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

FINAL MARKET CONDUCT EXAMINATION REPORT

HMO Business of

Community Health Plan
NAIC # 95145

MISSOURI EXAMINATION # 0612-52-TGT

NAIC EXAM TRACKING SYSTEM # MO268-M122

May 25, 2010

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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 Department of Insurance, Financial Institutions, and Professional Registration (DIFP). In performing this examination, the DIFP selected a portion of The Company's operations for its 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 Company's response and administrative actions based on the findings of the Director of the DIFP.

Wherever used in the report:

"Company" or "CHP" refers to Community Health Plan;

"CSR" refers to Code of State Regulation;

"DIFP" refers to the 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;

"COC" refers to Certificate of Coverage;

"EOB" refers to Explanation of Benefits.

SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, Sections: 354.190, 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 the Company's compliance with the Uniform Disposition of Unclaimed Property Act.

The Company reviewed was Community Health Plan (CHP).

The time period covered by this examination is primarily from January 1, 2005, through December 31, 2005, unless otherwise noted.

The State of Missouri completed a prior Market Conduct examination on February 4, 2003.

While the examiners reported on the errors found in individual files, the examination also focused upon 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 percent (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 (7%). Any operation with an error ratio exceeding these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business: Accident & Health insurance. The examination included, unless otherwise noted, a review of the following areas of the Company's operations for the lines of business reviewed: Forms and Filings, Underwriting and Rating, Claims, and Complaints.

COMPANY PROFILE

Missouri admitted Community Health Plan (CHP) as a Health Maintenance Organization (HMO) on December 29, 1994. CHP covers residents of the following counties in Missouri who enroll through employer groups.

County	Approval Date	County	Approval Date
Andrew	12/29/1994	Atchison	12/29/1994
Buchanan	12/29/1994	Caldwell	12/29/1994
Carroll	12/29/1994	Cass	02/09/1999
Clay	12/29/1994	Clinton	12/29/1994
Daviess	12/29/1994	De Kalb	12/29/1994
Gentry	12/29/1994	Grundy	12/29/1994
Harrison	12/29/1994	Henry	02/09/1999
Holt	12/29/1994	Jackson	12/29/1994
Johnson	02/09/1999	Lafayette	12/29/1994
Livingston	12/29/1994	Mercer	12.29.1994
Nodaway	12/29/1994	Platte	12/29/1994
Putnam	11/01/2006	Ray	12/29/1994
Saline	06/27/1997	Sullivan	11/01/2006
Worth	12/29/1994		

EXECUTIVE SUMMARY

This examination revealed the following principal areas of concern:

- The Company allows small employer groups to select the minimum number of hours that it requires its employees to work to be eligible for medical insurance. The employers selected over 30 hours as the minimum limit a large percentage of the time. This limit allowed the employer to exclude employees who should be covered. CHP acknowledged that it did not follow the application specifications with regard to work hours but does not audit the employer records to verify that all eligible employees are included. The examiner's review found 36 of 50 applications in which the employer selected over 30 hours as the minimum to qualify for medical coverage.

- The Company requires claim submissions to be complete without error (a clean claim) to be acceptable as a claim. When a claim is submitted with errors or is incomplete, CHP denies the claim. CHP does not perform an investigation to obtain missing or corrected information, so some claims are unpaid. If the provider discovers that the claim was not paid and resubmits a corrected claim at a later date the claim is denied as a late claim submission.

- The Company advises providers that it uses certain guidelines to approve certain medical procedures. CHL states that it notifies providers that these guidelines are used but is not able to provide each provider with access. It does not appear to be appropriate to require a provider to be subject to a specific source and then fail to provide free access to it. It also does not appear to be appropriate to use a reference as a guide, then, apply the qualifiers stringently. The judgment of two medical doctors was overruled by the guidelines.

- The Company paid claims to network providers for members' injuries from motor vehicle accidents as full settlement of its contractual obligation. Then, it allowed some providers, who subsequently received payment from the motor vehicle insurance carrier, to return the payment made by CHP. In so doing, the Company failed to allow its member to receive full payment from the auto insurance carrier for personal injury damages incurred. Effectively, the Company improperly coordinated benefits with an auto insurance carrier's liability coverage and failed to enforce the COB provision in the policy. The Company also allowed providers to receive more than the contracted amount for treatment of the injured members.

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

In this section of the report, the examiners reviewed the Company's underwriting and rating practices. These practices included use of policy forms, adherence to underwriting guidelines, assessment of premiums and procedures to decline or terminate coverage. Because there were a large number of policy files, examining each and every policy file was not appropriate. To reduce the duration of the examination, while still achieving an accurate evaluation of the Company's practices, the examiners employed a statistical sampling of the Company's policy files. A policy file as a sampling unit is one complete premium unit representing the coverage provided or restricted by the riders attached to the policy. The most appropriate statistic to measure the Company's compliance with the law is the percent of files in error. An error can include but is not limited to any miscalculation of the premium based on the information in the file or any improper acceptance or rejection of applications, misapplication of the Company's underwriting guidelines and any other activity violating Missouri laws.

A. Forms and Filings

The examiners reviewed the Company's policy forms to determine its compliance with filing, approval and content requirements to ensure that the contract language is not ambiguous and is adequate to protect those insured. The examiners reviewed the forms used by the Company for the specified type of business.

The examiners noted no errors in this review.

B. Underwriting and Rating

The examiners reviewed policies already issued by the Company to determine the accuracy of rating and adherence to prescribed and acceptable underwriting criteria.

Following are the results of the reviews.

1. Small Employer Group Underwriting

Field Size:	104
Sample Size:	50
Type of Sample:	Random
Number of Errors:	36
Error Rate:	72%
Within Dept. Guidelines:	No

The examiners noted the following errors in this review.

a. Under Missouri statute, all qualified employees in small employer groups (from 2 to 50) must be offered coverage under the group plan. One of the specified criteria for small groups states that the employee must not be required to work more than 30 hours per week to qualify for medical coverage.

As a small group provider, CHP is required to make sure that any eligible employee is not excluded by the small group employer who would otherwise impose an eligibility requirement of more than 30 hours. It is clear from the underwriting documentation reviewed that CHP allowed employers to choose work weeks that exceeded 30 hours before employees would be eligible for coverage in at least 36 instances.

Allowing the small group employer to arbitrarily select the number of work hours required for coverage negates both the spirit and the intent of the Small Employers Act. The 30 hour requirement is neither a suggested guideline nor is it a minimum number of hours to qualify. On the contrary, it is the maximum number of hours an employee can be required to work before being eligible to obtain group coverage. Such conduct on the part of CHP constitutes an unfair trade practice.

References: Section 379.930.2(15), RSMo, and DIFP Bulletin 07-07.

The Company stated that it did not allow companies to limit acceptance of an employee based upon the number of hours worked if it was more than 30 hours. Further inquiry found that CHP did not take precautions to assure that this was not done. The application form addressed the number of hours and allowed the input of more than 30 hours. Without a verification process, CHP cannot know that all eligible employees are covered as required.

GROUP NUMBER	Hrs Selected For Eligibility	GROUP NUMBER	Hrs Selected For Eligibility
10080	40	11450	32
10145	38	11605	40
10190	40	11740	32
10205	40	11780	48
10700	40	11790	40
10720	35	11810	40
10760	40	12080	40
10790	40	12150	35
11010	40	12260	40
11050	40	12290	40
11115	32	12390	40
11145	40	12490	40
11150	40	12510	40
11195	40	12530	40
11255	40	12620	32
11355	40	12700	40
11395	40	12830	40
11435	40	12900	40

II. CLAIM REVIEWS

In this section, the examiners reviewed the claim practices of the Company to determine its accuracy of payment, efficiency in handling, adherence to contract provisions and compliance with Missouri law. Because there were a large number of claim files, examining each and every file was inappropriate. The examiners conducted a statistical sampling of the Company's claim files. A claim file as a sampling unit is an individual demand/request for payment under an insurance contract for benefits that may or may not be payable. The most appropriate statistic to measure a company's compliance with the law is the percent of files in error. An error can include but is not limited to any unreasonable delay in the acknowledgment, investigation or payment/denial of a claim, the failure to calculate the claim benefits correctly, or the failure to comply with Missouri law on claim settlement practices.

The following reviews included all of the claims that fit specific parameters. After researching all files, the claims relevant to Missouri laws that pertain to mandated benefits were selected for review.

A. Unfair Settlement and General Handling Practices

The examiners reviewed paid and denied claims for adherence to claim handling requirements and contract provisions.

The following are the results of the reviews.

1. Pre-Examination Re-Review of Claims

The Examiners asked the Company to review certain claims that it denied during the review period and verify proper handling. The Company's re-review resulted in one payment of an ER and Ambulance claim for $277.80. Interest for delayed payments was also paid during this process.

2. Claim Processing

a. The Company will accept a claim for payment only if it is a "clean claim" which requires all information to be included and correct. If a submission is not complete or has incorrect information, it is not considered a claim and is denied on an EOB using a code indicating information is incorrect or missing.

Missouri law does not contain a provision for clean claims.

References: Sections 376.383 and 376.384, RSMo

b. The Company advises providers that it uses Milliman guidelines to approve certain medical procedures. CHP states that it notifies providers that these guidelines are used but due to licensing agreements are not able to provide each provider with access. It does not appear to be appropriate to require a provider to be subject to a specific source and then fail to provide free access to it. It also does not appear to be appropriate to use a reference as a guide, then apply the qualifiers stringently.

References: Section 376.1361.6, RSMo and 20 CSR 400-10.010(1)

3. <u>Denied Childhood Immunization Claims</u>

Field Size:	257 (63 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual reviews.

The examiners noted no errors in this general review.

4. <u>Denied Mammogram Claims</u>

Field Size:	167 (124 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual reviews.

The examiners noted no errors in this review.

5. <u>Denied PAP Smear Tests</u>

Field Size:	142 (119 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual reviews.

The examiners noted no errors in this review.

6. <u>Denied PSA Test Claims</u>

Field Size:	92 (72 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual reviews.

The examiners noted no errors in this review.

7. <u>Denied Cancer Screening Tests</u>

Field Size:	56 (43 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual

The examiners noted no errors in this review.

8. Denied ER and Ambulance Claims

Field Size:	909 (462 Patients)
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners conducted an electronic worksheet review of the entire field size to determine how the Company claim practices operated in the handling of these claims. After this review, the examiner selected specific denial codes to review. These reviews follow the individual reviews.

The examiners noted no errors in this review.

9. Denied Claims due to Late Filing by Provider

The Company's agreement with providers includes a time limitation for filing claims. If the provider does not file a claim within 120 days of the incurred date, CHP will deny the claim unless the provider can produce proof that it was submitted previously. Claims that are submitted with errors or missing information are denied. The Company's claim handling procedures do not include a requirement for follow up investigations to obtain missing or correct information. CHP does not maintain its claim records in a manner to show relationships to prior submissions. This lack of continuity is problematic when a provider is required to submit a claim within a specified time frame. When a claim is denied, the provider must submit a new claim to which CHP assigns a new claim number and dates it received with the current date.

The examiners reviewed a census of 130 claims that were denied for this reason. All of these claims were recorded as received more than 120 days after the incurred date. The providers were required to waive these claim payments. CHP has failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

References: Section 375.1007(3) and (4), RSMo

10. Third Party Payor Claims

During the period under review, CHP paid claims for members' injuries from motor vehicle accidents according to its contract with its network providers. The providers in the following four claims also received payment from the motor vehicle insurance carriers so they returned the payment made by CHP. Missouri requires an HMO to include in its contract with providers a Hold Harmless provision to accept the contractual benefit as payment for the HMO members' care. Missouri does not consider payment from a Third Party Carrier from liability coverage as a COB carrier. This is clearly stated in the Member Contract. When CHP allowed the provider to accept payment from the motor vehicle insurance carrier in excess of its payment, it failed to abide by its contract with these providers to the financial detriment of the member. In so doing, CHP failed to allow its member to receive full liability payment from the auto insurance carrier for personal injury damages incurred. Effectively, the Company coordinated benefits with an auto insurance carrier's liability coverage, which is not allowed in Missouri.

References: Section 354.606, RSMo and 20 CSR 400-2.030(2)(F)4

Claim #

05342E029900

05315E073200

122105044200

122105044300

III. COMPLAINTS

A. Missouri Department of Insurance, Financial Institutions, and Professional Registration

The examiners reviewed the Company's handling of DIFP complaints processed during the period under review.

Field Size:	2
Type of Sample:	Census
Number of Errors:	None
Within Dept. Guidelines:	Yes

The examiners noted no exceptions in this review.

B. Appeals

The examiners reviewed the Company's handling of appeals during the period under review.

Field Size:	37
Type of Sample:	Census
Number of Errors:	2
Error Ratio:	5.4%
Within Dept. Guidelines:	Yes

The examiners noted the following exceptions in this review.

a. The patient, a three year old, was treated by his doctor 12 times during 2003 for tonsillitis and related conditions. During 2004 he had been treated five times for the same conditions, and during 2005 he was treated four more times. The provider requested authorization to perform a tonsillectomy. The Company refused because its reference manual required:

   6 or more tonsillar infections in 1 year
   5 or more tonsillar infections annually over a 2 year period, despite appropriate antibiotic treatment
   3 or more episodes annually over a 3 year period, despite appropriate antibiotic treatment

   The company refused authorization for a tonsillectomy for a child who had seen the doctor on multiple occasions for illnesses with symptoms

similar to tonsillitis and three times specifically for tonsillitis. The member was treated nine times in 2004 and 2005 for tonsillar or a related condition. He appears to satisfy the Milliman standard which relates pharyngitis and tonsillitis as complimentary illnesses in the rationale for tonsillectomy.

Two physicians recommended surgery for this member who incurred 21 office visits for related conditions over a three year period.

The Company's actions in the treatment requirements for this three-year-old child are neither fair nor equitable. CHP incurred expense for over 21 office visits and treatments.

The member has transferred coverage to a different group which relieves CHP from any liability in the child's treatment. Nevertheless, while covered, the Company failed to handle the claim in a fair and equitable manner.

Reference: Section 375.1007(1), (3) and (4), RSMo

Appeal Number	Member Number
051227000001	041103169

b. The Company denied benefits to a provider for treatment of TMJ. Part of the treatment was to determine that TMJ was the diagnosis. When the examiner requested a reason for the denial of the treatment to obtain a diagnosis, the Company agreed to pay benefits for that treatment.

References: Section 375.1007(1), (3) and (4), RSMo

Appeal Number

05042100002

IV. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the Company's ability to provide the examiners with requested material or to respond to criticisms within the 10 calendar day time limit required by Section 374.205.2(2), RSMo, and 20 CSR 300-2.200(5)&(6).

A. Criticism Time Study

Calendar Days	Number of Criticisms	Percentage
0 to 10	7	100%
Total		

The Company responded to all criticisms within the 10 calendar days required by Missouri.

Reference: Section 374.205.2(2), RSMo and 20 CSR 300-2.200(5)(6)

B. Formal Request Time Study

Calendar Days	Number of Requests	Percentage
0 to 10	32	100%
Total		

The Company responded to all formal requests within the 10 calendar days required by Missouri.

Reference: Section 374.205.2(2), RSMo and 20 CSR 300-2.200(5) and (6)

V. EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Community Health Plan (NAIC #95145), Examination Number 0612-52-TGT. This examination was conducted by Michael D. Gibbons, Gary Land, and Walt Guller. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated September 10, 2009. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

_____

Jim Mealer Date
Chief Market Conduct Examiner

November 12, 2009

Carolyn H. Kerr
Senior Counsel
Market Conduct Section
301 West High Street, Room 530
P.O. Box 690
Jefferson City, Missouri 65102-0690

RE: Missouri Market Conduct Examination #0612-52-TGT
Community Health Plan (NAIC #95145)

Dear Ms. Kerr:

Enclosed is Community Health Plan's Formal Response to the examiners' market conduct report of our company dated October 13, 2009.

For those areas that we disagree with the examiners' report, we have included substantiation of our reasons.

If you have any questions or comments please contact me at (816) 271-7765, or by e-mail at stan.vaughan@heartland-health.com.

Sincerely,

Stan Vaughan
Director of Finance and Compliance
Community Health Plan

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Community Health Plan Formal Response
Missouri Market Conduct
Examination # 0612-52-TGT
October 13, 2009

Executive Summary

While the Company will reply more fully to the issues raised in the executive summary in its responses to the examination findings, it offers the following comments with regard to the four matters in the executive summary:

- The Company did not allow small employer groups to select a minimum number of hours for its employees to be eligible for medical insurance. The Company's application included a question, not used in underwriting, where the employer reported its practice. Nothing in the small employer insurance law grants any authority to the Company to take any actions against employers' determinations if erroneous.
- The Company performs completely appropriate procedures, for review of claims when complete information necessary for adjudication of the claim is received, as stipulated by DFIP regulations.
- The Company provides sufficient opportunity for providers to know the guidelines it follows for approving medical procedures which is within the contractual arrangements it has with those providers.
- The DFIP examiners have completely mischaracterized the activity which has occurred regarding a few providers involvement with motor vehicle accident settlements where the provider may be paid twice. The company is not engaging in a COB operation in those circumstances as it has no control over how the motor vehicle insurer makes payments in settlement of claims in order to receive waivers from an injured party. Precisely because the company does not coordinate benefits with an auto insurance carrier it has no ability to know what that carrier is doing with regard to settlement or payment.

Response to examination findings

I. Underwriting and rating practices

A. Forms and fillings – no comment

B. Underwriting and rating

1. Small employer group underwriting

a. The Company acknowledges a line in its application, which was approved by the Missouri DFIP, inquired as to the minimum hours an employer used for determining eligible

employees. The Company did not use that information in underwriting and is unaware of any small employer which it insured which imposed a limitation that excluded any eligible employee from coverage. In addition, even with such a discovery, the small employer law provides no mechanism for the Company to provide any enforcement of such a requirement. The Company is required to offer coverage to any small employer making application, through one plan or another. The employer has an obligation to determine its eligible employees and to ensure that they have the opportunity to enroll for benefits.

Further, the conduct of the Company can not in any way constitute an unfair trade practice and such an allegation is unfounded and unsupported. The section cited by the examiners references unfair representations of the policy or advertising. The application is clearly not advertising. The policy language itself provides precise and accurate information regarding the coverages of the policy, so that 375.936(6) is inapplicable. Even more egregious is the allegation that the company violated 375.936(7) since the company made no statement or representation on the application, it merely made an inquiry. This section does not apply to the format of an application, certainly not when the application has been submitted and approved by the Missouri DFIP.

II. Claim reviews

A. Unfair settlement and general handing practices

1. No comment

2.

a. The examiners assert that in order to substantiate that it has reasonable standards for prompt investigation and settlement of claims that the Company has to adopt some specific second request for missing or incorrect information. Further, in their prior inquiry, the examiners asserted that the Company must submit at least two inquiries to a provider for further information to verify that it has an investigative procedure. Neither of these assertions have any foundation in any statute or regulation in effect at the time frame being examined. Indeed, until the adoption of 20 CSR 100-1.060, the Standards for Prompt, Fair, and Equitable Settlements

under Health Benefit Plans, on May 30, 2009, no specific regulatory standards for requesting information from a provider or policyholder were in effect.

These assertions by the examiners are based upon speculation as to what method of inquiry by the Company best results in providers supplying additional necessary information not included in the initial claim submission. The Company's procedure is based upon its real world experience as to claim submission operations of providers and as to what procedures result in the most prompt responses by providers to requests for additional information, which ultimately results in a more prompt payment by the Company. The Company's procedure allows it to send a remittance advice which advises the provider that additional information is needed. The company's experience is that this notice results in more prompt responses by providers, because it is more easily understood by the provider's office.

The notice in the remittance advice fully complies with Section 376.383.2(2) in making a request for additional information. In fact, Section 376.383 does not mention the suspension of a claim until fifteen days after a carrier has received information in response to a final request for information. As elaborated by the company in its responses to the examiners, the remittance advice notice that additional information is needed is not the Company's final request for information. In fact, the Company continues to send additional requests for information to the providers until such information is received.

Nothing in the Company's procedure in any way violates Section 376.383 and therefore clearly does not violate Section 375.1007(3) which only requires the adoption of reasonable standards. Compliance with a specific state statute which outlines a specific claims procedure to follow is certainly reasonable.

Further, the Company's procedure fully complies with 20 CSR 100-10.050(1) which requires only that a claim be accepted or denied "after the submission of **all** forms necessary to establish the nature and extent of a claim." Incomplete claims do not meet the requirements of the regulation or the cited statutes.

b. The Company is in compliance with all statutes regarding utilization review. It does provide all members and providers with all guidelines and materials that are used to make adverse determinations. The Company's denial letters include the following statement, "You are entitled to receive, upon your request, access to and copies of all documents relevant to the denial."

Section 376.1361.6 RSMo and 20 CSR 400-10.010 were referenced in the examination. In reviewing these regulations and statutes, along with Section 376.1363 RSMo, the Company cannot find a requirement to provide "free access" as is mentioned in the examination.

- According to 20 CSR 400-10.010,1,3 – "Instructions for requesting a written statement of the clinical rationale, including the review criteria, used to make the determination." As mentioned above and as evidenced in the Company's denial letter, members and providers are provided with instructions on how to obtain the information. This statement again does not indicate that paper documentation cannot be used and that only online access is acceptable.
- Section 376.1361 RSMo – does not mention providing free access. Item 1 does state the following "A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request by either the Director of the Department of Health and Seniors Services or the Director of the Department of Insurance, Financial Institutions and Professional Registration." The Company can provide hard copies of any criteria if requested.

As mentioned in the examination, the Company does use Milliman Care Guidelines and purchases licensing agreements. It would be economically unfeasible to pay for Milliman licenses for the thousands of providers the Company has in their network. Purchasing licenses for all providers would be the only way to provide free access and the Company does not feel that is the fiscally responsible way to use the premiums they receive from individuals and employer groups.

The Company does provide its providers with access to its guidelines and research materials that have been used to

make an adverse determination as required by the regulations and statute required by Missouri. It is not uncommon for the Care Management Department to send copies of guidelines to physicians or their office staff and then walk them through guidelines. In the past, even the Provider Relations Representatives have taken guidelines out to physician offices.

3. No Comment

4. No Comment

5. No Comment

6. No Comment

7. No Comment

8. No Comment

9. See the Company's response to paragraph 2b. above.

10. As a preliminary matter, the Company is unaware that the examiners actually reviewed these claims since they were not in the claims for which access was requested by the examiners. Any information about the claims occurred by telephone call. The Company denies giving any indication that the providers "accepted larger amounts of benefits for the treatment of members." The Company has no information at all as to what the providers accepted and would not characterize the providers compensation.

The Company's provider contract includes language as required by 354.606.2. So far as the Company is aware, no provider sought any additional compensation from an enrollee. The statute specifically states the provider is not prohibited "From pursuing any available legal remedy; including but not limited to, collecting from any insurance carrier remedy specially allowed to the provider." The Company has no real authority under the statutory provision to prevent the funds being returned to the Company by providers only attempting to prevent being compensated twice.

Finally the COB regulation, 20 CSR 400-2.030 is not applicable to these matters. The Company did not apply any COB provision. The Company processed the claim and executed a check for full compensation. The Company's tender was simply refused. The Company took no action to make any type of COB offset, with individual car insurance or otherwise.

III. Complaints

A. No Comment

B.

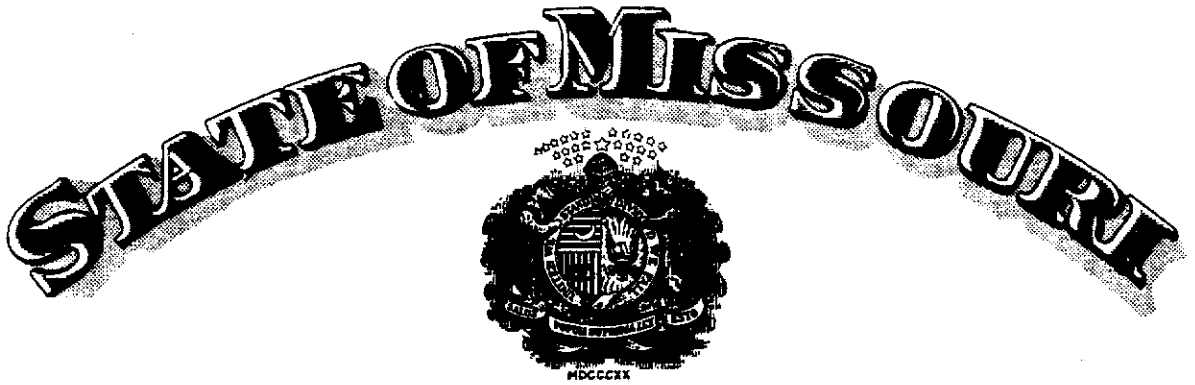
1. The Medical Director, a board certified pediatrician, did not authorize this tonsillectomy based upon the medical information submitted by the primary care physician. This information did not meet Milliman Care Guidelines. The Milliman Care Guidelines are nationally recognized evidence based clinical guidelines. The examiners noted it was refused by the Company because of their reference manual which is not the case. The Company notified the member and provider of their appeal rights and followed all utilization management and appeals timeframes as required by the DIFP. The allegation that the Company's actions are neither fair nor equitable is unfounded and unsupported. The examiner's concluded that the Company failed to handle the claim in a fair and equitable manner citing Section 375.1007 (1), (3) & (4) RSMo. The Company did not receive a claim for this tonsillectomy, therefore, the Company cannot be in violation of this section.

2. No Comment

VI. Criticisms and Formal Request Time Study

A. No Comment

B. No Comment



DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

In re:	)	
	)	Examination No. 0612-52-TGT
Community Health Plan (NAIC #95145)	)	

ORDER OF THE DIRECTOR

NOW, on this 22ND day of JUNE, 2010, Director John M. Huff, after consideration and review of the market conduct examination report of Community Health Plan (NAIC #95145), (hereafter referred to as "CHP") report numbered 0612-52-TGT, 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. 2009), is in the public interest.

IT IS THEREFORE ORDERED that CHP 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 CHP shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place CHP 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 CHP shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $8,948, 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 22ND day of JUNE, 2010.

John M. Huff
Director