200 per year."

"After PPO or RHP coverage is in force for 12 months, various preventive healthcare services such as routine physical exams, lab tests, immunizations, vaccinations and booster shots are covered at 100 percent, with no deductible or coinsurance, up to $200 per person per year."

Under Missouri's required benefit provisions preventive services must be treated as any other illness, and coverage for immunizations from birth to age five shall not be subject to any deductible and co-payment limits.
Reference: Section 376.1215 and 376.1250, RSMo

In addition, the Med IV sales brochure is misleading because it fails to disclose that benefits for preventive care are not available when such services are received out of network.

Reference: 20 CSR 400-5.700 (4) & (5)

Brochure Number	Policy Forms
CMO1001	GHC8783 & IHP-8826

The Classic Choice sales brochure contains the following statement: "Preventive services are covered at 100%, after your selected copay, up to $500 per person per year, starting in the second year of coverage."

Under Missouri's required benefit provisions preventive services must be treated as any other illness and coverage for immunizations from birth to age five shall not be subject to any deductible and co-payment limits.
Reference: Section 376.1215 and 376.1250, RSMo

Policy Forms

GHP-8978 and IHP-8978

SECTION II

II. UNDERWRITING AND RATING PRACTICE

This section of the report details the examination findings regarding underwriting and rating practices. Such practices include the use of policy forms.

The examiners did not undertake a review of underwriting practices because CMIC notified affected policyholders, by letter dated June 25, 2001 of its intent to exit the small employer group market. In addition, CMIC notified affected policyholders, by letter dated July 24, 2001 of its intent to exit the individual major medical market.

The examiners did review policies that were canceled or rejected.

A. ANNUAL STATEMENT

Annual Statement Supplement

Lines 5.1 and 7.1 of the 2000 Annual Statement Supplement for Missouri did not contain any information on Small Employer business. The Company revised the Supplement during the examination and it now shows 19 Small Employers groups and 89 insured's.

Schedule F

CMIC rescinded 20 policies in 1999, 24 policies in 2000 and 14 policies in 2001 for a total of 58 rescissions. These rescissions were not listed on Schedule F of the 1999, 2000 and 2001 Annual Statements. CMIC failed to follow the instructions on the Annual Statement for completion of Schedule F that requires it to show: "...all claims for death losses and all other policy claims resisted or compromised during the year, and all claims for death losses and all other policy claims resisted December 31 of current year."
Reference: 20 CSR 300-2.200 (2)

B. Forms and Filings

The examiners reviewed policy contracts and related forms to determine whether CMIC complied with Missouri law and requirements for the filing, approval and content of policy and related forms. These forms were also reviewed to ensure that the contract language used is not ambiguous and is adequate to protect the consumer.

Group Certificate form number GHC-8783 has a 12-month waiting period and a $200 maximum annual benefit for in-network preventive services. This plan does not pay benefits for out of network preventive services. The provisions in this certificate are discussed in more detail in the Target Claims review and the Complaint Section of this report.

C. Cancellations and Rejections

1. Schedule F

Field Size:	58
Type of Sample:	Census
Number of Errors:	28
Error Rate:	48%
Within DIFP Guidelines:	No

The examiners found the following errors in this review:

The following policies were rescinded and the listed claims were denied because of misrepresentation of health history on the applications. However, these claims are *payable* under Missouri law because the illnesses and injuries involved are not related to the medical conditions not disclosed on the applications for coverage. The matters misrepresented on the applications did not contribute to the contingency or event on which the following claims became payable.

In addition, interest is due at the rate of one percent per month on these claims from the date investigation was complete to the date the claims are paid. Reference: Sections 376.580, 376.800 and 376.383 3, RSMo

(1)	Policy Number	Effective Date	Rescission Date
	H57242657	02-01-00	03-27-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FK2109601	02-02-01	03-09-01	348.30	$53.00
EY1141701	04-10-00	08-17-00	461.90	53.00
FE8744301	11-22-00	12-20-00	V583	26.00
			Total	$132.00

(2)	Policy Number	Effective Date	Rescission Date
	H57227178	06-01-00	2-06-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EZ5900402	07-21-00	09-14-00	233.1	$120.00
EX9001502	07-20-00	08-11-01	599.7	58.00
FB3085702	07-21-00	10-16-00	622.1	410.00
FG0242501	11-06-00	01-10-01	622.1	360.00
FE0969202	11-06-00	12-05-00	622.1	1,356.00
FF5266902	11-06-00	01-03-01	622.1	3,527.55
FF4095702	12-05-00	12-29-00	622.1	100.00
FF8285302	12-21-00	01-08-01	627.1	60.00
FL8849601	01-08-01	04-11-01	786.5	24.00
FH0761301	01-08-01	01-30-01	786.5	40.00
FL8849701	01-09-01	04-11-01	786.5	24.00
FJ2869001	01-09-01	02-19-01	786.5	84.00
FH0761201	01-09-01	01-30-01	786.5	553.00
FW6605601	01-08-01	11-19-01	789.0	7,176.00
FJ2868901	01-08-01	02-19-01	796.2	105.00
FD4463702	11-06-00	11-28-00	V72.83	36.00
			Total	$14,033.55

(3)	Policy Number	Effective Date	Rescission Date
	H52135264	10-02-00	05-11-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FF9130001	12-06-00	01-09-01	296.89	$200.00
FG0180101	12-27-00	01-11-01	296.62	60.00
FH4960901	01-10-01	02-06-01	296.62	60.00
FH7599901	01-24-01	02-12-01	296.89	60.00
FL4011801	03-16-01	03-27-01	300.21	200.00
FL8656201	12-06-00	04-12-01	296.89	380.00
FM4145401	04-13-01	04-27-01	300.21	75.00
			Total	$1,035.00

(4)	Policy Number	Effective Date	Rescission Date
	H57349921	11-27-00	07-16-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FJ4988901	02-10-01	02-23-01	784.00	$906.64

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FJ6339801	02-13-01	02-28-01	V70.0	201.00
			Total	$1,107.64

(5) Policy Number H52132086 Effective Date 11-01-00 Rescission Date 07-19-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FB1282501	04-01-01	07-11-01	847.0	$507.93
FR0112001	02-02-01	07-10-01	487.1	46.00
FR0112101	12-18-00	07-10-01	034.0	46.00
FN7629901	05-08-01	05-22-01	216.2	86.00
FQ5636701	11-29-00	07-03-01	780.79	63.80
			Total	$749.73

(6) Policy Number H57282723 Effective Date 04-22-00 Rescission Date 08-23-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FJ7824102	01-19-01	03-01-01	788.5	$162.00
FK5007702	01-16-01	03-19-01	560.1	1,020.00
FK6585802	01-20-01	03-19-01	276.6	334.50
			Total	$1,516.50

(7) Policy Number H57337382 Effective Date 07-15-00 Rescission Date 01-24-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FC9405301	11-08-00	11-16-00	V723	$137.00
FG2233201	01-03-01	01-15-01	V7612	44.76
FG2980601	01-03-01	01-19-01	V7612	37.00
			Total	$218.76

(8) Policy Number: H52136685 Effective Date: 08-21-00 Rescission Date: 06-15-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FL3098901	03-16-01	04-02-01	V72.3	$110.00
FM7107301	03-16-01	05-01-01	V72.3	40.00
FP4584101	05-04-01	06-06-01	V675.9	40.00
			Total	$190.00

(9) Policy Number: H57319303 Effective Date: 09-01-00 Rescission Date: 10-23-01

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FM8761302	02-24-01	05-02-01	786.59	$1,446.00
FR8016202	03-14-01	06-26-01	341.0	40.00
FP6201201	02-27-01	04-23-01	786.52	76.00
FN5469302	02-24-01	05-16-01	426.5	25.00
FE7032502	10-07-01	12-12-00	739.1	185.00
FL1816101	02-24-01	03-28-01	786.5	36.00
FT8291901	09-17-01	09-20-01	473.9	87.00
FU6641901	09-06-01	10-09-01	112.1	588.00
			Total	$2,483.00

(10) Policy Number: H57096789 Effective Date: 01-07-98 Rescission Date: 03-12-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DS0617501	10-02-98	11-23-98	V761	$122.32
DU1524901	11-24-98	01-11-99	477.9	40.40
			Total	$162.72

(11) Policy Number: H57118922 Effective Date: 06-01-98 Rescission Date: 01-15-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DT7245701	08-28-98	12-31-98	V76.0	$42.00
DS3298401	08-28-98	11-24-98	V72.3	61.75
DH9631701	08-28-98	09-23-98	V72.3	10.00
DH9635701	08-28-98	09-23-98	V72.3	125.00
			Total	$238.75

(12)	Policy Number	Effective Date	Rescission Date
	H57181251	12-02-98	09-01-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EQ1699101	01-08-99	03-14-00	780.60	$55.00
DZ6783801	02-24-99	05-06-99	382.00	55.00
EC4312701	02-24-99	07-07-99	382.00	55.00
DW4309701	01-21-99	02-25-99	366.01	80.00
EK1128101	11-16-99	11-30-99	558.90	55.00
FJ7171101	01-23-01	02-27-01	463.00	33.75
EC8346801	07-02-99	07-14-99	75.00	75.00
EB0109601	03-15-99	06-08-99	V68.1	52.49
			Total	$461.24

(13)	Policy Number	Effective Date	Rescission Date
	H57142240	09-01-98	08-06-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DN2358101	10-08-98	10-23-98	V72.3	$20.00
EA2731401	12-11-98	05-18-99	558.9	108.00
DW0592502	01-28-99	02-15-99	309.0	842.55
DW2530401	12-11-98	02-22-99	787.01	53.90
EA4099401	01-28-99	05-17-99	309.28	963.53
DU3933502	12-11-98	01-15-99	558.9	945.80
DV3368502	01-21-99	02-04-99	558.9	183.30
DV6889501	01-28-99	02-10-99	309.28	783.00
			Total	$3,900.08

(14)	Policy Number	Effective Date	Rescission Date
	H57129395	07-01-98	08-30-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DU3372101	11-20-98	01-08-99	218.9	$ 570.00
DT6140402	11-20-98	12-28-98	621.0	1,930.95
DR4923601	08-28-98	11-13-98	V70.0	132.00
DV6485401	11-20-98	02-08-99	621.0	252.00
DV6486902	10-05-98	02-08-99	V72.5	255.00
DX1869501	09-10-98	03-11-99	V72.3	594.50
DX3208901	11-20-98	03-17-99	626.4	750.00
DR4931201	08-24-98	11-13-98	V07.4	178.00
DT5634002	11-03-98	12-28-98	780.2	91.00
			Total	$4,753.45

(15)	Policy Number	Effective Date	Rescission Date
	H57285811	03-01-00	10-16-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
FB4863901	09-06-00	10-17-00	V72.3	$156.00
FB4899701	09-07-00	10-16-00	626.8	93.00
EU2798101	04-27-00	06-08-00	625.9	93.00
ES4484002	04-20-00	06-08-00	V70.0	346.00
FA6165301	09-06-00	09-28-00	V76.2	37.00
EY2390101	08-15-00	08-18-00	477.0	55.00
ES5676602	05-03-00	04-21-00	V70.0	576.00
			Total	$1,356.00

(16)	Policy Number	Effective Date	Rescission Date
	H57157644	03-24-00	09-18-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
ES0713701	04-10-00	04-24-00	382.9	$205.00
ES3967701	04-20-00	05-01-00	923.2	317.00
EY2618401	04-19-00	08-21-00	786.5	340.00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EY3113501	08-14-01	08-23-00	599.0	137.00
			Total	$999.00

(17) Policy Number: H57241754 Effective Date: 03-03-00 Rescission Date: 10-27-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
ET9525301	05-26-00	06-05-00	296.2	$55.00
EX1645801	07-21-00	07-31-00	296.2	55.00
EZ0966701	08-29-00	09-07-00	296.2	55.00
EW1557502	07-05-00	07-13-00	477.9	180.00
			Total	$345.00

(18) Policy Number: H57092506 Effective Date: 02-01-98 Rescission Date: 03-19-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DS5188001	11-12-98	11-30-98	V70.0	$226.00
BY4559001	02-20-98	03-02-98	V72.3	95.00
DX1161801	09-23-98	03-10-99	296.7	39.00
DW8618101	02-24-99	03-05-99	465.9	62.00
DR5049701	10-13-98	11-13-98	296.89	34.00
DR6538801	10-13-98	11-17-98	296.7	160.00
DU6455401	12-11-98	01-19-99	311.0	39.00
			Total	$655.00

(19) Policy Number: H57124393 Effective Date: 06-08-98 Rescission Date: 02-05-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
DL8681601	09-03-98	10-19-98	V20.2	$35.00

(20)	Policy Number	Effective Date	Rescission Date
	H57162939	03-19-99	10-12-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
ED4759101	04-13-99	07-29-99	918.1	$150.00

(21)	Policy Number	Effective Date	Rescission Date
	H57142460	10-12-98	10-28-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EE5005201	05-20-99	08-23-99	V76.2	$ 50.00

(22)	Policy Number	Effective Date	Rescission Date
	H57151582	10-12-98	11-04-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EA3765201	04-21-99	05-24-99	V72.3	$202.00
DY7230301	03-28-99	04-15-99	995.3	277.35
			Total	$479.35

(23)	Policy Number	Effective Date	Rescission Date
	H57108202	05-01-98	11-04-99

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EB0211701	05-04-99	06-04-99	620.2	$106.00
EW9825601	09-08-99	07-21-00	780.79	71.00
EB5541401	05-04-99	06-17-99	620.2	321.60
EB9829601	05-20-99	06-25-99	616.1	81.00
EC1006201	05-24-99	06-29-99	V71.8	321.60
EG5150001	05-07-99	10-05-99	614.0	92.00
EB0972801	05-03-99	06-08-99	625.9	88.00
EB9419701	05-24-99	06-29-99	621.3	106.00
			Total	$1,187.20

(24) Policy Number: H57168125 Effective Date: 12-20-98 Rescission Date: 01-10-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EE8984201	07-21-99	09-01-99	794.31	$30.00
EE6992001	07-21-99	08-26-99	971.2	631.00
EF3686301	08-17-99	09-13-99	V20.2	79.00
EQ3134001	12-01-99	03-16-00	723.5	150.00
EN4559701	12-22-99	02-09-00	725.0	80.00
EL5786801	11-23-99	12-31-99	723.5	80.00
			Total	$1,050.00

(25) Policy Number: H57219255 Effective Date: 08-18-99 Rescission Date: 01-24-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EG9968201	10-07-99	10-15-00	V048	$175.00

(26) Policy Number: H57173210 Effective Date: 04-15-99 Rescission Date: 03-08-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EP3321801	12-10-99	02-29-00	486.0	$33.00
FA2481901	03-07-00	09-20-00	789.0	105.00
EQ9346801	03-07-00	03-29-00	376.75	376.75
			Total	$514.75

(27) Policy Number: H57123022 Effective Date: 06-06-98 Rescission Date: 03-08-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EJ2925401	10-30-99	11-12-99	300.1	$40.00
EK0177901	11-17-99	11-30-99	311.0	$40.00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EJ1786201	11-02-99	11-10-99	311.0	$40.00
			Total	$120.00

(28)	Policy Number	Effective Date	Rescission Date
	H57255937	12-01-99	07-07-00

Claim Number	Date of Service	Date Received	ICD-9 Code	Amount
EN5113601	01-26-00	02-11-00	V761.2	$78.25

2. Small Employer Group Health Terminations

1. CMIC cancelled "all" of its small employer group health plans effective October 1, 2000, and then offered all the affected small employers the choice to enroll in one new plan being offered by CMIC. Cancellation of these eight plans affected 211 small employer groups.

The Cancellation letter sent to the affected small employers was dated June 26, 2000 and stated in part:

> Conseco Medical Insurance is canceling all small group major medical insurance plans **like yours** (emphasis added) in your state.
>
> Your Conseco Medical Insurance small group health insurance plan will terminate on October 1, 2000 at 12:00 A.M. local time.
>
> Your group has the option of obtaining new coverage under the small group major medical plan that Conseco is currently marketing in your state.
>
> This new coverage will be available on a guaranteed issue basis. It features a $5,000 per person calendar year deductible and a $5,000,000 per person lifetime maximum benefit. The cost for the new coverage will be based on all applicable risk factors permitted by your state.

Small Employer health insurance plans in Missouri must be guaranteed renewable, unless the carrier elects to non-renew ***all of its health benefit plans*** delivered or issued for delivery to small employers in Missouri.

In addition, the insurance carrier must give the DIFP and affected policyholders 180 days notice of its intent to cancel a small employer health plan. Also, a carrier that elects to non-renew ***a health benefit plan*** is prohibited from writing new business in the small employer market in Missouri for a period of five (5) years from the date of notice to the director.

Cancellation of the 211 Small Employer groups forced the affected employers to seek coverage elsewhere if they would not accept the new benefit plan with the increased cost offered by CMIC. The affected employers were restricted in their search for other coverage because CMIC failed to give them the required 180 notice of intent to cancel.
Reference: Section 379.938 and 379.940, RSMo

2. CMIC notified each Small Employer group with an effective date prior to July 1, 2000 that their plan would change to a $5,000 deductible effective on October 1, 2000. Also, these Small Employers were informed that a 50% premium increase would take effect on their first policy anniversary.

The only policy offered by CMIC to Small Employer groups with an effective date of July 1, 2000 or later was a $5,000 deductible plan at a premium rate 50% more than for those plans sold prior to July 1, 2000.

Under the circumstances, the affected Small Employers were left with no choice but to accept the new plan with a 50% increase in premium or seek health coverage for their employees from other carriers.

A Small Employer carrier that elects to non-renew ***a health benefit plan*** is prohibited from writing new business in the small employer market in Missouri for a period of five (5) years from the date of notice to the director.

Reference: 379.938 2., RSMo

Small Employer Group Terminations, Calendar Year 2001

Field Size:	14
Size of Sample:	Census
Number of Errors:	13
Error Rate:	93%
Within DIFP Guidelines:	No

Fourteen small employer group medical policies were terminated in 2001. The underwriting files in 13 of these cases were incomplete because the files did not contain enough documentation for the examiners to determine the reason the policies terminated.

Reference: 20 CSR 300-2.200 (2)

Policy Number	Policy Number
2006562001	MK8008011A
2006058001	MK8008450A
2007721001	MK8007718A
DK0051388A	MK8010624A
DK0029059P	CK8002353A
MK8007711A	MK8007789A
MK8007753A	

Small Employer Group Health Terminations, Calendar Year 2000

Field Size:	170
Sample Size:	50
Type if Sample:	Systematic
Number of Errors:	30
Error Rate:	60%
Within DIFP Guidelines:	No

The examiners reviewed 50 of the 170 small group medical policies that terminated in calendar year 2000. The underwriting files in 30 of the cases were incomplete because the files did not contain enough documentation for the examiners to determine the reason the policies terminated.

Reference: 20 CSR 300-2.200 (2)

Policy Number	Policy Number
2000220002	2004870001
2002048001	2004093002
2000867001	2004829001
2001712001	2003624001
2002535002	2006412001
2000765001	2002301001
2008240001	2004140001
2005401001	2001522001
2001937001	2007109001
2001931001	CK8001303A
2002071001	CK8006127A
2005978001	DK0088939A

Policy Number	Policy Number
2004967001	MK8006648A
2002445001	MK8007714A
2003580001	MK8010001A

3. Denied, Rejected on Cancelled

Field Size:	393
Sample Size:	25
Type of Sample:	Systematic
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

4. Non-taken/Free Looks

Field Size:	169
Sample Size:	50
Type of Sample:	Systematic
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

SECTION III

A. CLAIM PRACTICES

This section of the report details examination findings regarding Conseco Medical Insurance Company's claim practices. The examiners reviewed such practices to determine whether claims submitted to CMIC are efficiently processed and accurately paid, and for adherence to contract provisions, Missouri law and DIFP regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners reviewed a statistical sampling of the claims processed. A claim file, as a sampling unit, is defined as an individual demand or request for payment or action under an insurance contract. Benefits may or may not be payable under the contract when the request or demand is made.

The most appropriate statistic to measure compliance with Missouri law and DIFP regulations is the percentage of files found to be in error. A claim error includes, but is not limited to, any of the following:

- An unreasonable delay in the acknowledgement of a claim.
- An unreasonable delay in the investigation of a claim.
- An unreasonable delay in the payment or denial of a claim.
- A failure to calculate claim benefits correctly.
- A failure to comply with Missouri law regarding claim settlement practices.

A. Claims Time Studies

In order to determine the efficiency of claims processing, the examiners reviewed claim records and calculated the amount of time taken by the Company to: (1) acknowledge receipt of claims, (2) investigate claims, and (3) make payment or provide an explanation for the denial of claims.

DIFP regulations provide for the following time requirements in non-assigned claims processing:

- Acknowledgement of the notification of a claim must be made within 10 working days.
- Completion of the investigation of a claim must be made within 30 calendar days after notification of the claim.
- Payment or denial of a claim must be made within 15 working days after investigation of the claim is complete.

Missouri law provides for the following time requirements in assigned claims processing:

Upon receipt of an assignment of benefits made by the insured to a provider, the insurer is required to issue the instrument for payment of benefits for health services, within 30 days of receipt by the insurer of all documents reasonably needed to adjudicate the claim.

Following are the results of the time study reviews:

Paid Claims

1. **Paid Association Group Medical Claims**

Field Size:	55,339
Sample Size:	100
Type of Sample:	Computer Generated Random
Number of Errors:	7
Error Rate:	7%
Within DIFP Guidelines:	Yes

The examiners found seven errors in this assigned claims review.

Calendar Days	Number of Claims	Percent
0-30	93	93%
Over 30	7	7%
Total	100	100%

The Company failed to pay the following seven assigned claims within 30 days after receipt of all forms necessary to establish the nature and extent of the claims.

Reference: Section 376.427 2., RSMo and 20 CSR 100-1.300

Claim Number	Date Inv. Completed	Date Paid	Number of Days
FF3476402	12-29-00	01-31-01	33
FK6686401	03-14-01	05-07-01	54
FF8154301	01-17-01	03-21-01	63
FE5689601	12-15-00	01-23-01	39
FE9502601	12-21-00	02-02-01	43
FL9829603	04-16-01	08-27-01	133
FL2781901	03-30-01	04-30-01	31

2. Paid Small Employer Group Medical Claims

Field Size:	279
Sample Size:	50
Type of Sample:	Computer Generated Random
Number of Errors:	10
Error Rate:	20%
Within DIFP Guidelines:	No

The examiners found 10 errors in this assigned claims review.

Calendar Days	Number of Claims	Percent
0-30	40	80%
Over 30	10	20%
Total	50	100%

The Company failed to pay the following 10 assigned claims within thirty days after receipt of all forms necessary to establish the nature and extent of the claims.

Reference: Section 376.427 2., RSMo and 20 CSR 100-1.300

Claim Number	Date Inv. Completed	Date Paid	Number of Days
EV2378804	06-16-00	01-01-01	38
EQ5604502	03-24-01	08-16-01	145
EJ0717602	11-08-99	01-31-01	450
FF5401002	12-29-00	03-28-01	90
FH1840802	01-30-01	03-28-01	57
FF3353002	12-28-00	03-28-01	90
ES9546503	04-17-01	05-25-01	38
FG3793103	01-10-01	04-12-01	92
FE1027801	12-04-00	01-04-01	31
ET6386402	05-24-00	03-14-01	294

3. Paid Individual Medical Claims

Field Size:	69
Type of Sample:	Census
Number on Errors:	4
Error Rate:	6%
Within DIFP Guidelines:	Yes

The examiners found four errors in this assigned claims review.

Calendar Days	Number of Claims	Percent
0-30	65	94%
Over 30	4	6%
Total	69	100%

The Company failed to pay four assigned claims within 30 days after receipt of all forms necessary to establish the nature and extent of the claims.

Reference: Section 376.427 2., RSMo and 20 CSR 100-1.300

Claim Number	Date Inv. Completed	Date Paid	Number of Days
FK7902801	03-23-01	05-16-01	54
FS0211401	08-11-01	09-24-01	44
ET2700302	05-18-00	01-15-01	242
FQ6151101	07-18-01	09-07-01	51

Denied Claims

1. **Denied Association Group Medical Claims**

Field Size:	14,759
Sample Size:	100
Type of Sample:	Computer Generated Random

The examiners found five errors in the acknowledgement time studies.

Acknowledgement Time Studies

Working Days	Number of Claims	Percent
0-10	95	95%
Over 10	5	5%
Total	100	100%

The Company failed to acknowledge receipt of the following five claims within 10 working days after receiving notification of the claims.

Reference: 20 CSR 100-1.030 (1)

Claim Number	Date Claim Received	Date Claim Acknowledged	Working Days
FQ7300201	07-09-01	07-24-01	11
FX4088701	12-05-01	12-20-01	11
FF3361801	12-28-00	01-13-01	11
FN0122601	04-25-01	05-12-01	13
FP8988701	05-29-01	06-20-01	16

The examiners found no errors in the investigation time studies.

The examiners found four errors in the determination time studies.

Determination Time Studies

Working Days	Number of Claims	Percent
0-15	96	96%
Over 15	4	4%
Total	100	100%

The Company failed to deny four claims within 15 working days after receipt of all information necessary to establish the nature and extent of the claims.

Reference: 20 CSR 100-1.050

Claim Number	Date Inv. Complete	Date Claim Denied	Working Days
FE8831801	12-30-00	02-01-01	23
FV8431901	11-07-01	12-19-01	28
FG9497601	01-24-01	03-09-01	32
FG0305901	01-16-01	03-13-01	40

2. **Denied Small Group Medical Claims**

Field Size:	511
Sample Size:	50
Type of Sample:	Computer Generated Random

The examiners found seven errors in the acknowledgement time studies.

Acknowledgement Time Studies

Working Days	Number of Claims	Percent
0-10	43	86%
Over 10	7	14%
Total	50	100%

The Company failed to acknowledge receipt of the following seven claims within 10 working days after receiving notification of the claims.

Reference: 20 CSR 100-1.030 (1)

Claim Number	Date Claim Received	Date Claim Acknowledged	Working Days
FH6491601	01-31-01	02-15-01	11
FS0611301	07-24-01	08-09-01	12
FU7803701	10-02-01	10-20-01	13
FK0521301	02-21-01	03-14-01	15
FQ0942401	05-25-01	06-25-01	20
FH2644401	12-22-00	02-08-01	32
FF2008401	11-15-00	01-04-01	32

The examiners found no errors in the investigation time studies

The examiners found two errors in the determination time studies.

Determination Time Studies

Working Days	Number of Claims	Percent
0-15	48	96%
Over 15	2	4%
Total	100	100%

The Company failed to notify the first party claimants of the denial of the following two claims within 15 working days after receipt of all information necessary to establish the nature and extent of the claims.

Reference: 20 CSR 100-1.050

Claim Number	Date Inv. Complete	Date Claim Denied	Working Days
FQ0942401	05-25-01	06-25-01	20
FH2644401	12-22-00	02-08-01	32

3. **Denied Individual Medical Claims**

Field Size: 39
Type of Sample: Census

The examiners found three errors in the acknowledgement time studies.

Acknowledgement Time Studies

Working Days	Number of Claims	Percent
0-10	36	90%
Over 10	3	8%
Total	39	100%

The Company failed to acknowledge receipt of the following three claims within 10 working days after receiving notification of the claims.

Reference: 20 CSR 100-1.030 (1)

Claim Number	Date Claim Received	Date Claim Acknowledged	Working Days
FR9382701	07-27-01	08-13-01	11
FX1957301	12-07-01	12-26-01	11
FW3110901	11-15-01	12-06-01	13

The examiners found no errors in the investigation time studies.

The examiners found one error in the determination time studies.

Determination Time Studies

Working Days	Number of Claims	Percent
0-15	38	97%
Over 15	1	3%
Total	39	100%

The Company failed to deny the following claim within 15 working days after receipt of all information necessary to establish the nature and extent of the claim.

Reference: 20 CSR 100-1.050

Claim Number	Date Inv. Complete	Date Claim Denied	Working Days
FD2512101	12-09-00	01-18-01	27

B. Unfair Settlement

Missouri law requires an insurer and its agents to disclose to first party claimants all pertinent benefits, coverage or other provisions of an insurance contract under which a claim is presented. Also, the denial of a claim must be given to the claimant in writing and a copy of the denial must be maintained in the claim file.

Following are the results of this review:

Paid Claims

1. Paid Association Group Medical Claims

Field Size:	55,339
Sample Size:	100
Type of Sample:	Computer Generated Random
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

2. Paid Small Group Medical Claims

Field Size:	279
Sample Size:	50
Type of Sample:	Computer Generated Random
Number of errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

3. Paid Individual Medical Claims

Field Size:	69
Type of Sample:	Census
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

Denied Claims

1. Denied Association Group Medical Claims

Field Size:	14,759
Sample Size:	100
Type of Sample	Computer Generated Random
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

2. Denied Small Group Medical Claims

Field Size:	511
Sample Size:	50
Type of Sample:	Computer Generated Random
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

3. Denied Individual Medical Claims

Field Size:	39
Type of Sample:	Census
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

C. General Handling Practices

The examiners reviewed Company claim processing practices to determine adherence to its contract provisions and compliance with Missouri law and regulations.

Following are the results of this review:

Paid Claims

1. Paid Association Group Medical Claims

Field Size:	55,339
Sample Size:	100
Type of Sample:	Computer Generated Random
Number of Errors:	2
Error Rate:	2%
Within DIFP Guidelines:	Yes

The examiners found two errors in this review:

Interest at the rate of one percent per month is due on the following two claims because CMIC did not pay the claims within 45 days after receipt or send notice of receipt and the specific reason why additional time was needed to investigate the claims.

Reference: Section 376.383 2. & 3., RSMo

Claim Number	Date Received	Date Paid	Number of Days
FK6686401	03-14-01	05-07-01	54
FF8154301	02-02-01	03-21-01	47

2. Paid Small Group Medical Claims

Field Size:	279
Sample Size:	50
Type of Sample:	Computer Generated Random
Number of Errors:	9
Error Rate:	18%
Within DIFP Guidelines:	No

The examiners found nine errors in this review:

Interest at the rate of one percent per month is due on the following nine claims because CMIC did not pay the claims within 45 days after receipt or send notice of receipt and the specific reason why additional time was needed to investigate the claims.

Reference: Section 376.383 2. & 3., RSMo

Claim Number	Date Claim Received	Date of Payment	Number of Days
EV2378804	06-16-00	02-08-01	237
EQ5604502	03-24-01	08-16-01	145
FE0508901	12-05-00	01-22-01	48
FF5401002	12-29-00	03-28-01	89
FH1840802	01-30-01	03-28-01	57
FF3353002	12-28-00	03-28-01	90
ES6950902	05-08-00	03-06-01	302
FG3793103	01-10-01	04-12-01	92
ET6386402	05-24-00	03-14-01	294

3. **Paid Individual Medical Claims**

Field Size:	69
Type of Sample:	Census
Number of Errors:	3
Error Rate:	4%
Within DIFP Guidelines:	Yes

The examiners found three errors in this review:

Interest at the rate of one percent per month is due on the following three claims because CMIC did not pay the claims within 45 days after receipt or send notice of receipt and the specific reason why additional time was needed to investigate the claims.

Reference: Section 376.383 2. & 3., RSMo

Claim Number	Date Claim Received	Date of Payment	Number of Days
FK7902801	03-23-01	05-16-01	54
FS0211401	08-03-01	09-24-01	52
FQ6151101	07-02-01	09-07-01	67

Denied Claims

1. **Denied Association Group Medical Claims**

Field Size:	14,759
Size of Sample:	100
Type of Sample:	Computer Generated Random
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

2. **Denied Small Group Medical Claims**

Field Size:	511
Sample Size:	50
Type of Sample:	Computer Generated Random
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

3. **Denied Individual Medical Claims**

Field Size:	39
Type of Sample:	Census
Number of Errors:	0
Within DIFP Guidelines:	Yes

The examiners found no errors in this review.

D. Target Claims Review

The examiners and CMIC performed a targeted claims review to determine if the Company claims paying procedures were in compliance with Missouri's mandated coverage laws. CMIC claim denial codes, Current Procedural Terminology Codes (CPT Codes), and International Classification of Diseases Codes (ICD-9 Codes) were used as the selection criteria.

A large number of the claims reviewed were claims that had been denied under Major Medical Expense Certificate GHC-8783. This certificate has a 12-month waiting period before benefits are payable for in-network preventive services, and coverage is limited to a $200 annual maximum benefit. Out of network preventive services are not covered under this plan.

1. Complication of Pregnancy Claims

In Missouri, claims for complications of pregnancy must be covered the same as any other illness.

Reference: Section 375.995 4. (6), RSMo

Five hundred 42 claims for complication of pregnancy were selected for review from claims adjudicated in calendar years 1999, 2000 and 2001. CMIC deleted 118 of these claims from the field because the certificates were not in-force at the time of service.

During the targeted review CMIC reopened and paid 36 of the 424 remaining claims totaling $10,835 in benefits plus interest of $2,361. The benefits on an additional six claims were applied to the certificate deductibles or coinsurance. The Company maintained its denial of the remaining 382 claims.

The examiners requested that CMIC reconsider the remainder of the denials based on ICD-9 Codes 630 through 677, excluding claims with code 650, which is the code used for normal delivery.

The Company continues to maintain its denial of these claims stating that; "...the policy contains a definition of complication of pregnancy. All claims are handled in accordance with policy language."

Complication of pregnancy is defined in Certificate form number GHC-8783 as follows:

Complications of Pregnancy means:

1. when pregnancy is not terminated; conditions that require medical treatment, whose diagnoses are distinct from pregnancy but are adversely affected by or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and eclampsia, puerperal infection, R.H. Factor problems, severe loss of blood requiring transfusion and other severe conditions related to pregnancy.

2. when pregnancy is terminated; non-elective caesarian section; ectopic pregnancy that is terminated; and spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.

   Complications of pregnancy will **not** include false labor, occasional spotting; doctor prescribed rest during the period of pregnancy and morning sickness.

Delivery by caesarian section is considered a complication of pregnancy if the caesarian section is non-elective. A caesarian section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness, or Injury if a caesarian section is not performed. A caesarian section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal deliver is attempted but discontinued due to immediate danger of death, Sickness, or Injury to the child or mother.

As a result of the refusal by the Company to reconsider these claims the examiners reviewed all of the claims in question. The review was performed using the Certificate definition of complication of pregnancy and the ICD-9 codes identified above. After reviewing these claims, the examiners concluded that the conditions described in 202 of the claims meet the Certificate definition and fall within the respective ICD-9 codes for complications of pregnancy. The 202 claims that were denied included the following diagnosis:

ICD-9 Code	Description of Code
631	Other Abnormal product of conception
632	Missed Abortion
633.9	Unspecific ectopic pregnancy
634.9	Spontaneous abortion without mention of complication
635.9	Legally induced abortion without mention of complication. (Note: this claim also included ICD-9 codes of 655.83 and 658.03)
640.0	Threatened Abortion
640.9	Unspecified Hemorrhage in early pregnancy
641.9	Unspecified Antepartum Hemorrhage
642.3	Transient hypertension of pregnancy
642.9	Unspecified hypertension complicating pregnancy, childbirth or the puerperium
643.0	Mild hyperemesis gravidarum
644.0	Threatened premature labor
646.6	Infection of genitourinary tract in pregnancy
646.8	Other specified complication of pregnancy (example: fatigue during pregnancy; herpes gestationis; Insufficient weight gain; and uterine size-date discrepancy)
646.9	Unspecified complication of pregnancy
648.0	Diabetes mellitus
648.4	Mental disorders

ICD-9 Code	Description of Code
648.8	Abnormal glucose tolerance
654.2	Previous cesarean delivery (uterine scar from previous cesarean)
654.5	Cervical incompetence
655.7	Decreased fetal movements
655.8	Other known or suspected fetal abnormality, not elsewhere specified. (Suspected damage to fetus from: environmental toxins; or intrauterine contraceptive device.)
655.9	Unspecified
656.1	Rhesus isoimmunization (Anti-D [Rh] antibodies; or Rh incompatibility
656.3	Fetal distress
656.5	Poor fetal growth
656.6	Excessive fetal growth
656.9	Unspecified fetal and placental problem
658.0	Oligohydramnios
658.1	Premature rupture of membranes
659.5	Elderly primigravida
659.6	Elderly multigravida
660.6	Failed trial of labor, unspecified
661.0	Primary uterine inertia
661.3	Precipitate labor
663.3	Other and unspecified cord entanglement without mention of compression
664.0	First-degree perineal laceration
664.2	Third-degree perineal laceration
664.4	Unspecified perineal laceration
666.1	Other immediate postpartum hemorrhage
669.5	Forceps or vacuum extractor delivery without mention of indication
669.70	Cesarean delivery without mention of indication
648.93	Antepartum condition or complication
652.9	Unspecified malposition or malpresentation
641.03	Placenta previa without hemorrhage
642.00	Benign essential hypertension complicating pregnancy, childbirth and the puerperium
642.4	Mild or unspecified pre-eclampsia
644.1	Other threatened labor
644.2	Early onset of delivery
645.1	Post term pregnancy

ICD-9 Code	Description of Code
646.1	Edema or excessive weight gain in pregnancy, without mention of hypertension
648.2	Anemia
648.9	Other current conditions classifiable elsewhere
654.1	Tumors of body of uterus
659.7	Abnormality in fetal heart rate or rhythm
663.11	Cord around neck, with compression (cord tightly around neck)
663.6	Vascular lesions of cord
664.8	Other specified trauma to perineum and vulva
664.11	Second-degree perineal laceration
674.84	Other: (Hepatorenal syndrome, following delivery. Postpartum: cardiomyopathy, subinvolution of uterus, uterine hypertrophy, puerperal, postpartum, childbirth cardiac thrombosis)

When informed of the examiners findings the Company again refused to reconsider these denied complication of pregnancy claims. CMIC based its position on the allegation that the DIFP had misinterpreted the ICD-9 Codes and Missouri law, specifically section 375.995 4. (6), RSMo.

Subsequent to this review the examiners again recommended that CMIC reconsider the remaining denied complication of pregnancy claims. The Company did reopen and pay seven claims totaling $8,755 in benefits. Benefits were applied to the certificate deductibles on three claims. CMIC failed to pay interest on these seven claims as required by Missouri law.

Reference: Section 376.383 and 375.995 4. (6), RSMo

The examiners found that 12 denied complications of pregnancy claims the examiners repeatedly asked CMIC to reconsider for benefits, were actually paid in 1999 and 2000. *This indicates that CMIC did not re-review these 12 claims when repeatedly requested to do so by the examiners.*

The officers, directors, employees and agents of the Company failed to facilitate the examination and aid in the examination so far as it was in their power to do so.

Reference: Section 374.205 2. (2), RSMo

CMIC failed to provide any documentation to support its continued denial of the following 190 complications of pregnancy claims, even though the examiners repeatedly requested such documentation.

Under the circumstances, the following claims appear to be payable based on the Certificate of coverage definition of complications of pregnancy, as well as the applicable ICD-9 Codes and Missouri law.

Reference: Section 375.995 4. (6), RSMo

Certificate Number	Claim Number	Date of Service	Claim Amount
H57147251	D-N32508-02	08-03-98	$ 350.00
H52155002	F-A13894-01	09-07-00	5.00
H57192802	F-E50196-01	10-16-00	154.60
H57192802	F-C92519-01	10-22-00	1,672.46
H57143308	E-A99797-01	04-02-99	$ 4,215.35
H57143308	E-A73268-01	03-30-99	1,414.00
H57170343	E-Q04542-01	07-07-99	138.00
H57170343	E-D54274-02	07-07-99	159.00
H57151212	E-H40336-01	09-28-99	5,485.89
H57151212	E-K62013-01	09-29-99	8.50
H57151212	E-T48328-01	03-17-99	150.00
H57053548	E-B87090-01	05-13-99	3,841.15
H57189961	E-W56074-01	07-13-00	30.15
H57189961	F-B86111-01	10-14-00	3,216.04
H57189961	F-B78168-0 1	10-13-00	148.38
H57163203	E-Z25784-01	05-05-00	137.00
H57017859	E-A50758-01	04-21-99	728.00
H57017859	E-B68116-01	04-21-99	5,265.20
H57017859	E-B34602-01	02-15-99	2,148.90
H57017859	E-H19527-01	03-08-99	34.00
H57017859	E-A51913-01	04-16-99	277.00
H57017859	D-Z06166-01	04-01-99	210.00
H57017859	D-Z20231-01	04-01-99	105.00
H57017859	D-Y84886-01	03-26-99	105.00
H57017859	D-Y85005-01	03-29-99	105.00
H57017859	E-C19781-01	02-24-99	170.00
H57269087	E-X90765-01	08-08-00	242.00
H57125301	E-D35614-01	07-26-99	200.00
H57125301	D-W66365-01	06-26-98	380.00
H57104321	D-X93927-01	01-19-99	345.00
H57104321	D-X11449-01	01-19-99	1,338.00
H57030571	D-U33203-01	11-04-98	280.00
H57227197	E-U01088-01	12-22-99	61.75
H57265157	E-T81144-01	03-28-00	218.00
H57040049	E-E21196-02	08-05-99	598.25
H57040049	E-E98511-02	08-25-99	135.14
H57040049	E-H65339-01	09-23-99	2,698.98

Certificate Number	Claim Number	Date of Service	Claim Amount
H57040049	E-J34150-01	10-20-99	40.00
MK8007192A	E-Q57112-01	01-14-00	4.00
MK8007192A	E-J81841-01	08-10-99	131.96
H57053409	E-N22826-01	11-11-99	7,869.76
H57053409	E-N57949-01	11-10-99	247.00
H57053409	E-N57950-01	11-12-99	1,401.00
H52022628	E-D36684-01	01-20-99	2,050.70
H52022628	E-T47945-01	01-20-99	1,975.70
H57275409	F-D79431-01	11-22-00	260.00
H57275409	E-Y71334-01	08-10-00	$ 125.00
H57014049	E-N61884-01	01-21-00	409.00
H52134789	F-B66672-01	08-17-00	66.00
H57014049	E-K32778-01	11-30-99	93.00
H57107460	E-P94223-01	01-03-00	3,167.64
H57279702	E-X21884-01	07-13-00	50.00
H57187968	E-M31359-01	01-03-00	200.00
H57187968	E-R72786-01	03-28-00	135.00
H57073569	E-F51105-01	09-01-99	452.00
H57188435	E-G70882-01	09-01-99	806.00
H57263709	E-W49863-01	07-05-00	122.00
H57263709	E-X22000-01	07-06-00	300.00
H57134781	E-M85438-01	11-30-99	17.20
H57134781	E-M15158-01	11-30-99	116.00
H57134781	E-P32599-01	10-26-99	356.95
H57134781	E-N01185-01	10-26-99	5.50
H57134781	E-R04594-01	07-02-99	131.96
H52011346	E-C85755-01	07-08-99	38.70
H57115101	E-G02213-01	04-25-99	27.00
H57192691	E-G33221-01	08-25-99	245.00
H57192691	E-K25006-01	10-29-99	2,650.00
H57058448	E-T47929-01	05-14-98	7,603.73
H57161590	D-Z19876-01	04-12-99	65.00
H57200167	F-D51071-01	11-01-00	682.00
H57200167	F-D67395-01	11-01-00	9,012.30
H57200167	E-P14761-01	01-01-00	363.00
H57200167	E-P02706-01	01-01-00	197.00
H57039588	D-W39374-01	12-22-98	20.70
H57039588	D-W05006-02	01-04-99	89.00
H57039588	E-B79076-01	01-04-99	25.50
H57039588	D-W04816-01	01-14-99	147.00
H57039588	E-E24389-01	01-18-99	225.00
H57039588	D-X60805-01	02-08-99	75.00

Certificate Number	Claim Number	Date of Service	Claim Amount
H57039588	D-W96725-01	02-09-99	2,600.00
H57039588	D-X88884-01	02-09-99	780.00
H57146134	E-Z99308-02	07-14-00	2,800.00
H57146134	E-S57835-01	12-06-99	270.00
H57176741	E-Z73332-01	09-11-00	48.00
H57170122	E-M35131-01	10-27-99	3,132.73
H57169873	E-U95327-01	05-23-00	150.00
H57037694	D-T56021-01	11-23-98	132.55
H57037694	D-T56033-01	12-01-98	4,982.69
H57130483	F-A40690-01	08-22-00	$ 562.91
H57130483	E-Y75392-01	08-23-00	175.00
H57110189	E-V63754-01	06-07-00	364.00
H57110189	E-Z46243-01	08-18-00	2,020.75
H57110189	F-A67289-01	09-01-00	300.00
H57110189	F-B19712-01	09-08-00	150.00
H57110189	F-B19713-01	09-12-00	150.00
H57110189	F-B46439-01	09-29-00	150.00
H57110189	F-C34450-01	10-02-00	150.00
H57110189	F-D08186-01	10-06-00	150.00
H57110189	F-D08187-01	10-09-00	150.00
H57110189	F-D08171-01	10-13-00	300.00
H57110189	F-D55965-01	10-20-00	150.00
H57110189	F-D55966-01	10-23-00	150.00
H57110189	F-D10611-01	10-24-00	6,035.50
H57283085	F-C96679-01	11-02-00	429.00
H52016120	E-T48305-01	08-26-98	4,853.15
H57169282	E-Z85760-01	09-26-00	424.00
H57012979	D-U88232-01	01-04-99	31.59
H57157163	E-G81067-01	09-13-99	215.00
H57157163	E-G30956-01	09-13-99	1,870.01
H52139989	F-C84726-01	10-16-00	6,086.25
H57126182	E-Z17677-01	10-20-99	86.00
H57157214	E-P80675-01	02-10-00	60.00
H57157214	E-Q44193-01	03-03-00	518.00
H57157214	E-R16154-01	03-06-00	420.00
H57195363	E-N98698-01	02-08-00	4,994.00
H57195363	E-F46292-01	08-24-99	185.00
H57130483	E-W96848-01	06-01-00	966.00
H57130483	E-V98143-01	06-01-00	850.00
H57130483	E-Y93832-01	08-08-00	43.00
H57130483	E-Z14981-01	08-22-00	200.00
C-K8006953A	E-K04458-01	07-29-98	277.79

Certificate Number	Claim Number	Date of Service	Claim Amount
H57234847	E-Z40979-01	08-15-00	1,713.00
H57234847	F-B46503-01	08-25-00	2,200.00
H57234847	E-Z37052-01	08-25-00	12,432.50
H57234847	E-M69991-01	01-11-00	210.00
H57188682	E-F83846-01	07-23-99	1,450.00
H57188682	E-P88541-01	07-23-99	145.00
H57109989	D-Y38583-01	03-04-99	125.00
H57109989	E-E01806-01	07-28-99	1,870.39
H57114732	E-M28802-02	11-13-99	478.50
H52127609	E-Y86832-01	06-27-00	$180.00
H52127609	E-X48679-01	06-28-00	200.00
H52127609	E-W96822-01	06-29-00	5,057.00
H57187193	F-B81137-01	09-19-00	2,911.00
H57187193	F-B19700-01	09-19-00	840.00
H57187193	F-B75214-01	09-19-00	10,058.25
H57269149	F-B48251-01	09-25-00	2,291.80
H57124903	E-G86583-01	09-27-99	573.00
H57194942	F-D34255-01	07-25-00	5,540.90
H57019939	D-U07392-01	08-13-98	2,081.15
H57094289	D-V73897-01	12-23-98	2,976.10
H57094289	D-W15684-01	01-03-99	34.00
H57094289	E-B21771-01	05-21-99	42.00
H57358426	F-D68243-01	11-07-00	221.00
H57143047	D-W44917-01	10-04-98	191.00
H57184416	E-D26817-01	06-22-99	15.00
H57184416	E-C99743-01	06-24-99	185.00
H57115374	E-V68648-01	05-16-00	17.00
H57115374	E-V09597-01	05-26-00	77.00
H57103715	D-T97705-01	11-16-98	4,182.17
H57103715	D-U43968-01	11-16-98	650.00
H57129271	D-X39504-01	12-19-98	537.00
H57113509	D-U01200-01	12-08-98	2,500.00
H57175528	E-U45204-01	04-11-00	177.00
H57175528	E-T03799-01	04-11-00	533.00
H57175528	E-U54699-01	04-14-00	222.75
H57067688	D-X92383-01	03-19-98	180.00
H57042889	E-F22891-01	08-26-99	4,274.97
H57042889	E-G21034-01	08-26-99	285.00
H57157836	E-U76290-01	06-01-00	10.00
H57157836	E-U51347-01	05-24-00	110.00
H57157836	E-P02414-01	02-01-00	20.00
H57157836	E-N53142-01	01-18-00	10.00

Certificate Number	Claim Number	Date of Service	Claim Amount
H57157836	F-E19827-01	01-12-00	243.00
H52009257	E-H50292-01	09-20-99	3,313.23
H57099227	E-M87518-01	12-10-99	177.72
H57202836	E-V74425-01	06-09-00	113.86
H57062831	D-U70178-01	11-16-98	55.00
H57268909	E-T88487-01	04-30-00	1,533.06
H57268909	E-Y87633-01	04-30-00	29.10
H57209162	E-V78060-01	06-21-00	30.00
H57206361	E-J47310-01	10-27-99	113.00
H57172775	E-V56924-01	06-04-00	$ 3,798.95
H57105570	E-X24849-01	07-05-00	56.50
H57015911	E-G97062-01	11-12-98	204.00
H57183602	E-T98764-01	05-08-00	2,500.00
H57183602	E-L55822-01	12-20-99	225.00
H57301211	E-X30769-01	06-15-00	100.00
H57301211	E-W35081-01	06-15-00	123.00
H57154226	D-W11079-01	01-26-99	61.00
H57154226	D-X30194-01	02-23-99	61.00
H57075969	F-D12290-01	08-02-00	379.00
H57075969	F-B07264-01	10-09-00	255.00
H57075969	F-E24292-01	10-18-00	294.00
H57075969	F-E50220-01	10-24-00	5,608.30
H57100830	E-W96852-01	06-30-00	3,036.18
H57100830	E-P58181-01	02-02-00	175.00
H57181634	E-Z80266-01	09-04-00	328.00
H57235411	E-V31596-01	06-01-00	9,000.05
H57150658	F-C88756-01	11-01-00	167.00

2. Preventive Care Claims

Missouri law requires that all health plans issued, continued or renewed on or after August 28, 1999 must provide coverage for pelvic examinations, pap smears, prostate examinations, colorectal examinations and laboratory tests.

The coverage and benefits related to these examinations and tests must be *at least* as favorable and subject to the same dollar limits, deductible, and co-payments as other covered benefits or services. American Cancer Society Guidelines were also applied in this review.

Reference: Section 376.1250, RSMo

During this claims review the Company reopened and paid 677 pelvic, pap smear, colorectal and prostate (PSA) claims, totaling $35,037 in benefits plus interest of $10,381. Benefits for an additional 136 claims were applied to the certificate deductibles or coinsurance.

The examiners found no additional errors in this portion of the claims review performed by CMIC.

3. **Immunization Claims**

Missouri law requires all managed health care delivery entities of any type or description to provide coverage for immunizations of a child from birth to five years of age, as provided by department of health regulations. Such coverage must not be subject to any deductible or co-payment limits.
Reference: Section 376.1215, RSMo

During the target claims review the Company reopened and paid 184 immunization claims totaling $17,286 in benefits plus interest of $4,263.

In regard to the following eight claims:

1. The examiners performed an audit of the immunization claims review conducted by CMIC. The examiners found eight claims in this audit that were initially denied because ..."preventive benefits paid after the first 12 months of coverage." When questioned CMIC provided verification that the claims were initially denied but were reopened and paid at a later date.

2. Major Medical Expense Certificate GHC-8783 has a 12-month waiting period before benefits are payable, and a $200 maximum annual benefit. Out of network preventive services are not covered under this plan. The certificate has a Missouri Amendment that is in compliance with the Missouri immunization law but it appears that CMIC chose to ignore this Contract Amendment.

3. The foregoing indicates that CMIC knew or should have known that it had been improperly adjudicating Missouri immunization claims as early as 2001. Under the circumstances, CMIC failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims.

References: Section 376.1215, 375.1005, 375.1007 (3), (4) and (6), RSMo

Policy Number	Claim Number	Date Initially Denied	Claim Number	Reopened and Paid
H52141582	FE8701802	01-05-01	FE8701803	02-06-01
H57347421	FL4883102	04-20-01	FL4883104	05-08-01

Policy Number	Claim Number	Date Initially Denied	Claim Number	Reopened and Paid
H57316802	FG0478701	01-22-01	FG0478701	02-05-01
H57259437	FL3729902	04-10-01	FL3729904	04-19-01
H57291919	FH4454401	02-06-01	FG2818202	02-19-01
H57189961	FF0422101	01-08-01	FF0422102	03-16-01
H57344222	FF9356602	01-17-01	FF9356603	02-20-01
H52119289	FJ2716901	03-01-01	FJ2716902	03-07-01

During an audit of the claims review performed by CMIC the examiners found the following six childhood immunization claims that were payable. It appears that CMIC chose to ignore the immunization Contract Amendment mentioned above.

Under the circumstances, CMIC failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims.

References: Section 376.1215, 375.1005, 375.1007 (3), (4) and (6), RSMo

Claim Number	Date Initially Denied	Date Reopened and Paid	Under Payment
FG10414	01-22-01	08-29-02	210.00
FL83360	03-15-01	08-29-02	99.00
FN97999	06-05-01	08-29-02	91.42
FJ27016	03-26-01	08-29-02	208.60
FG00597	01-19-01	08-28-02	42.53
FG17036	02-12-01	07-19-02	208.00

These claims were paid during the examination.

4. Emergency Room Claims

Under Missouri law a health carrier must cover emergency services necessary to screen and stabilize an enrollee and cannot require prior authorization for such services.

Reference: Section 376.1367, RSMo

On June 28, 2002 the examiners requested that CMIC re-review all emergency room claims denied in 1999, 2000 and 2001 and if the Company maintained its denial of any of these claims to provide paper copies of the claim files and related explanation of benefits for the examiners review.

During the targeted claims review the Company advised that it reviewed 192 emergency room claims adjudicated in 1999, 2000 and 2001.

One claim was reopened and benefits were credited to the certificate deductible.

The examiners performed an audit of the emergency room claims review conducted by CMIC. The examiners found that the following claims should have been paid in 2001 when the claims were initially received by CMIC.

Reference: Section 376.1367, RSMo

Claim Number	Initially Denied	Date Reopened	Amount Credited to Deductible
FK3271801	04-20-01	08-22-02	$77.00
FP7241101	06-25-01	08-22-02	77.00
FS6703601	11-01-01	08-22-02	175.00
FF7322001	01-17-01	08-26-02	109.00
FL2402001	05-10-01	08-22-02	163.00

The above claims were reopened and benefits were credited to the certificate deductibles during the examination.

The Company refused to provide paper copies of the claim files and explanation of benefits to support its denial of the remaining 1999, 2000 and 2001 emergency room claims.

Under the circumstances, the officers, directors, employees and agents of the Company failed to facilitate and aid in the examination so far as it was in their power to do so.

Reference: Section 374.205 2. (2), RSMo

CMIC did provide worksheets for the claims that gave the reasons for the denials. The various reasons given were:

Expenses excluded by rider excepting risk,
Pre-existing condition not covered,
Pre-existing investigation,
Claim suspended for medical records, and
Waiting on claim form.

On December 13, 2002 the examiners again asked CMIC to reconsider the denials and provide copies of all explanations of benefits. Also, in any case where CMIC maintained its denial of the claim CMIC was requested to provide

the complete claim file and all documentation to support the Company's position. CMIC again failed to provide any documentation to support its continued denial of these claims.

The Company disagreed with the examiners interpretation of Section 376.1367, RSMo but did agree that some of the claims were payable and agreed to re-review the denied claims.

Reference: Section 376.1367, RSMo

On April 1, 2003 CMIC reopened and paid 13 emergency room claims, totaling $1,130.86 in benefits. Benefits for an additional 17 claims were applied to the certificate deductibles/coinsurance.

CMIC did not pay any interest on the 13 claims, but sent letters to the claimants stating that any interest due would be paid by separate check.

The Company maintained its denial of the following four emergency room claims but did not provide documentation to support its position. These claims should be reopened and properly adjudicated or the Company should provide documentation to support its position.

Reference: Section 376.1367, RSMo

Certificate Number	Claim Number	Date of Service	Reason Claim Denied
MK8008459A	E-E05951-01	06-06-99	Dental, not emergency
H57191556	E-A26893-01	03-28-99	Need medical records
H57088269	D-V29779-01	03-10-98	Only one service of this type can be billed per day
H57158298	F-L96988-01	05-18-00	Expenses excluded by rider; does not meet ER test

According to the explanation of benefits the following emergency room claim was denied, "Well benefit allowed only for in network providers." The worksheet provided with the denied claim states "...appears to be a routine exam in er."

Because the claim is illegible the examiners could not make a determination whether the service provided was for emergency services or for a routine preventive examination. If the service provided was for a wellness examination the claim for preventive services would be payable under Missouri law. This claim should be reopened and properly adjudicated. Also, legible documentation should be provided to support the Company's position.

Reference: Section 376.1250, 376.1367, RSMo and 20 CSR 300-2.200 (2)(A)

Certificate Number	Claim Number	Date of Service
H57190187	E-Q25142-01	02-14-00

According to the explanation of benefits, the following emergency room claim was denied, "Mental nervous benefit, we have considered maximum benefits payable." The worksheet provided with the denied claim states, "...we have er record-indicates 28y/o female presents at noon on a Friday-drove herself to and from home; nothing in notes to indicate an emergent situation."

The claim file indicates that the claimant was suffering from depressive disorder.

Reference: Section 376.1367, RSMo

Certificate Number	Claim Number	Date of Service
H57070926	D-V90786-01	01-22-99

According to the worksheet provided, benefits on the following claims were either paid or applied to the certificate deductibles. CMIC failed to provide the explanation of benefit forms or any other documentation with the claims to support this statement, consequently the examiners could not verify that the claims were paid.

Reference: 20 CSR 300-2.200 (2)(A)

Certificate Number	Claim Number	Date of Service	Worksheet Explanation
H57146888	E-Q32458-01	05-27-99	Paid under E-J7720302
H57195529	F-K90996-01	03-11-01	Paid on 07-31-02
H57315103	F-L52552-01	01-18-01	Paid on 04-25-01
H57368606	F-S67036-01	07-24-01	Applied to ded 08-21-02

4. Adjudicated Out of Network Claims

The examiners selected 50 claims for review from a field of 5329 claims that were adjudicated as out of network in calendar year 2000. This review was performed because 17 grievances were filed against CMIC for paying claim benefits as out of network when in-network benefits should have been paid.

The examiners found 50 errors in this review.

The following claims were paid without any indication on the Explanation of Benefits that out of network penalty co-payment/deductible amounts were applied when determining benefits. This appears to be a standard business practice of CMIC.

References: Section 375.1005, 375.1007 (10), RSMo & 20 CSR 100-1.020 (1)

Certificate Number	Claim Number	Date Processed
H52016327	EV5872801	07-14-00
H52120622	ET3904501	06-09-00
H52123401	EU3283002	10-11-00
H57006769	ET1373501	06-02-00
H57049291	EZ8773501	10-06-00
H57051318	EY3857001	08-30-00
H57058201	EW7571101	08-10-00
H57058787	FA1726901	10-09-00
H57075809	FD5428901	12-04-00
H57090369	FB9832501	11-09-00
H57090369	FD2165001	11-28-00
H57105784	EY4984001	09-21-00
H57108322	ET0583102	08-11-00
H57108666	EW2317501	08-08-00
H57110349	EY4662902	10-06-00
H57113983	EW2051001	08-02-00
H57118144	FB2450101	10-20-00
H57119731	EW7962401	08-01-00
H57126023	FD7627704	12-21-00
H57143514	EV2524401	07-17-00
H57145062	EX7879801	08-21-00
H57155134	EV9881301	08-11-00
H57157214	FC4947601	11-15-00
H57166762	EV5702501	07-18-00
H57191971	FE9202801	12-28-00
H57192695	EZ2444801	09-21-00
H57193979	EW1474601	08-04-00
H57194963	FB5093602	11-01-00
H57197561	EX7815601	08-31-00
H57197754	FA4999801	10-09-00
H57198802	FC3732401	11-09-00
DK0077773A	EY6915402	10-16-00
H57208555	FA4065201	10-05-00
H57214958	EZ7314201	09-26-00
H57219483	EX4616101	08-23-00
H57229531	EV9962201	08-04-00

Certificate Number	Claim Number	Date Processed
H57229531	EZ6678201	10-10-00
H57231617	EW9894001	08-04-00
H57235131	FC1466701	11-07-00
H57247696	EY6125401	10-09-00
H57247696	FA1063801	10-11-00
H57250003	FA2015501	10-03-00
H57250863	EY5625401	09-18-00
H57253337	EU9548001	07-27-00
H57254751	FA5777001	10-25-00
H57258723	FB0406201	10-30-00
H57285862	EW3919501	07-25-00
H57289840	EZ6749201	10-09-00
H57298523	FB9276302	11-30-00
H57316342	FD3233401	12-27-00

SECTION IV

IV. MANAGED CARE

1. CMIC does not perform any internal or external reviews of the operations of the third party administrators (TPA) it uses.

In cases where a TPA administers benefits for more than one hundred certificate holders on behalf of an insurer, Missouri law requires that the insurer shall, at least sem-annually, conduct a review of the operations of the administrator, and at least one such review shall be an on-site audit of the operations of the administrator.

Reference: Section 376.1084 2. & 3., RSMo

Administrators used by CMIC

Kanawha Benefit Services, Inc.
Health Plan Administrators, Inc.
Express Scripts, Inc.

2. The medical director that administers the Utilization Review program and oversees the review decisions for the PPO plans covering Missouri residents is not licensed as a physician in Missouri.

Reference: Section 376.1361 2., RSMo

3. The Company does not include "other enrollees" in its second level grievance advisory panel.

Reference: Section 376.1385, RSMo

SECTION V

IV. GRIEVANCES/COMPLAINTS

This section of the report details the examination findings regarding managed care requirements for grievances. Missouri law requires health carriers who market managed care products to maintain a register of all grievances received by the Company, and to retain the documentation on the handling of these cases. The examiners reviewed a total of 180 grievances/complaints submitted directly to the Company or through the DIFP from January 1, 1999, to December 31, 2002.

The examiners found the following errors in this review:

1. The Company failed to notify the plan enrollees, the enrollee's representative or the provider acting on behalf of the enrollees of their right to file an appeal in the following nine cases.

Reference: Sections 376.1382 and 376.1385, RSMo

Policy/Certificate	Policy/Certificate
H57132760	H57104301
H57138882	H57273715
H57144682	H36937687
H57110420	H57061051
H57162763	

2. Two grievances were filed against the Company because it denied claims for Preventive Services. Missouri law requires that all health plans issued, continued or renewed on or after August 28, 1999 must provide coverage for pelvic examinations, pap smears, prostate examinations, colorectal examinations and laboratory tests. The coverage and benefits related to these examinations and tests must be *at least* as favorable and subject to the same dollar limits, deductible, and co-payments as other covered benefits or services. Further, all health plans issued, delivered, continued or renewed after August 28, 1991 must provide benefits for low dose mammography screening.

These two claims were denied because the certificates issued under plan GHC-8783 improperly contain a 12-month in-network waiting period and a $200 annual maximum benefit for in-network preventive services. Out of network preventive services are *not* covered under this plan. In addition, the examiners found that the certificate schedule page is misleading because it does not disclose the 12-month waiting period for in-network preventive services.

Reference: Sections 376.1250 and 376.782, RSMo

Policy/ Certificate	Claim Number	Service Date	Underpaid Payment	Interest Paid
H67004050	F-P09851-01	03-15-01	$145.00	$15.95
H52156701	F-G03336-01	12-11-00	$ 61.00	$ 8.17

The above claims were reopened and paid during the examination.

3. The following grievance was filed because benefits for services provided on August 27 and 29, 2000, were reduced for non-compliance with pre-certification requirements.

The insured was injured in an auto accident while intoxicated and was admitted to the hospital from the emergency room. The Company would not certify the hospital stay because it said that claims for intoxication were excluded under the policy. The insured explained to CMIC that injuries from intoxication were not excluded on his policy. The Company ultimately certified the hospital stay but paid benefits as out of network which resulted in an underpayment of $500.

Reference: Section 376.1361 13, RSMo

Policy/Certificate	Underpayment	Interest Paid
H57218317	$500.00	$69.83

The claim was reopened and paid during the examination.

4. The following grievance file is incomplete because the second page of the consumer complaint is not in the file.

Reference: 20 CSR 300-2.200 (2) & (3)(D)

DIFP Number	Policy/Certificate
99K00517	H57176511

5. The following three grievances were not recorded on the Company grievance or complaint registers. CMIC failed to keep a record of all grievances it received for a period of not less than three years.

Reference: Section 376.1375 and 375.936 (3), RSMo

Policy/Certificate	Grievance Received
2001455000	07-23-99
H57173210	03-30-00
H57275307	04-17-00

6. The following grievance involved the issue of a policy with an attached amendment (offer by CMIC) dated February 16, 2001, that had to be signed and returned to CMIC within 30 days (acceptance by applicant), or the policy would be null and void. The applicant *did not* sign and return the amendment, and notified CMIC by FAX on March 1 to *refund the initial premium.*

However, instead of refunding the initial premium CMIC placed the policy in force and withdrew two additional premiums from the complainant's checking account.

The Company response to the complaint was that the FAX it received did not request *cancellation* of the policy (i.e. it only asked for a refund.)

It was not necessary for the complainant to request cancellation of the policy because he *did not* sign and return the amendment, which means that the policy was never in force (offer not accepted). The Company improperly put the policy inforce and withdrew additional premiums from the complainant's bank account and, then attempted to shift the blame for these mistakes to the complainant.

CMIC did refund the premium after the applicant filed a complaint with the DIFP, but interest was not paid on the unearned premium refund.

Reference: Section 376.426, RSMo

DIFP Number	Policy/Certificate
01S000407	H67007251

Interest on the unearned premium was paid during the examination.

7. Six complaints were filed because of CMIC's practice of withholding premiums refunds for 30 days on cases that are paid by electronic funds transfer (EFT) and other premium paying methods. The letter sent to the complainants/insured's states in part: "When refunding premiums due to cancellation of a contract it is Company policy to hold all premium payments which were deducted within the last 30 days. After your draft clears your bank, the portion of unearned premium will be refunded to you."

Electronic fund transfers clear the bank on the date they are electronically remitted to the Company. If a premium is paid by check/draft on a quarterly, semi-annual or annual basis, in many cases the premium check/draft has cleared the bank weeks or months prior to the request for cancellation. There is no justification for CMIC to retain premium refunds for 30 days after the EFT date.

Also, there is no justification for the retention of premium refunds for 30 days on policies where premiums are paid by check/draft that have been received by the

Company weeks or months prior to the request for cancellation.

Interest at the rate of 9% is due on the following six cases from the date of the cancellation/refund request to the current date.

Reference: Section 408.020, RSMo

Certificate Number	Date of Request	Date of Refund	Number of Days
H57233581	09-08-00	10-16-00	38
H57151883	10-03-01	11-14-01	42
H57303579	05-22-01	06-19-01	28
H57194009	10-01-01	11-05-01	35
H57286905	07-01-01	01-14-02	197
H52102210	10-22-99	11-29-99	38

8. The following grievance was filed regarding the denial of benefits for an MRI examination. The grievance file provided was incomplete as it did not contain a copy of the invoice from the provider for the MRI charges in question, nor was there any indication in the file that the Company ultimately paid or denied benefits for the MRI.

Reference: 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate
01S000445	H57153551

9. CMIC applied out of network coinsurance and/or policy deductible penalties when determining benefits on the following four claims. However, these facts were not disclosed or indicated on the Explanation of Benefits. This appears to be a standard business practice of CMIC.

Reference: Section 375.1005 & 375.1007 (10), RSMo and 20 CSR 100-1.020 (1)

Policy/Certificate	Claim Number
H57147402	E-Y04126-01
H57293169	F-E70906-01
H57127283	F-C24767-01
H57237737	F-K61604-01

10. The facts in the following case are that: Healthlink was the preferred provider organization contracted by CMIC to provide services in the area where the claimant resides; and (b) the claimant had directed three letters of complaint to the Healthlink

offices in St. Louis, Missouri regarding a claim that was incorrectly processed by CMIC; and (c) Healthlink failed to forward these complaints to CMIC; and (d) neither Healthlink nor CMIC responded in any way to these complaints.

It is reasonably foreseeable that a person insured by CMIC under this arrangement could mistakenly come to believe that Healthlink and CMIC are one and the same, or related entities. Under the circumstances, it is also reasonably foreseeable that such a person might mistakenly direct letters of complaint to Healthlink instead of CMIC.

To comply with Missouri requirements CMIC should have had procedures in place to ensure that either Healthlink or CMIC responded promptly and appropriately to any communications received from CMIC claimants using the Healthlink network. CMIC failed to have such procedures in place and consequently failed in its obligation to make an appropriate reply to the claimant within 10 working days.

Reference: 20 CSR 100-1.030 (2)

DIFP Number	Policy/Certificate
01J002095	H57184374

11. In the following three cases the complainants received services from CMIC network providers. CMIC either knew or should have known these facts, and, with respect to claims administration, CMIC is responsible for maintaining up to date records of its preferred providers. Charged with the above knowledge and responsibility, the Company chose to improperly characterize the claims for in network services as ones for out of network services.

As a result the Company (a) wrongly denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services; and (b) misrepresented relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claims when liability was clear.

Reference: Section 375.1007 (1), (3), (4) & (6), RSMo, 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate
00J002547	H52137009
00J002674	H57242083
00J002663	H57239447

12. In the following case the enrollee had obtained pre-authorization for surgery from CMIC, and in reliance on the actions/representations of CMIC the claimant went

forward with the surgery performed by a CMIC network provider.

The Company either knew or should have known the above-recited facts, and, with regard to claims administration, CMIC is responsible for maintaining up to date records of its preferred providers and the pre-authorizations issued by or on behalf of the Company.

Also, CMIC cannot retract a pre-authorization or reduce the benefits after the service has been rendered. Charged with that knowledge and responsibility, the Company chose to improperly deny benefits for the pre-authorized in-network surgery in question.

As a result, the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear. Also, the complainant in this case was compelled to obtain legal counsel in order to recover the insurance benefits due.

Reference: Section 376.1361.13, 375.1007(5) & (6), RSMo, and 20 CSR 300-2.200 (3)(B)

DIFP Number	Policy/Certificate
00J002158	H57191611

13. In the following case, the complainant had testing and surgery performed by CMIC network providers. Also, the complainant had obtained written pre-certification from CMIC and/or its agent (National Health Services, Inc.) for the services received, and in reliance on the actions/representations of the Company and/or its agent the claimant went forward with the surgery in question.

CMIC either knew or should have known the above recited facts, and, with regard to claims administration, CMIC is responsible for maintaining up to date records of its preferred providers and the pre-authorizations issued by or on behalf of the Company.

Also, CMIC cannot retract a pre-authorization of services or reduce the benefits after the service has been rendered. Charged with that knowledge and responsibility the Company chose to improperly characterize the pre-authorized in-network services as out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable

settlement of the claim when liability was clear.

Reference: Section 376.1361 13, 375.1007 (1) and (4), RSMo, and 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate	Interest Paid
00J000314	MK8007718A	$54.35

14. A CMIC network doctor referred the complaintant in this case to a CMIC network surgeon who performed the needed surgery at a CMIC network hospital listed on the claimant's most recent provider directory. The complainant also obtained pre-authorization for the surgery from CMIC and/or its agent (National Health Services, Inc.) In reliance on the actions/representations of the Company or its agent the complainant went forward with her treatment at the aforesaid facility.

CMIC either knew or should have known the above-recited facts and, with respect to claims administration, CMIC is responsible for maintaining up to date records of its preferred providers and the pre-authorizations issued by or on behalf of the Company. Also, CMIC cannot retract a pre-authorization of services or reduce the benefits after the service has been rendered. Charged with that knowledge and responsibility the Company chose to improperly characterize the claim for pre-authorized in-network services as one for out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts in determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear.

Reference: Section 376.1361 13, 375.1007 (1) & (4), RSMo, and 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate	Interest Paid
01J0001759	H57151670	$153.29

15. In the following case, the health care facility in which the claimant was to receive treatment contacted CMIC on behalf of the claimant and was given pre-authorization to admit and treat the claimant. In reliance on the actions/representations of the Company the claimant went forward with her treatment at that facility.

CMIC either knew or should have known the above recited facts and, with respect to claims administration, CMIC is responsible for maintaining up-to-date records of the pre-authorizations issued by or on behalf of the Company. Also, CMIC cannot retract

a pre-authorization of services or reduce the benefits after the service has been rendered.

Charged with that knowledge and responsibility the Company chose to improperly characterize the claim for pre-authorized in network services as one for out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts in determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear.

Reference: Section 376.1361 13, 375.1007 (1) & (4), RSMo and 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate	Interest Paid
01K000093	CK8005609A	$191.88

16. In the following case a CMIC network doctor referred the claimant for pain management treatment. Further, the claimant obtained written pre-certification from CMIC and/or its agent (National Health Services, Inc.) for the treatment received at the pain management clinic. Further, in reliance on the actions/representations of the Company and/or its agent the claimant went forward with her treatment at that facility.

CMIC either knew or should have known the above-recited facts, and, with respect to claims administration, CMIC is responsible for maintaining up-to-date records of its preferred providers and the pre-authorizations issued by or on behalf of the Company. Also, CMIC cannot retract a pre-authorization of services or reduce the benefits after the service has been rendered. Charged with that knowledge and responsibility the Company chose to improperly characterize the claim for pre-authorized in-network services as one for out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear.

Reference: Section 376.1361 13, 375.1007 (1) & (4), RSMo, and 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate	Interest Paid
01K000584	H57242323	$252.44

17. In the following case the facts are that:

The claimant obtained letters from three different CMIC network providers verifying that the only facility at which he could receive proper treatment for his condition was the Mayo Clinic (out of network). The claimant contacted CMIC, explained the situation and provided CMIC with the subject letters and obtained verification from a CMIC representative that his proposed treatment at the Mayo Clinic would be considered as in-network service because there was no facility in his network area that could provide the treatment he required,

and in reliance on the actions /representations of the Company the claimant obtained the required treatment at the Mayo Clinic.

CMIC either knew or should have known the above-recited facts, and, with respect to claims administration, CMIC is responsible for maintaining up to date records of the pre-authorizations issued by or on behalf of the Company. Also, CMIC cannot retract a pre-authorization of services or reduce the benefits after the service has been rendered. Charged with that knowledge and responsibility the Company chose to improperly characterize the claim for pre-authorized in-network services as one for out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services; and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear.

Reference: Section 376.1361 13, 375.1007 (1), (4) & (6), RSMo and 20 CSR 300-2.200 (2) & (3)(B)

DIFP Number	Policy/Certificate	Interest Paid
01J000409	H57120103	$16.66

18. In the following case the claimant and his insured family members received services from CMIC network providers.

CMIC either knew or should have known the above recited facts and, with respect to claims administration, CMIC is responsible for maintaining up to date records of its preferred providers. Charged with that knowledge and responsibility the Company chose to improperly characterize the claim for in-network services as one for out of network services.

As a result the Company (a) wrongly denied/reduced benefits and/or applied penalty deductible/co-payments amounts when determining benefits for the health services;

and (b) misrepresented the relevant facts relating to the claimant's insurance coverage; and (c) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claim when liability was clear.

Reference: Section 375.1007 (1), (4) & (6), RSMo

DIFP Number	Policy/Certificate	Underpayment
01K000616	H57277127/H52155079	$8.61

The underpayment was paid during the examination.

19. While the insured persons in the following nine cases were using the PPO networks authorized by CMIC for their areas, CMIC contracted with new PPO organizations for those areas and at that same time terminated its contracts with the PPO networks these people had been using.

The parties in these cases dispute the claim of CMIC that it sent proper notice of the network changes to all affected parties in Missouri. In that regard, the files provided show that the complainants reside in six communities across Missouri, making it highly unlikely that any such notice was lost and/or undelivered by all six local post offices. Also, when CMIC was contacted by one of the complainants the customer service person at CMIC confirmed that neither a new provider list nor a new ID card had been sent to that person. Further, CMIC was unable to locate and/or produce satisfactory documentation for the examiners to verify that any notice was sent to these people.

Understandably, these people continued to use the service providers in the terminated PPO networks, as they were unaware that CMIC had terminated those networks and contracted with new ones.

CMIC or its agents controlled and were entirely responsible for the changeover process of terminating PPO networks, contracting with new networks and notifying covered persons of the network changes.

The Company admitted that it became aware, during the changeover process that at least 49 affected persons in Missouri were not sent timely notice of the network changes. The claims and written grievances of the parties below are further confirmation of the failure by CMIC to properly notify Missouri citizens of the critical health plan changes.

CMIC either knew or should have known of the failure to give notice and/or timely notice to the aggrieved parties, and other persons affected in Missouri.

Charged with that knowledge the Company still chose to unfairly characterize the claims of these people as claims for out of network services.

As a result the Company (a) wrongfully denied/reduced benefits and/or applied penalty deductible/co-payments amounts in determining benefits for the health services, and (b) did not attempt in good faith to effectuate prompt, fair and equitable settlement of the claims when liability was clear.

The records also show that these actions by CMIC resulted in stress and financial hardship for these people, and, in several cases, resulted in damage to their credit ratings.

Reference: Section 375.1007 (1), (4) & (6), 376.1361 13, RSMo and 20 CSR 300-2.200 (2) & (3)(B)

Missouri DIFP Grievances

DIFP Number	Policy/Certificate	City of Residence
01K000156	H57147402	Oak Grove, MO
01J001174	H57237737	St. Clair, MO
01J002204	H57299367	Kansas City, MO
01J003063	H57268147	Kansas City, MO
01S000219	H57127283	Manchester, MO
00K000560	H57223483	Kearney, MO

Direct Consumer Grievances

Claim Number	Policy/Certificate	City of Residence
FL0671601	H57258657	Kansas City, MO
FE9135101	H57293169	Kearney, MO
ES3514401	H57229555	Lees Summit, MO

Under the circumstances, it appears that the improper claims practices outlined in items 10 through 19 were committed by CMIC in conscious disregard of Section 375.1007, RSMo with such frequency as to constitute a general business practice to engage in that type of conduct.

Reference: Section 375.1005 and 375.1007 (1), (4) & (6), RSMo

SECTION VI

VI. UNCLAIMED PROPERTY

This section of the report details the examination findings regarding unclaimed property practices. The examiners reviewed practices for recording and reporting unclaimed property for the reporting years of 1999, 2000 and 2001 to determine compliance with Missouri law.

1. CMIC has the following procedures in place for disbursing funds for policy benefits.

   When an assignment is submitted with a claim the check for policy benefits is made payable to the health care provider, otherwise benefits are made payable directly to the claimant.

2. CMIC has the following procedures in place for disbursing premium refunds.

   Premium that has been paid on a direct-payment basis is refunded immediately and directly to the premium payer. When the premium is paid via bank draft payment of a refund is held back for thirty days to ensure the bank draft is not returned unpaid.

3. CMIC has the following procedures in place when a benefit or refund check is not presented for payment and/or becomes stale dated.

   Checks that are not presented for payment after 180 days are reported for handling to the Escheat Unit of the Company, which attempts to contact the payee by letter before paying the monies over to the state.

4. CMIC has the following procedures in place when mail containing a benefit or refund check is returned to the Company as undeliverable.

   CMIC attempts to determine the reason for the return, and tries through various means to ensure that the returned check is re-mailed to the correct address, with correct postage, etc. If this is not possible the funds are transferred to the Escheat Unit of the Company.

5. CMIC has the following procedures in place when it receives checks or money in the mail, which, due to loss or lack of identifying information cannot be credited to a specific account.

   CMIC does an alpha search on its system to locate the policy number. If the policy number cannot be found and if a telephone number is available on the check or located by other means (internet search, etc.), telephone contact is made to obtain the policy number and learn the purpose for the check.

If the above methods are not successful the check is returned to the sender with a letter asking that payment be resubmitted to CMIC with proper directions for processing and with a policy number properly noted.

CMIC made the following payments to the Missouri State Treasurer.

Date of Report	Report Year	Amount Paid
04-24-00	1999	$8,277.50
04-24-01	2000	$ 691.98
04-14-02	2001	$1,230.39

The examiners found no errors in this review.

SECTION VII

VII. CRITICISM & FORMAL REQUEST TIME STUDY

This study reflects the amount of time taken by Conseco Medical Insurance Company to respond to criticisms and requests submitted by the examiners.

A. Criticism Time Study

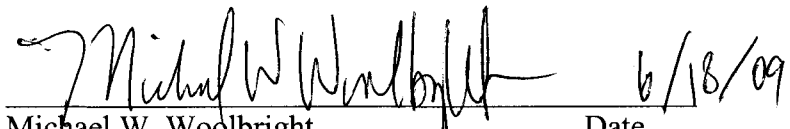
Calendar Days	Number Criticisms	Percentage
0 –10	93	98%
Over-10	2	2%
Total	95	100%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
0 -10	72	96%
Over-10	3	4%
Total	75	100%

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Conseco Medical Insurance Company (NAIC #93769), Examination Number 0207-02-LAH. This examination was conducted by Paul Baslee, Wesley Arbeitman, Austin Cowan, Linda Colston, and Gary Land. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 12, 2003. 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.



Michael W. Woolbright Date
Chief Market Conduct Examiner