STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

In re:	)	
	)	
Cox Health Systems HMO, Inc.	)	Examination No. 1003-05-TGT
(NAIC #95530)	)	
	)	

ORDER OF THE DIRECTOR

NOW, on this 20 day of May, 2013, Director John M. Huff, after consideration and review of the market conduct examination report of Cox Health Systems HMO, Inc. (NAIC #95530) (hereafter referred to as "Cox") report number 1003-05-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such report are 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. 2013), is in the public interest.

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

IT IS FURTHER ORDERED that Cox shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place the Company in full

compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that Cox shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $3,000 payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 20th day of MAY, 2013.

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: Cox Health Systems HMO, Inc.
PO Box 5750
Springfield, MO 65801

RE: Cox Health Systems HMO, Inc. (NAIC #95530)
Missouri Market Conduct Examination #1003-05-TGT

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and Cox Health Systems HMO, Inc. (NAIC #95530), (hereafter referred to as "Cox"), as follows:

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

WHEREAS, Cox has been granted a certificate of authority to operate as a health maintenance organization (HMO) in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of Cox and prepared report number 1003-05-TGT; and

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

1. In five (5) instances, Cox failed to pay interest on cancer screening claims that were paid more than 45 days after the original claim receipt date in violation of §376.383.5 RSMo Supp 2009 and §375.1007 (4) RSMo;

2. In seventy seven (77) instances, Cox failed to pay interest on childhood immunization claims that were paid more than 45 days after the original claim receipt date in violation of §376.383.5 RSMo Supp 2009 and §375.1007 (4) RSMo;

3. In thirty four (34) instances, Cox failed to pay interest on emergency room and ambulance service claims that were paid more than 45 days after the original claim receipt date in violation of §376.383.5 RSMo Supp 2009;

4. In four (4) instances, Cox improperly denied emergency room and ambulance service claims without first conducting a reasonable investigation of the claim in violation of §376.383.9 RSMo Supp 2009, and 20 CSR 100-1.060 (5) (A) 1;

5. In one (1) instance, Cox failed to pay interest on a PSA test claim that was paid more than 45 days after the original claim receipt date in violation of §376.383.5 RSMo Supp 2009;

6. In twenty eight (28) instances, Cox either failed to pay interest on claims for complications of pregnancy that were paid more than 45 days after the original claim receipt date or improperly processed claim submissions for complications of pregnancy in violation of §376.383.5 RSMo Supp 2009 and §375.1007 (4) RSMo;

7. Cox failed to maintain sufficient documentation in claim files to determine if it was complying with the 50% copayment limitation contained in 20 CSR 400-7.100 in violation of §374.205.2 (2) RSMo and 20 CSR 300-2.200 (2).

8. In one (1) instance, Cox exceeded the 50% copayment limitation on a claim in violation of §354.410.1 (2) RSMo and 20 CSR 400-7.100;

9. Cox failed to maintain procedures to comply with the 20% copayment limitation contained in 20 CSR 400-7.100.

WHEREAS, Cox hereby agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those corrective actions at all times, to reasonably assure that the errors noted in the above-referenced market conduct examination reports do not recur.

WHEREAS, Cox shall pay interest on all claims noted in the Final Market Conduct Examination Report where the claim was paid more than 45 days from the original claim receipt date. The total interest due claimants is $898.63. A letter must be included with the payments, indicating that "as a result of a Missouri Market Conduct examination" it was found that additional payment was owed on the claims. Additionally, evidence must be provided to the Department that such payments have been made within 90 days after the date of the Order finalizing this examination.

WHEREAS, Cox shall review all claims from January 1, 2007 to December 31, 2008 and from January 1, 2010 to December 31, 2010 to determine if any other claims were paid more than 45 days after the original claim receipt date. If the claim was paid more than 45 days after the original claim receipt date, the Company must pay the claimant 1% interest per month as required by §376.383.5 RSMo Supp 2009. A letter must be included with the payments, indicating that "as a result of a Missouri Market Conduct examination" it was found that additional payment was owed on the claims. Additionally, evidence must be provided to the Department that such payments have been made within 90 days after the date of the Order finalizing this examination. If the aggregate total interest due the claimant for all the claimant's claims within the specified period is less than $5.00, the Company is not required to make such payment.

WHEREAS, Cox shall review overpayments of copayments for the period beginning January 1, 2007 to December 31, 2011 to determine if members received refunds of excess copayments collected by providers. If the copayment exceeded 50% of the total cost of providing any single service to a member, and the excess copayment was not refunded to the member, the Company must issue any payments that are due to the members plus statutory interest calculated through December 31, 2011 at the rate of nine (9%) per annum, pursuant to §408.020. A letter must be included with the payments, indicating that "as a result of a Missouri Market Conduct examination" it was found that additional payment was owed to the member. Additionally, evidence must be provided to the Department that such payments have been made within 90 days after the date of the Order finalizing this examination. If the aggregate total payment, including interest, due the claimant for all of the claimant's claims within the specified time period is less than $5.00, the Company is not required to make such payment.

WHEREAS, Cox, 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, Cox hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #1003-05-TGT further agrees, voluntarily and knowingly to surrender and forfeit the sum of $3,000.

NOW, THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of Cox to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Cox does hereby voluntarily and knowingly waive all rights to any hearing, does consent to undertake the corrective actions set forth in this Stipulation, does consent to the ORDER of the Director and does surrender and forfeit the sum of $3,000, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 5/13/13

President
Cox Health Systems HMO, Inc.

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

FINAL MARKET CONDUCT EXAMINATION REPORT
Health Business of

Cox Health Systems HMO, Inc.
NAIC # 95530

MISSOURI EXAMINATION # 1003-05-TGT

NAIC EXAM TRACKING SYSTEM # MO341-M6

April 23, 2013

Home Office
P. O. Box 5750
Springfield, MO 65801-5750

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FOREWORD

This is a targeted market conduct examination report of the Cox Health Systems HMO, Inc., (NAIC Code # 95530). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP).

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP.

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

When used in this report:

- "CMS" refers to the Centers for Medicare & Medicaid Services;
- "Company" refers to Cox Health Systems HMO, Inc.;
- "CSR" refers to the Missouri Code of State Regulation;
- "Department " or "DIFP" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "Director" refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "NAIC" refers to the National Association of Insurance Commissioners;
- "RSMo" refers to the Revised Statutes of Missouri.

SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§354.465, 374.110, 374.190, 374.205, 375.445, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2007, through December 31, 2009, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: small employer group underwriting, claim handling practices for mandated benefits, compliance with limitations on health maintenance organization (HMO) copayments, and the handling of complaints and grievances for health benefit plans.

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

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

COMPANY PROFILE

Cox Health Systems HMO, Inc. was incorporated in the state of Missouri on April 2, 1996, as a network model health maintenance organization. The Company was issued a certificate of authority under Chapter 354, RSMo (Health service corporations-Health maintenance organizations-Prepaid dental plans) on October 24, 1996 and began issuing HMO coverage on January 1, 1997.

At incorporation, the Company was owned 50% by Cox Health Systems (CHS), Springfield, Missouri and 50% by Freeman Hospitals and Health System (Freeman), Joplin, Missouri. Effective January 1, 2001, CHS purchased the stock held by Freeman and became the sole stockholder.

The Company's original name of Cox-Freeman Health Plans, Inc. was changed to Cox Health Systems HMO, Inc. by amendment to the articles of incorporation on July 28, 2000.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Cox Health Systems HMO, Inc. The examiners found the following principal areas of concern:

I. UNDERWRITING AND RATING PRACTICES

Small Employer Group Underwriting

The examiners reviewed insurance forms and measures taken by the Company to assure its compliance with §§ 379.930 and 379.940, RSMo, as prescribed by the Director's January 3, 2008 order issued to the Company after the completion of Examination # 0612-53-TGT. No substantive issues were noted in this review. *(Page 8).*

II. CLAIM PRACTICES

A. Unfair Claim Practices – Denied or Suspended Claims for Cancer Screenings

The examiners found five instances where the Company failed to pay interest on benefits for Cancer Screenings paid more than 45 days after the original claim receipt date, contrary to §§ 375.1007 (4) and 376.383.5., RSMo. This resulted in a found error ratio of 20.83%. *(Page 10).*

B. Unfair Claim Practices – Denied or Suspended Claims for Childhood Immunizations

The examiners found 77 instances where the Company failed to pay interest on benefits for Childhood Immunizations paid more than 45 days after the original claim receipt date, contrary to §§ 375.1007 (4) and 376.383.5., RSMo. This resulted in a found error ratio of 26.28%. *(Page 11).*

C. Unfair Claim Practices – Denied or Suspended Claims for Emergency Room (ER) and Ambulance Services

The examiners found 38 instances where the Company mishandled emergency room and ambulance services claims. This resulted in a found error ratio of 1.91%. *(Pages 11-13).* Specifically:

- The Company failed to pay interest on 34 claims paid more than 45 days after receipt, contrary to §§ 375.1007 (4) and 376.383.5., RSMo.
- The Company improperly denied four claims without first conducting a reasonable investigation of the claim, contrary to §§ 375.1007(3), (4) and (6) and 376.383.9, RSMo.

D. Unfair Claim Practices – Denied or Suspended Claims for Mammograms

The examiners noted no errors in the review of the Company's handling of one denied claim for mammograms. *(Page 14).*

E. Unfair Claim Practices – Denied or Suspended Claims for Pap Smears

The examiners noted no errors in the review of the Company's handling of ten denied Pap smear claims. *(Page 14).*

F. Unfair Claim Practices – Denied or Suspended Claims for PSA Tests

The examiners found one instance where the Company failed to pay interest on a PSA Test benefit paid more than 45 days after the original claim receipt date, contrary to §§ 375.1007 (4) and 376.383.5., RSMo. This resulted in a found error ratio of 3.85%. *(Pages 14).*

G. Unfair Claim Practices – Denied or Suspended Claims for Complications of Pregnancy

The examiners found 28 instances where the Company failed to pay interest on Complications of Pregnancy benefits paid more than 45 days after the original claim receipt date, contrary to §§ 375.1007 (4) and 376.383.5., RSMo. This resulted in a found error ratio of 7.6%. *(Page 15).*

H. Determination and Refunds of Excessive Copayments

The Company's procedures for complying with the 50% copayment limitation in 20 CSR 400-7.100 failed to provide sufficient documentation in the claim files for the examiners to determine compliance, contrary to § 374.205.2(2), RSMo, and 20 CSR 300-2.200(2) (replaced by 20 CSR 100-8.040(2), effective 07/30/08).

The Company has no procedures in place to comply with the 20% copayment limitation in 20 CSR 400-7.100, contrary to the regulation, the provisions of its evidence of coverage documents and its obligation to provide basic health care services with reasonable copayments pursuant to § 354.410.1(2), RSMo. *(Pages 16-18).*

III. COMPLAINTS

The examiners verified the accuracy of the Company's complaint registry from January 1, 2007 through December 31, 2009. The examiners noted no errors in a review of 24 complaint files processed in calendar years 2007 through 2009. *(Page 19)*

Various non-compliant practices were identified, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the Missouri insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report is designed to provide a review of the Company's underwriting and rating practices. These practices included the use of policy forms, adherence to underwriting guidelines, assessment of premium, and procedures to decline or terminate coverage. Because this was a targeted examination, the examiners limited this portion of the examination to a review of the measures taken by the Company, including its implementation of the proper application and related forms, to assure its compliance with §§ 379.930 and 379.940, RSMo, as prescribed by the Director's January 3, 2008 order issued to the Company after the completion of Examination # 0612-53-TGT.

Small Employer Group Underwriting

Section 379.930(15), RSMo, establishes 30 hours per week as the minimum number of hours that an employee must work in order to be considered an "eligible employee" for the purpose of the "Small Employer Health Insurance Availability Act." All eligible employees of a small employer must be offered coverage pursuant to § 379.940, RSMo. During the Company's previous examination, the examiners criticized the Company for allowing employers to specify a greater number of hours per week than 30 for the purposes of health insurance eligibility. The Director's January 3, 2008 order adopting the examination report required the Company to cure this violation. To test for compliance with the Director's order, the examiners asked the Company for documentation of the measures it had taken to comply. The Company responded by providing copies of a sample letter to its producers, a written procedure and three application forms identified as CHP EAGP 12-2007, CHP EAGP 102009-CHMO and CHP EAGP 022010 – HMO.

Although the small employer group application forms used by the Company were found to be in compliance, the examiners found the producer letter and written procedure to contain certain misleading information. After being notified about such finding, the Company agreed to revise both documents to remove incorrect information.

II. CLAIMS PRACTICES

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

The examiners reviewed claim files of suspended or denied claims for mandated benefits processed by the Company from January 1, 2009 through December 31, 2009. The examiners also reviewed the Company's copayment application procedures to assure its compliance with 20 CSR 400-7.100.

A claim file is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g., §§ 375.1000 to 375.1018 and 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%). Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to the law. Examples of an error include, but are not limited to: (1) any unreasonable delay in the acknowledgment, investigation, or payment/denial of a claim; (2) the failure of the Company to calculate claim benefits or interest payments accurately; or (3) the failure of the Company to comply with Missouri law regarding claim settlement practices.

The examiners reviewed the claim files for timeliness. In determining timeliness, examiners looked at the duration of time the Company used to acknowledge the receipt of the claim, the time for investigation of the claim, and the time to make payment or provide a written denial.

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

Throughout the examination, the examiners noted many instances where the Company declined to pay claims pending the receipt of additional information. The Company eventually paid the claims once the additional information was received, but it did not pay interest in accordance with § 376.383.5, RSMo Supp. 2009, even though the claims were paid more than 45 days after they were initially received.

In response to the many criticisms of this practice by the examiners, the Company argued that the reference to suspension of claims in the statute meant that the 45 day time period stopped while the Company was waiting for additional information, and the Company cited 20 CSR 100-1.050(1)(A) and the CMS definition of "clean claim" in support of its position. Unfortunately, the Company's interpretation mistakenly confuses the "processing days" standard for calculating when a penalty is due under § 376.383.6,

RSMo Supp. 2009, with the standard for calculating when interest is due under § 376.383.5, RSMo Supp 2009.

The time period for the imposition of the penalty under § 376.383.6, RSMo Supp. 2009, is based upon "processing days," which specifically exclude "days in which the health carrier is waiting for a response to a request for additional information." By contrast, § 376.383.5, RSMo Supp. 2009, contains no reference to "processing days." This means the 45 day time period is based upon calendar days under general standards for the computation of time in Missouri statutes.

While amendments to § 376.383 in 2010 modified the statute to apply the "processing days" standard to both the interest and penalty, the claims reviewed in this examination were all subject to the prior law. Accordingly, the Company's failure to pay interest on many of the claims below are noted as errors for failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims pursuant to § 375.1007(4), RSMo, as well as errors pursuant to § 376.383.5, RSMo.

From the 2009 claims data supplied by the Company, the examiners extracted claims involving certain benefits, required by the statutes listed below, that were indicated as being "denied" in the data. These claims were then reviewed for compliance with general claims handling standards. Unless so noted, cited errors are related to claims processes, not the specific benefit requirements of the specific statutory sections.

A. Unfair Claim Practices – Denied or Suspended Claims for Cancer Screenings

The examiners reviewed the Company's adherence to claim handling requirements for denied cancer screening claims under § 376.1250.1(3), RSMo, for calendar year 2009.

Field Size:	24
Type of Sample:	Census
Number of Errors:	5
Error Ratio:	20.83%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review.

Criticism # 02: The Company initially suspended or denied five claims pending its receipt of requested information from the insureds or providers concerning other coverage, medical records or other additional information. The Company subsequently paid these claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

B. Unfair Claim Practices –Denied or Suspended Claims for Childhood Immunizations

The examiners reviewed the Company's adherence to claim handling requirements for denied childhood immunization claims under § 376.1215, RSMo, for calendar year 2009.

Field Size:	293
Type of Sample	Census
Number of Errors:	77
Error Ratio:	26.28%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review.

Criticism #s 03 and 05: The Company initially suspended 77 claims pending its receipt of requested information from the insureds or providers concerning other coverage. The Company subsequently paid these claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

C. Unfair Claim Practices – Denied or Suspended Claims for Emergency Room (ER) and Ambulance Services

The examiners reviewed the Company's adherence to claim handling requirements for denied emergency room and ambulance claims under §§ 376.1350(12), (22), and 376.1367, RSMo, for calendar year 2009.

Field Size:	1985
Type of Sample:	Census
Number of Errors:	38
Error Ratio:	1.91%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

1. Criticism #s 12, 13 and 15: The Company initially suspended 22 claims pending its receipt of requested information from the insureds concerning other coverage. The Company subsequently paid these claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009, and 20 CSR 100-1.060(5) (A)1.

2. Criticism # 14: The Company initially suspended six claims pending its receipt of an accident inquiry response from the insured. The Company subsequently paid these claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

3. Criticism # 16: The Company initially denied four claims stating that they were corrected claims and that the original claims ("previous claims") were to be adjusted. The Company later determined that these claims were separate claims from the "previous claims" and paid benefits for the claims more than 45 days after the original claim receipt date. The Company, however, failed to pay appropriate interest.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

4. Criticism # 17: The Company initially suspended two claims and requested the provider to resubmit them with a valid location code. The Company subsequently paid the claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

5. Criticism # 18: The Company received three claims on 12/23/08 (the "pended claims") and, without first conducting any investigation, denied them on 01/08/09 using a remark code stating that "Pended – Your claim is pended; Member Has Not Responded to Inquiry," The Company-provided documentation showed that the Company previously mailed its written requests for "other coverage" information to the member on 05/15/08 and 06/15/08, following its receipt of the member's 05/02/08 incurred claim (the "earlier claim").

   Although the Company received no response from the member to the Company's information requests, the Company paid the "earlier claim."

   The requests for other coverage information were mailed on 05/15/08 and 06/15/08, before the Company's receipt of the pended claims. As such, those requests did not constitute an investigation of the pended claims.

   By failing to pay the claims without making any additional inquiries, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims, failed to attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear, and refused to pay claims without conducting a reasonable investigation. The Company's EOB also failed to include the specific reason why the claim was denied when it relied solely on the usage of the denial remark statement "Member Has Not Responded to Inquiry," without any additional explanation or written request for any

specific information. Requests for additional information shall specify what additional information is necessary to process the claim for payment.

In response to the Criticism, the Company furnished additional information showing that it subsequently mailed three more "other coverage" information requests to the member on 01/19/10, 02/19/10 and 06/08/11. Since these additional information requests were made more than 12 months after the Company's receipt and denial of the pended claims, they failed to constitute a reasonable investigation of the pended claims. Had such requests been mailed to the member prior to the Company's claims denial (but after its receipt of the claims), they would readily be considered a reasonable claim investigation.

Reference: §§ 375.1007(3), (4) and (6), and 376.383.9, RSMo

6. Criticism # 19: The Company received a claim on 01/26/09 and, without first conducting any investigation, denied it on 01/29/09 using a remark code stating that "Pended – Your claim is pended; Member Has Not Responded to Inquiry," The Company-provided documentation showed that the Company mailed its written requests for "other coverage" information to the member on 12/02/08 and 01/13/09.

   Since the 12/02/08 and 01/13/09 "other coverage" information requests were mailed to the member before the Company's receipt of the claim, they did not constitute an investigation of the claim.

   By pending the claim without making any additional inquiries, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims, failed to attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear, and refused to pay claims without conducting a reasonable investigation. The Company's claim pending also failed to include the specific reason why the claim was pended when it relied solely on the usage of the remark statement "Member Has Not Responded to Inquiry," without any additional explanation or written request for any additional specific information.

   In its response to the Criticism, the Company repeated the fact that it had sent the claimant COB inquiry letters on 12/02/08 and 01/13/09 to which it received no response. The Company also responded that the contract holder terminated this member's coverage (as a dependent) effective 07/31/09, and that sending additional letters for each claim would be pointless, since the individual was no longer covered by the plan. The Company responded that its actions were reasonable and sensible.

   The member was properly covered by the plan when she incurred the claim, and her termination while her claim is under review does not in any way invalidate or terminate an otherwise legitimate claim.

   Reference: §§ 375.1007(3), (4) and (6), RSMo, and 376.383.9, RSMo Supp. 2009

D. Unfair Claim Practices – Denied or Suspended Claims for Mammograms

The examiners reviewed the Company's adherence to claim handling requirements for denied mammogram claims under § 376.782, RSMo, for calendar year 2009.

The examiners reviewed one claim and found no errors in this review.

E. Unfair Claim Practices – Denied or Suspended Claims for Pap Smears

The examiners reviewed the Company's adherence to claim handling requirements for denied Pap smear claims under § 376.1250.1(1), RSMo, for calendar year 2009.

The examiners reviewed 10 claims and found no errors in this review.

F. Unfair Claim Practices – Denied or Suspended Claims for PSA Tests

The examiners reviewed the Company's adherence to claim handling requirements for denied PSA test claims under § 376.1250.1(2), RSMo, for calendar year 2009.

Field Size:	26
Type of Sample	Census
Number of Errors:	1
Error Ratio:	3.85%
Within DIFP Guidelines?	Yes

The examiners found the following error in this review.

Criticism # 06: The Company initially suspended a claim pending its receipt of requested information from the insured concerning other coverage. The Company subsequently paid this claim more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009

G. Unfair Claim Practices -- Denied or Suspended Claims for Complications of Pregnancy

The examiners reviewed the Company's adherence to claim handling requirements for denied complications of pregnancy claims under § 375.995, RSMo, for calendar year 2009.

Field Size:	368
Type of Sample:	Census
Number of Errors:	28
Error Ratio:	7.6%
Within DIFP Guidelines?	No

The examiner noted the following errors in this review:

1. Criticism # 08: The Company initially suspended 18 claims pending its receipt of requested information from the insureds concerning other coverage. The Company subsequently paid these claims more than 45 days after the original claim receipt date, but it failed to pay appropriate interest.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009, and 20 CSR 100-1.060(5)(A)1.

2. Criticism # 09: The Company improperly processed 10 claim lines by denying the initial claim submission as a duplicate and failing to pay interest when it paid the 10 claim lines based upon a second claim submission. In response to the criticism, the Company explained that it had mistakenly paid based upon the second submission "due to a system error" in loading the initial claim submission into its system, and it agreed interest was due. The Company paid interest on these 10 claim lines during the examination, but it indicated that the interest was calculated based upon a received date of 10/29/09 for the initial claim. Since the original data provided by the Company at the start of the examination showed a received date of 10/26/09 for the initial claim submission, it is unclear whether or not the amount of interest paid was appropriate.

   Reference: §§ 375.1007 (4), RSMo, and 376.383.5, RSMo Supp. 2009, and 20 CSR 100-1.060(5)(A)1.

H. Determination and Refunds of Excessive Copayments

As a condition of licensure pursuant to § 354.410.1(2), RSMo, HMOs are required to demonstrate that they "will effectively provide or arrange for the provision of basic health care services . . . except to the extent of reasonable requirements for co-payments." To define what these reasonable requirements should be, the Department promulgated 20 CSR 400-7.100. This regulation provides that HMO copayments may not exceed:

- 50% of the total cost of providing any single service to an enrollee;
- In the aggregate, 20% of the total cost of providing all basic health services; or
- For basic health care services in a calendar year, 200% of an enrollee's total annual premium.

To review the Company's compliance with these limitations, the examiners reviewed the Company's Evidence of Coverage (EOC) forms. The EOC forms contained language that mirrored the limitations in 20 CSR 400-7.100 along with a statement that, "In most cases, the Provider may request you pay the Coinsurance/Copayment due at the time of service." Since collection of a copayment at the time of service can lead to situations where an HMO enrollee has paid copayments in excess of the regulation's limitations and is entitled to a refund, the examiners sought further clarification as to the Company's procedures for making copayment refunds in Formal Request # 62.

1. Copayments may not exceed 50% of any single service: In the Company's response to Formal Request # 62, it described its procedures for complying with the 50% limitation as follows:

> During adjudication of the claim if it is determined that the provider allowable is less than 50% of the copayment the copayment would be reduced so that the claim pays 50% and applies 50% to the copayment (i.e. allowable is $45.00, $22.50 would pay to the provider and $22.50 would apply to the copayment). We would then expect the provider to refund the overpayment to the member. We do not currently have procedures in place to monitor that the provider(s) refund the overpayment. We could not refund $2.50 to the member, as we did not receive the copayment funds. Nor could we deduct it from future payments to the provider, as we are not always provided with evidence that the provider has actually received the copayment, thus the deduction would be an inappropriate deduction from our contract with the provider.

HMOs are responsible for complying with the provisions of 20 CSR 400-7.100. The Company appears to rely on its participating providers to act as its agent for handling refunds of excessive copayments paid by enrollees. The Company's lack of any process to verify whether refunds have been made, however, means that its claim files lack documentation of the ultimate disposition of the claim. Missouri law requires that the Company maintain its claims files "so as to show clearly the inception, handling, and disposition of each claim" and in a manner that is "sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed." Because the Company's claim files lacked such documentation, the examiners could

not readily ascertain whether the Company complied with the provisions of 20 CSR 400-7.100.

Reference: § 374.205.2 (2), RSMo, and 20 CSR 300-2.200(2) (replaced by 20 CSR 100-8.040(2), effective 07/30/08), and 20 CSR 400-7.100

Despite the Company's procedures to identify and correct copayments that exceed 50% of the cost of the service, the examiners indentified one claim where the scheduled copayment exceeded this limitation and brought the error to the Company's attention in Criticism #01. In the Company's response to Criticism # 01, it acknowledged that the copayment imposed for this claim exceeded 50%. After determining that the enrollee had not paid the copayment balance to the provider, the Company paid an additional amount plus interest to the provider during the course of the examination.

Reference: § 354.410.1(2), RSMo, and 20 CSR 400-7.100

2. Copayments may not exceed 20% of the aggregate total cost of providing basic health services, and 200% of the total annual premium: In the Company's response to Formal Request #62, it made the following statement regarding compliance with the 20% and 200% limitations:

> We cannot determine any means by which we can apply the 20% aggregate rule as the total cost of health services differs in a capitated or non-capitated environment. The regulation does not define aggregate or the time period for which it would apply. Based on our testing on a retrospective basis, the total of most copayments are 10% or less of an enrollee's annual premium, and none exceed 200%.

Because the Company's response indicated it had no procedure in place to comply with the 20% limitation, the examiners noted in Criticism # 21 that the Company's failure to have a procedure in place may have resulted in the imposition of copayments in excess of the 20% limitation, contrary to the provisions of its EOCs and its obligation to provide basic health care services with reasonable copayments. The Company's response to Criticism # 21 reiterated its argument that it could not determine how to comply with the 20% limitation. Company representatives subsequently met with the Director and the Chief Market Conduct Examiner and filed the following supplemental response to Criticism # 21:

> Having now met with members of the Department's Market Regulation staff regarding the use of aggregate in testing the 20 percent copayment provisions, the Company desires to supplement its response to Criticism 21. The Company can and has run testing which measures the contractual copayment amounts against the total of allowed services for members from the time of initial membership with the Company to the present date. What the Company is not able to do is determine from providers whether the allowed copayment

amounts under the policy are actually charged and collected by the providers. As noted in the Company's prior response, the global capitation of HMOs at the time the regulation was adopted provided mechanisms for an HMO to track collection of copayments through business practices no longer in place with global capitation no longer in use by the industry at large.

Reference: §§ 354.410.1(2) and 354.430, RSMo, and 20 CSR 400-7.100

III. COMPLAINTS

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

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

The examiners verified the Company's complaint registry, dated January 1, 2007 through December 31, 2009. The registry contained a total of 24 complaints. They reviewed all that went through DIFP and all that did not come through the Department, but went directly to the company.

The review consisted of a review of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint as required by § 375.936(3), RSMo, and 20 CSR 300-2.200(3) (D).

The examiners discovered no issues or concerns in the review.

IV. CRITICISMS AND FORMAL REQUESTS TIME STUDY

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

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
Received w/in time-limit, incl. any extensions	21	100.0%
Received outside time-limit, incl. any extensions	0	0.0%
No Response	0	0.0%
Total	21	100.0%

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
Received w/in time-limit, incl. any extensions	64	95.52%
Received outside time-limit, incl. any extensions	3	4.48%
No Response	0	0.0%
Total	67	100.0%

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

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Cox Health Systems HMO, Inc. (NAIC #95530), Examination Number 1003-05-TGT. This examination was conducted by Gary Kimball, CIE, Martha Long, CIE, and Bunlue Ushupun. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated November 21, 2011. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

Jim Mealer 5/21/2013

Jim Mealer Date
Chief Market Conduct Examiner

COX HEALTHPLANS
CoxHealth

Cox Health Systems Insurance Company
Cox Health Systems HMO, Inc.

Cox Health Systems HMO, Inc.

NAIC # 95530

Home Office P.O. Box 5750 Springfield, MO 65801-5750

Response to
Draft Market Conduct Examination Report

Missouri Examination # 1003-05-TGT

NAIC Exam Tracking System # MO341-M6

May 20, 2013

COX HEALTHPLANS
CoxHealth

Cox Health Systems Insurance Company
Cox Health Systems HMO, Inc.

RESPONSE TO EXECUTIVE SUMMARY

Cox Health Systems HMO, Inc. (the "Company") makes the following responses to the Executive Summary found in the draft examination report. A more detailed response is incorporated in the Company's response to the Examination Findings. The responses are made to Section headings as listed in the draft examination report.

II. CLAIM PRACTICES

The company makes the following general comments with regard to the summary of findings for subparagraphs A through G in the Executive Summary.

First, none of the cited practices in Sections A through G with regard to suspended claims constitute a violation of the cited unfair claims practice found in 375.1007 (4). It is abundantly clear from the findings in the draft examination report itself with regard to the cited claims that liability had not become reasonably clear, as required by the statute. The entire reason that the claims were suspended, in compliance with the statutory standards, is that the information submitted by the claimant had not made liability reasonably clear.

Therefore, any reference to an unfair claim practice with regard to suspended claims in Sections A through G should be removed from the examination.

The company continues to disagree with the examiner's interpretation of Section 376.383. That interpretation is erroneous and contrary to the concepts of statutory interpretation.

Secondly, the company cannot verify the number of instances noted as errors in Sections A through G.

Finally, with regard to subsection H, the company's evidence of compliance with the fifty percent co-payment limitation in 20 CSR 400-7.100 indicates full compliance with this regulation. In addition, the draft examination report's assertion that the company has no procedures in place to comply with its obligation to provide basic health care services with reasonable co-payments is a misstatement. All of the co-payments used by the company have been submitted to the Department for review and accepted and do not interfere in any way with its ability to provide basic health care services.

Jeffrey Bond, Chief Executive Officer

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COX HEALTHPLANS
CoxHealth

Cox Health Systems Insurance Company
Cox Health Systems HMO, Inc.

RESPONSE TO EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

Small Employer Group Underwriting

No Comment.

II. CLAIMS PRACTICES

This portion of the draft examination report initially focuses on a specific legal question, the payment of interest under the provisions of Section 376.383.5 RSMo supp. 2009. The draft examination report asserts that the Company confuses "processing days" standard for when a penalty is due under Section 376.383.6 RSMo with the standard for calculating interest under Section 376.383.5. However, the Company's position needs not rely on the definition of "processing days." The examination report ignores the definition and use of the term "suspends a claim" in the cited statutes.

"Suspends the claim" has a separate and distinct definition in Section 376.383.1RSMo from the definition of "processing days". However, suspending a claim has no meaning or effect in the statute as interpreted in the draft examination report. In every instance in which the term "suspends the claim" is used in Sections 376.383.5 and 376.383.6 it is used as an alternative to "deny." However, despite having separate statutory definitions, the draft examination report essentially contends that deny and suspend are the same. In the draft examination report's interpretation, the suspending of a claim does not alter whether the claim is paid, does not alter the interest payments and does not alter the penalty provisions. In the examination report's interpretation, both simply mean the insured was notified the claim is not paid. This interpretation ignores well settled rules of statutory interpretation.

The first of those rules is that one must consider words used in the statute in their plain and ordinary meaning. "The primary rule of statutory construction is to ascertain the intent of the legislature from the language used, to give effect to that intent if possible, and to consider words used in the statute in their plain and ordinary meaning." *Wolff Shoe Co. v. Director of Revenue*, 762 S.W.2d 29, 31 (Mo. Banc 1988); *State v. Kraus*, 530 S.W.2d 684, 685 (Mo. banc 1975). Further, "the ordinary sense of a word is generally ascertainable by means of dictionary definition." *Abrams v. Ohio Pacific Exp.*, 819 S.W.2d 338, 340 (Mo. Banc 1991).

In Webster's New World Dictionary Third College Edition one can determine that suspend has three separate definitions which are instructive in this matter:

- To cause to cease or become inoperative for a time; to stop temporarily
- To defer or hold back (judgment), as until more is known
- To hold in a beyance or defer action

Clearly, "suspend the claim" means more than "deny". It means it has become inoperative for a period of time.

The Second applicable rule of statutory interpretation is that everything within a legislative act must be given some meaning. The rule is that the "entire legislative act must be considered together and all provisions must be harmonized, if reasonably possible, and every word, clause, sentence, and section of an act must be given some meaning . . ." *City of Willow Springs v. Missouri State Librarian*, 596 S.W.2d 441 (Mo., 1980), citing *McCord v. Missouri Crooked River Backwater Levee District*, 295 S.W.2d 42, 45 (Mo.1956).

The interpretation in the draft examination report ignores both principles. Suspend means clearly the claim activity stops for all purposes. Otherwise there is no incentive for any claimant to submit appropriate and correct claim information. Merely stating a claim exists provides the claimant with payment within 45 days and/or substantial interest thereon. Furthermore, without the calculation of interest stopping during the suspension of a claim, suspending the claim is no different than denial of a claim, despite having a separate definition within the statute. Then "suspending the claim" has no actual meaning within the statutory construction.

More specifically, the regulation on claims settlement practices and the standards for prompt, fair, and equitable settlement of claims in 20 CSR 100-1.050(1)A provides that a claim must be addressed after the submission of all forms necessary to establish the nature and extent (emphasis added) of any claim. This regulation was in effect prior to the 5/30/09 effective date of the specific regulation on settlements of health claims found at 20 CSR 100-1.060 and was not specifically pre-empted by that new regulation. Likewise, Section 376.383 does not contain an specific definition of claim and the definition applicable to 20 CSR 100-1.050(1)(A) is not noted as inapplicable to interpretations of Section 376.383 RSMo. Therefore, for claims prior to 5/30/09 20 CSR 100-1.050(1)(A) is applicable for determining when a claim is ripe for determination, which is when all forms necessary to determine the nature and extent of the claim are filed. The information requested from the Company on these claims is required for the Company to determine the extent of the claim. Therefore they are appropriate suspensions and until such information is provided the claim cannot be considered complete for processing and therefore is not a claim within the meaning of Section 376.383.5.

The Company also wishes to address a second legal interpretation which is consistently applied in subsections A through G, which is that the failure to pay interest under the interpretation in the draft examination report is a violation of Section 375.1007(4). Even if one is to conclude that the failure to pay interest is a violation of Section 376.383.5, a finding that it likewise violates Section 375.1007(4) is misguided. In all but four of the

instances cited by the examiners in subsections A through G a claim was suspended after the Company requested additional information to investigate the claim. Section 375.1007(4) applies only in instances of claims submitted "in which liability has become reasonably clear." The examination report contains no information leading to a conclusion that the information requested by the Company during its investigation was an unreasonable request. In fact, the examination report finds that when the requested information was received, the Company completed its investigation and paid each of the cited claims. There is nothing even remotely improper about that practice. In fact, Section 376.383 recognizes the potential for suspension of claims and the potential for requests of additional information. The exercise of that right under that statute cannot then be an improper claim practice under another statute.

A. **Unfair Claim Practices – Denied Claims for Cancer Screenings**

For the reasons enunciated above, the practices cited in the examination report are not unfair claim practices and the Company is not in violation of Section 376.383.5. In addition, the report indicates only a violation of and no violation of the specific coverage and claim requirements of Section 376.1250.1(3).

B. **Unfair Claim Practices – Denied Claims for Childhood Immunizations**

For the reasons enunciated above, the practices cited in the examination report are not unfair claim practices and the Company is not in violation of Section 376.383.5.

Also, the examination report, indicates there were 77 claims suspended and refers to Criticism #s 03 and 05, however according to our records, Criticism 03 questioned six claims and Criticism # 05 questioned ten claims for a total of 16 claims, not 77.

In addition, the report indicates only a violation of Section 376.383.5 and no violation of the specific coverage and claim requirements of Section 376.1215.

C. **Unfair Claim Practices – Denied Claims for Emergency Room (ER) and Ambulance Services**

For the reasons enunciated above, the practices cited in the examination report are not unfair claim practices and the Company is not in violation of Section 376.383.5.

Also, C.1. in the examination report indicates there were 22 claims suspended and refers to Criticism #s 12, 13 and 15, however according to our records, Criticism 12 questioned four claims, Criticism 13 questioned two claims and Criticism 15 questioned 14 claims for a total of 20 claims, not 22.

C.3. in the examination report indicates there were four claims denied and refers to Criticism # 16, however according to our records, Criticism 15 questioned two claims, not four.

C.5. in the examination report indicates there were three claims denied and refers to Criticism # 18, however according to our records, Criticism 18 questioned two claims, not three.

In addition, the report indicates only a violation of Section 376.383.5 and no violation of the specific coverage and claim requirements of Section 376.1230(12).

D. Unfair Claim Practices – Denied Claims for Mammograms

No comments.

E. Unfair Claim Practices – Denied Claims for Pap Smears

No comments..

F. Unfair Claim Practices – Denied Claims for PSA Tests

For the reasons enunciated above, the practices cited in the examination report are not unfair claim practices and the Company is not in violation of Section 376.383.5.

In addition, the report indicates only a violation of Section 376.383.5 and no violation of the specific coverage and claim requirements of Section 376.1250.1(2).

G. Unfair Claim Practices – Denied Claims for Complications of Pregnancy

For the reasons enunciated above, the practices cited in the examination report are not unfair claim practices and the Company is not in violation of Section 376.383.5.

Also, G.1.in the examination report indicates there were 18 suspended claims and refers to Criticism # 08, however according to our records, Criticism 08 questioned five claims, not 18.

In addition, the report indicates only a violation of Section 376.383.5 and no violation of the specific coverage and claim requirements of Section 375.995.

H. Determination and Refunds of Excessive Copayments

1. Copayments may not exceed 50% of any single services:
   The Company has admitted the one error cited in examination report. As for the conclusion that the Company's procedures lack complete documentation, the documentation requested by the examiners would defy logic. The Company must act with its participating providers as its agents for handling refunds of excessive copayments if paid by enrollees. The Company's adjudication process clearly identifies such instances. The Company is always without

means to determine whether a provider has in fact collected any copayment with the provision of its services. The Company's filings with the Department clearly indicate the copayments are going to be requested and will be collected by the provider. Only the provider could supply records to indicate whether appropriate copayments are collected. This is likely true with regard to every procedure and service of a provider since the Company is not present when the copayment is charged on any service. The Company's procedures are adequate given its contracts with its providers and the notices it gives its providers regarding the appropriate copayment amounts.

2. Copayments may not exceed 20% of the aggregate total cost:
   The Company stands by its response and supplemental response to criticism #21. The Company further notes that while given direction by the Department as to a testing procedure that was considered acceptable, such procedures are not based upon a precise definition of aggregate or the time period for testing.

III. Complaints

No comments.

IV. Criticisms and Formal Requests Time Study

No comments.

Jeffrey Bond, Chief Executive Officer

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