

# STATE OF MISSOURI



## DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION

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

In re: )  
 ) Examination No. 0609-32-LAH  
Coventry Health & Life Insurance Co. )  
(NAIC #81973) )

### ORDER OF THE DIRECTOR

NOW, on this 30<sup>TH</sup> day of December, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of Coventry Health & Life Insurance Co. (NAIC #81973), report numbered 0609-32-LAH, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2006), is in the public interest.

IT IS THEREFORE ORDERED that Coventry Health & Life Insurance Co. 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 Coventry Health & Life Insurance Co. shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Coventry Health & Life Insurance Co. 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 Coventry Health & Life Insurance Co. shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$154,497.43, 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 30<sup>th</sup> day of DECEMBER, 2009.

  
John M. Huff  
Director



**DEPARTMENT OF INSURANCE, FINANCIAL  
INSTITUTIONS AND PROFESSIONAL REGISTRATION**

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

TO: Office of the President  
Coventry Health & Life Insurance Co.  
6705 Rockledge Drive  
Bethesda, MD 64126

RE: Missouri Market Conduct Examination 0609-32-LAH  
Coventry Health & Life Insurance Co. (NAIC #81973)

**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 Coventry Health & Life Insurance Co., (hereafter referred to as "Coventry"), as follows:

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

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

WHEREAS, Coventry Health Care of Kansas (hereafter referred to as "CHC-KS") and Group Health Plan (hereafter referred to as "GHP") are subsidiaries of Coventry and administer its business operations; and

WHEREAS, the Department conducted a Market Conduct Examination of Coventry, which included the business practices of CHC-KS and GHP, and prepared report number 0609-32-LAH; and

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

1. In some instances, CHC-KS and GHP incorrectly entered license numbers for producers appointed by the Company, in violation of §375.022.1, RSMo and 20 CSR 700-1.130.
2. In some instances, the examiners could not determine the producers' number and the date on which Coventry recorded the appointment or termination information to its register, thereby violating 20 CSR 300-2.200(2) and (3)(C) (as amended 20 CSR 100-8.040(2) and (3)(C), eff. 7/30/08).
3. In some instances, GHP incorrectly listed appointment dates for some of its producers, in violation of §375.022.1, RSMo and 20 CSR 700-1.130.
4. In some instances, GHP failed to report termination dates for its producers, in violation of §§375.012(4), and 375.014, RSMo, and 20 CSR 700-1.020.
5. In some instances, GHP continued its contracts with producers after they had terminated their license with the DIFP, in violation of §§375.141.1(12) and 375.071.1, RSMo.
6. In some instances, GHP allowed individuals to solicit for the company before obtaining their producer license, in violation of §§375.014.1, and 374.017.1, RSMo.
7. In some instances, GHP accepted applications from producers who indicated associations with producer entities that did not report to the DIFP, in violation of §§375.015.5 and 375.226, RSMo, and 20 CSR 700-1.130(2).
8. In some instances, CHC-KS and GHP entered into contracts with third party administrators which were not currently licensed in Missouri, as required by §376.1092.1, RSMo, and 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800.
9. In some instances, CHC-KS's advertisements and Benefit Summaries contained language that had the tendency, capacity, or effect of being misleading and unclear, in violation of §§375.995.4(6), and 376.1225, RSMo, 20 CSR 400-5.700(4) and (5)(A)1. and 20 CSR 400-10.200(1).
10. In some instances, GHP used communications that failed to clearly identify Coventry as the insurer of record and that it is the company of record with financial responsibility claims presented under its contracts, in violation of §375.936(4), RSMo, and 20 CSR 400-5.700(2), (12)(A) – (D).
11. In some instances, GHP failed to make a reasonable disclosure in its solicitation and sales materials of certain information relating to premium rates and provisions for health benefit plans for small employers, renewability of policies and contracts, and preexisting conditions, as required by §379.936.4, RSMo.

12. In some instances, GHP's advertisements and policy brochures included information about benefits and rates but failed to include information relating to limitations and exclusions, in violation of 20 CSR 400-5.700(5)(B).

13. Some of CHC-KS Schedules of Benefits forms, which are no longer in use, failed to include mandated benefit coverage without any deductible or co-pay expense, as required by §376.1215.1 and .2, RSMo.

14. In some instances, CHC-KS and GHP policies failed to include maternity benefits unless the member purchased a Maternity Benefits Rider, resulting in the exclusion of complications of pregnancy claims in its policies, in violation of §375.995.4(6), RSMo.

15. In some instances, GHP used the verbiage "Sole and Absolute Discretion" in its policy forms to describe its contractual rights under its policies, in violation of §375.936(16), RSMo.

16. In some instances, GHP's policy and rider forms included improper language relating to chiropractic benefits and used riders to provide chiropractic coverage rather than including the coverage as part of the policy, thereby violating §§376.405 and 376.1230, RSMo.

17. In some instances, GHP added a 1% charge in its premium for Domestic Partner coverage, in violation of §§375.936(11)(e), 375.995.4(11), and 20 CSR 400-2.120(2)(E)

18. In some instances, GHP allowed small group employers to establish the number of hours required to be eligible for group health benefits at more than 30 hours per week, in violation of §379.930.2(15), RSMo, and DIFP Bulletin 07-07.

19. In some instances CHC-KS and GHP failed to maintain and provide requested documents in a timely manner and in such a way so that the Company's underwriting practices could be evaluated, in violation of §§375.205.2, 379.940, RSMo, and 20 CSR 300-2.200(2) and (3)(A) and (E) (as amended 20 CSR 100-8.040(2) and (3)(A) and (E) (eff. 7/30/08)).

20. In some instances, GHP failed to maintain its individual health insurance policy files in such a way so that the Company's underwriting and rating practices could be readily ascertained, in violation of §376.783.2, RSMo, and 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08).

21. In some instances, GHP included a reference in its Broker Manual and Field Underwriting Guidelines to a \$500 reinstatement fee that was not disclosed in its policy provisions, unfairly discriminated based on gender, and passed underwriting costs to the applicant by requiring the applicant to pay for the collection of medical records, thereby violating §375.936 (7), (11)(e) and (g), RSMo, and 20 CSR 400-8.200(2)(B).

22. In some instances CHC-KS failed to maintain and provide claim-specific documentation on its files and failed to record a grievance on its complaint register, as required by §376.936(3), RSMo, and 20 CSR 300-2.100 and 20 CSR 3.200(2) and (3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08).

23. In some instances, GHP required its providers to obtain approval for mandated benefits and failed to pay for the benefits, thereby violating §§376.429, 376.1199(3), 376.1219.1, 376.1250 and 408.020, RSMo. RSMo.

24. In some instances, CHC-KS failed to maintain its claim files so that the examiners could reconstruct the pertinent events and determine the company's claims handling practices, including how the company responded to its claims, thereby violating 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100 and 20 CSR 3.200(2) and (3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08).

25. In some instances, GHP required the submission of a Treatment Plan in advance of treatment rather than basing the determination of coverage on medical necessity, in violation of §376.1230, RSMo.

26. In some instances, GHP improperly denied or failed to properly pay chiropractic, mental health, in-network urgent care, pharmacy, emergency care, and ambulance claims, in violation of §§354.442.1(3), 375.1007(3) and (4), 376.441(3), 376.782, 376.811.4(2), 376.816.2(2), 376.827, 376.1230, 376.1350(12), 376.1365, 376.1367, 376.1382, and 376.1385, RSMo and 20 CSR 100-1.050(1)(H).

27. In some instances, GHP refused to pre-authorize treatment for its members and improperly applied a limitation that was not specified in the contract, in violation of §§375.1007(1), 376.1365, 376.1382, and 376.1385, RSMo.

28. In some instances, GHP's claim processing practices relating to the implementation and compliance with the investigation and proper and timely payment of claims violated §375.1007, RSMo, 20 CSR 100-1.010, and 20 CSR 100-1.030.

29. In some instances, CHC-KS failed to timely pay and correctly calculate the total due on claims after completing its investigation, in violation of §§376.1007(1), (3), (4), and (6), and 376.383.5, RSMo, and 20 CSR 100-1.050(1)(A).

30. In some instances, CHC-KS paid claims at non-participating provider rates and allowed the member to be balance billed by the provider, in violation of 20 CSR 400-7.130.

31. In some instances, CHC-KS improperly denied coverage on pharmacy claims benefits and failed to include documentation in its file to show why a certain treatment was inappropriate, in violation of §§375.1007(4) and 376.441, RSMo.

32. In some instances, CHC-KS failed to maintain documentation of the postmark for the DIFP complaints it received during the exam period and could not locate an appeal file when requested by the examiners, in violation of 20 CSR 100-4.100(2)(A), 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08) and 20 CSR 400-7.110.

33. In some instances, the forms and letters that GHP sent to complainants contained conflicting and misleading information relating to the Coventry's responsibilities for the benefits in the policy, in violation of §§375.936(4) and 376.1088, RSMo.

34. In some instances, GHP failed to include all complaints and information for all required fields in its complaint register, as required by §§376.936(3) and 376.1375, RSMo, and 20 CSR 300-2.200(3)(D) (as amended 20 CSR 100-8.040(3)(D), eff. 7/30/08).

35. In some instances, GHP's second level appeals committees failed to include members of the plan on the committee, in violation of §§354.442 and 376.1385, RSMo.

WHEREAS, Coventry 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, including, but not limited to, taking the following actions:

1. Coventry agrees to take corrective action to assure that the errors noted in the above-referenced market conduct examination reports do not recur; and

2. Coventry agrees to file documentation of all remedial actions taken by it to implement compliance with the terms of this Stipulation and to assure that the errors noted in the examination report do not recur, including explaining the steps taken and the results of such actions, with the Director within 60 days of the entry of a final Order closing this examination;

3. GHP and CHC-KS agree to reopen and pay the full amount of all improperly denied or rejected claims noted by the examiners, including all applicable interest due through the date of payment. Evidence shall be provided to the Department that such payments have been made within 90 days after a final Order concluding this exam is entered by the Director; and

4. GHP agrees to reopen all of its denied chiropractic claims dated August 28, 2003, through the date that an Order is entered by the Director finalizing this exam, to make sure that no claims were improperly denied. If any claims should have been paid, the Company readjudicated all such claim and issue all payments that are due to the claimants, including all applicable interest through the date of payment. Evidence shall be provided to the Department that such payments have been made within 120 days after a final Order concluding this exam is entered by the Director.

WHEREAS, Coventry neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

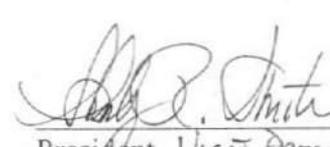
WHEREAS, Coventry is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

WHEREAS, Coventry, 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, Coventry hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0609-32-LAH further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$154,497.43.

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 Coventry to transact the business of insurance in the State of Missouri or the imposition of other sanctions, Coventry does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of \$154,497.43, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED: 11/24/09

  
~~President~~ VICE PRESIDENT AND SECRETARY  
Coventry Health & Life Insurance Company



June 29, 2009

Ms. Carolyn Kerr  
Senior Counsel  
Missouri Department of Insurance  
Market Conduct Section  
301 West High Street, Room 530  
Jefferson City, Missouri 65101

RECEIVED  
JUN 30 2009  
DEPT. OF INSURANCE  
FINANCIAL INSTITUTIONS &  
PROFESSIONAL REGISTRATION

Re: Missouri Market Conduct Examination #0609-32-LAH  
Coventry Health and Life Insurance Company  
Written Response to Examination Report

Dear Carolyn,

Please find attached 1 copy of Coventry Health and Life Insurance Company's ("CHL") Response to the Missouri Department of Insurance ("MDI") Market Conduct Examination Report (Report Number #0609-32-LAH) (the "Report"). This Report examines CHL's practices at both Coventry Health Care of Kansas, Inc. ("CHL-KS") and Group Health Plan, Inc. ("CHL-GHP"). As directed in your letter dated March 23, 2009, CHL has also attached an electronic copy of this response and its exhibits. Pursuant to our telephone conversation on May 19, 2009, the MDI extended the deadline for CHL's response to June 30, 2009.

As you are aware, the Report sets forth MDI findings regarding CHL-KS's and CHL-GHP's business practices from as far back as 2003. As such, the Report focuses on many business practices that are old and no longer followed by these companies. As you will see in the attached response, CHL-KS and CHL-GHP have already corrected many of the practices cited in the Report. Nonetheless, in addition to the attached response, CHL would like to register its disagreement with the various Findings citing CHL for policy forms that do not comply with Missouri law. With the exception of certain Findings addressing CHL-GHP's chiropractic riders, these Findings inequitably penalize CHL for using the very policy forms that the MDI reviewed and deemed sufficiently compliant to merit MDI approval.

Please feel free to contact me regarding any questions or comments you may have concerning this letter or CHL's response to the Report. My work phone is 301-581-5560, and my email address is [mportnoy@cvty.com](mailto:mportnoy@cvty.com). We look forward to working with you to complete this examination.

Sincerely,

A handwritten signature in cursive script that reads "Michael Portnoy".

Michael Portnoy  
Senior Attorney  
Coventry Health Care, Inc.

Encl.

cc: Roman Kulich, Group Health Plan, Inc.  
Michael Murphy, Coventry Health Care of Kansas, Inc.  
Jonathan Weinberg, Esq., Coventry Health Care, Inc.

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

RESPONSE TO  
MARKET CONDUCT  
EXAMINATION

REPORT NUMBER: 0609-32-LAH

June 30, 2009

**I. SALES AND MARKETING**

**A. Company Authorization**

Regarding the Company's operation in Missouri, the examiners found Coventry Health and Life Insurance Company ("CHL") within the scope of its Certificate of Authority.

**B. Licensing of Producers and Producer Entities**

**CHC-KS**

1. **MDI Finding:** The Company provided its Producer Appointment Register to the DIFP with incorrect information and without a method to show when it entered the information. The Company entered a number for 144 producers that was not the producer license number assigned by the DIFP. Furthermore, the date that the Company added the appointment information to the register could not be determined. Reference: Section 375.022, RSMo and 20 CSR 700-1.130

**CHL-KS Response:** CHL-KS partially disagrees and agrees with this Finding.

First, CHL-KS respectfully disagrees that the Producer Appointment Register ("Register") failed to list each producer's MDI-assigned producer number. Along with this response are copies of the agent licenses received by CHL-KS showing the "Ident. No." assigned to each producer by the MDI and as entered in the Register. See Exhibit [KS001]. CHL-KS believes that the discrepancy may be due to a change at the MDI whereby the MDI-assigned producer number changed from a Social Security Number ("SSN") based number to a non-SSN based number.

Second, even if it could be argued CHL-KS did not display the MDI-assigned producer number, CHL-KS disagrees that it violated section 375.022, RSMo. and 20 CSR 700-1.130. Section 375.022, RSMo. and 20 CSR 700-1.130, RSMo. do not require a company to record the MDI-assigned producer number in the Register or set forth that such number is required element of an accurate, complete and auditable register. If this understanding is incorrect, CHL-KS respectfully requests the examiners to provide the statutory/regulatory citation setting forth this requirement.

CHL-KS agrees that the Register did not include the date that the appointment or termination date was entered into the Register. However, neither section 375.022, RSMo, nor 20 CSR 700-1.130 require the Entry Date to be included in the Register. It is CHL-KS's policy to enter the appointment date and termination date into the Register within 30 days. Attached is a copy of CHL-KS's policy regarding entry of appointment and termination dates. Please reference pages 4 and 5 of the policy regarding appointments and terminations. See Exhibit [KS002]

**GHP**

1. **MDI Finding:** The Company provided a list represented as its Producer Appointment Register to the DIFP for review. The examiners could not accept the list as a Producer Appointment Register because it included appointment dates that did not reflect the actual date CHL-GHP appointed the producer, the producer license number was not always the one assigned by the DIFP, and the date that the Company entered the appointment in the register could not be determined.

Reference: Section 375.022, RSMo, and 20 CSR 700-1.130

**CHL-GHP Response:** CHL-GHP partially agrees and partially disagrees with this Finding.

CHL-GHP disagrees that the date on which CHL-GHP entered the appointment in the register (the "Entry Date") could not be determined. Neither section 375.022, RSMo, nor 20 CSR 700-1.130 require the Entry Date to be included in the Register.

CHL-GHP did not receive a Criticism stating it could not accept the Register; it only received Requests # 40, 41, 42, and Criticism #24, on which it appears this Finding is based.

As stated in CHL-GHP's response to these Requests and Criticism, CHL-GHP agrees with the following:

- With respect to Producer PR331125, CHL-GHP agrees that the appointment date set forth in Register did not reflect the actual date that Company appointed this producer. CHL-GHP has corrected this error. **See Exhibit [GHP-01]**
- CHL-GHP also agrees that the producer license numbers in the Register did not match the producer license numbers assigned by the DIFP with respect to the following producers: PR288261; PR101858; and PR338822. CHL-GHP corrected this error. **See Exhibit [GHP-02]**

2. **MDI Finding:** The Company failed to report termination dates for three producers who were not shown as active in the DIFP records.

Reference: Sections 375.012(4), 375.014, RSMo, and 20 CSR 700-1.020

<u>Producer Number</u>	<u>Company ID</u>	<u>Termination Date</u>
PR155263	22109	12/4/2002
PR160477	18370	12/6/2003
PR165483	20348	1/23/2004

**CHL-GHP Response:** CHL-GHP agrees with this Finding and has corrected this error. See Exhibit [GHP-03]. CHL-GHP's producer appointment/termination policy requires that it record producer termination dates in its Register. See Exhibit [GHP-04].

3. **MDI Finding:** The Company continued contracts with two producers after they had terminated their license in Missouri. The producers signed contract forms after the suspension of their license.

References: Sections 375.141.1(12), and 375.071.1, RSMo

<u>Producer Number</u>	<u>Company Number</u>
PR327168	25422
PR225943	18725

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP's producer appointment/termination policy prohibits contracting with producers without producer licenses in good standing. See Exhibit [GHP-04].

4. **MDI Finding:** The Company allowed the following two persons to solicit for the Company before they obtained their license.

References: Sections 375.071.1, and 375.014.1, RSMo

<u>Producer Number</u>	<u>Company Number</u>
PR342398	24405
PR350513	9270

**CHL-GHP Response:** CHL-GHP, respectfully disagrees with this Finding. With regard to Producer Number PR342398, this producer requested that his license be suspended effective June 30, 2006. The producer subsequently signed an updated attachment to his broker contract on January 18, 2007. However, CHL-GHP was unaware that the producer had suspended his license at the time of signature, and therefore did not knowingly allow such producer to continue to solicit on behalf of CHL-GHP. On January 31, 2007, CHL-GHP learned through a market conduct examination criticism that the broker's license was suspended. Upon receipt of this criticism, the Company terminated the producer's license on February 1, 2007. See Exhibit [GHP-05].

With regard to Producer Number PR350513, CHL-GHP originally requested the Agent of Record change to be effective 7/1/05. This request was not honored because of the producer's license was effective as of 7/1/05. Therefore, CHL-GHP subsequently made the Agent of Record change effective on 8/1/05. CHL-GHP did not pay commissions prior to 8/1/05. See Exhibit [GHP-05].

Finally, CHL-GHP did not violate the statute cited in this Criticism (375.041.1 RSMo) with respect to these two brokers as this statute does not regulate an insurer's conduct with respect to an insurance producer; rather, it prohibits a producer from selling insurance without a license. In addition, 375.071.1 RSMo allows the director to participate in a centralized producer license registry and CHL-GHP has not violated this statute.

5. **MDI Finding:** The Company accepted applications written by producers who indicated associations with specific producer entities. DIFP records did not reflect these associations. A producer entity must advise the DIFP of all producers with whom it is associated. Missouri requires that a producer entity must report any changes to the DIFP within 20 days. The Company allowed the following producer entities to associate with producers who the entity did not report to the DIFP. References: Sections 375.015.5, and 375.226, RSMo, and 20 CSR 700-1.130(2)

<u>Producer Number</u>	<u>Producer Entity</u>	<u>Certificate Number</u>
PR288915	Spetner Associates, Inc.	901164455-01
PR278685	Conrad Consulting	901146217801
PR128891	Daniel & Henry Ins Co	6600001001
PR285663	Eagle Insurance Services	9011153696-01

**CHL-GHP Response:** The Company respectfully disagrees with this Finding. None of the statutes or regulation cited above impose an obligation to inform the MDI of changes in associations between producers and producer entities. The producer entity is responsible for advising the MDI of all producers with which it is associated and any changes thereto.

Section 375.015.5, RSMo. puts the obligation on the producer entity to notify the DIFP of any changes, and therefore the Company did not violate this statute. Also, 20 CSR 700-1.130(2) does not create any obligation on an insurer to notify the DIFP of any producer entity changes.

Finally, Section 375.226 RSMo allows an insurer to restate its charter. This statute does not appear to apply to this Finding; CHL-GHP certainly has not violated it.

6. **MDI Finding:** The Company contracted with Producer # 331125, Company # 23570 on November 28, 2005. However, the date of appointment noted in the Company's Appointment Register was June 21, 2004. The Company entered an incorrect date into its Appointment Register for this producer.  
Reference: Section 375.022.1, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP actually entered this producer into the Register on the same date he was appointed – November

30, 2005. Unfortunately, however, CHL-GHP entered the incorrect appointment date – June 21, 2004 – into the Register. CHL-GHP corrected this error. See Exhibit [GHP-01]. CHL-GHP's producer appointment/termination policy requires that it record producer appointment dates in its Register. See Exhibit [GHP-04].

### C. Third Party Administrators

#### CHC-KS & GHP

1. **MDI Finding:** The administrators, GHP and CHC-KS, entered into a contract with CareMark, Inc. to manage the CHL prescription drug program. This contract was first signed in 1999 and has renewed to this current date. On December 12, 1996, prior to its contract with GHP, CareMark, Inc. caused its TPA license to be inactive and did not renew its license in Missouri. It continued operating without a license until June 19, 2006. Because CareMark, Inc. did not maintain a TPA license, it also did not submit all required reports and forms. An insurance Company is required to operate within Missouri law when dealing with Missouri residents, which includes contracting with companies who are properly licensed.  
References: Section 376.1092.1, RSMo, and 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800

**CHL Response:** CHL respectfully disagrees with this Finding because it has not violated the statute and regulations cited above. Section 376.1092.1 RSMo, prohibits an entity from holding itself out to be an administrator without a certificate of authority. This statute creates an obligation on the administrator, not CHL. As such, CHL is not in violation of this statute.

Further, 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800 set forth the process by which an administrator applies for and renews a certificate of authority and files its annual reports. These regulations create an obligation on the administrator, not CHL. As such, CHL is not in violation of these regulations.

2. **MDI Finding:** The administrator GHP maintained a relationship with Cole Vision Services, Inc. d/b/a Cole Managed Vision to provide vision care as a TPA for its members from at least January 1, 2002. Missouri issued a TPA Certificate of Authority to Cole Vision Services, Inc. d/b/a/ Cole Managed Vision on June 20, 1995, but that license became inactive on May 19, 2006. As noted in the Company's GHP Network Connection, Cole Managed Vision began integrating into Eye Med Vision Care on July 1, 2005. It continues to operate under the EyeMed name. GHP stated that it maintained its relationship with Cole Managed Vision and continues to contract with EyeMed Vision Care. EyeMed Vision Care is not a TPA in the DIFP records. The Company advised that First America Administrators (FAA), a sister company, was providing the vision care services that are required under the CHL contract with

EyeMed Vision Care. However, there is no contract between FAA and CHL.

Missouri requires a business to obtain and maintain a TPA certificate of authority while it operates. Missouri also requires a TPA to have an agreement with an insurer and to notify the DIFP of all insurers and trusts with which it had an agreement during the preceding fiscal year. Since EyeMed Vision Care does not have a TPA certificate of authority and there is no agreement between FAA and CHL, the Company is providing vision care services through a business relationship that does not meet Missouri's specifications.

An insurance Company is required to operate within Missouri law when dealing with its residents, which includes contracting with properly licensed companies. References: Section 376.1092.1, RSMo, and 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800

**CHL Response:** EyeMed Vision Care ("EyeMed") has entered into an administrative services agreement with its sister company, First American Administrators, Inc. ("FAA"), to administer TPA services under the EyeMed contracts, including EyeMed's contract with CHL-GHP. FAA is a licensed Missouri TPA.

The statute and regulations cited above do not prohibit (i) CHL-GHP from entering into the EyeMed contract or (ii) EyeMed from delegating the TPA services under such contract to FAA, an EyeMed affiliate licensed in Missouri as a TPA. Although section 376.1092.1, RSMo prohibits an entity from holding itself out to be an administrator without a certificate of authority, this statute creates an obligation on the administrator, not CHL-GHP. As such, CHL-GHP is not in violation of this statute.

Further, 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800 set forth the process by which an administrator applies for and renews a certificate of authority and files its annual reports. These regulations create an obligation on the administrator, not CHL-GHP. As a result, CHL-GHP is not in violation of these regulations.

Notwithstanding CHL-GHP's disagreement with this Finding, CHL-GHP will have added FAA as a party to its current agreement with EyeMed to address the issue identified above.

#### **D. Marketing Practices**

##### **1. Advertising**

###### **CHC-KS**

a. **MDI Finding:** The following listed exclusions in the Company's Coventry One

BENEFIT SUMMARIES FOR MISSOURI have the tendency or effect of misleading prospective purchasers because the descriptions do not clarify Missouri mandated benefits or required coverage.

- (1) The exclusion, "Any service or supply that is not Medically Necessary," is included without a definition of Medical Necessity.
- (2) The Dental Services exclusion is included without the Missouri requirement of coverage for administration of anesthesia and hospital charges for dental care provided to the following covered persons:
  - (a) A child under age five
  - (b) A person who is severely disabled, or
  - (c) A person who has a medical or behavioral condition, which requires hospitalization or general anesthesia when dental care is provided.
- (3) Maternity Services – Expenses incurred for any condition of or related to pregnancy, unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy. Because the Company's medical insurance policy does not provide maternity benefits except with the purchase of an additional rider, this exclusion operates to exclude coverage for complications of pregnancy. A medical insurance policy must cover complications of pregnancy as any other illness.

References: Sections 376.1225, and 375.995.4(6), RSMo, and 20 CSR 400-5.700 (5)(A)1

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for three reasons.

First, the marketing materials identified as "Coventry One BENEFIT SUMMARIES FOR MISSOURI" clearly state that there is more information regarding the policy available and invite the potential purchasers to inquire further. In particular, there is a disclaimer at the bottom of these documents that states "This Summary is a partial description of the plan shown and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the Evidence of Coverage, Group Master Contract, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms." See Exhibit [KS046].

Second, the marketing materials identified as "Coventry One BENEFIT SUMMARIES FOR MISSOURI" includes the entire exclusion and limitation section from the CoventryOne policy. See Exhibit [KS047].

Third, it is important to understand that CHL-KS's "Coventry One BENEFIT SUMMARIES FOR MISSOURI" are not distributed as stand-alone marketing pieces. Rather, they are part of an entire packet of information distributed specifically to brokers for their review with potential purchasers. The entire packet consists of "CoventryOne Your Guide to Individual PPO Health Benefit Policies", "CoventryOne Individual Health Insurance Find out how it can be the One for you", as well as the "CoventryOne Benefit Summaries For Missouri".

In addition to the details and clarification referenced above, page 7 of "CoventryOne Your Guide to Individual PPO Health Benefit Policies" clearly states:

1. "Read all the materials in this booklet, as well as the materials found in the back pocket."
2. "If you need particular questions answered that aren't addressed in these materials, talk to your broker or call Coventry's Individual Sales department at 816-221-8400 or toll-free at 1-866-795-3995."
9. "Carefully read your policy when you receive it. The information in this booklet contains summary information only. The actual coverage you receive is conditional on the policy you select and the terms, conditions, limitations and other details contained in the policy."

Based on the above, CHL-KS disagrees that the document has the tendency to mislead or deceive potential purchasers as to the nature or extent of any policy benefit payable in violation of 20 CSR 400-5.700 (5)(A)1, and as applicable for MDI Findings below, 20 CSR 400-5.700 (4).

Finally, CHL-KS respectfully disagrees that above-referenced policy violates Section 375.995.4(6), RSMo. Section 375.995.4(6), RSMo., prohibits an insurer from "Treating complications of pregnancy differently from any other illness or sickness under the contract." CHL-KS's policy, in fact, does not treat complications of pregnancy any differently from any other illness under the policy.

To clarify, CHL-KS's individual policies did not and do not offer a maternity benefits rider, contrary to this Finding's statement. Although the policy excludes coverage for Maternity Services including services related to pregnancy, as permitted by Missouri law, the policy also excludes coverage for services to treat certain other illness or sickness – for example, the surgical treatment for morbid obesity or dental services for certain diseases of the gums and oral cavity.

CHL-KS's policy applies Exclusion #45 – "Medical complications arising directly or indirectly from a non-Covered Service" – consistently with regard to all non-Covered Services or benefit exclusions. As a result, complications from non-covered services such as Maternity Services, including services related to

pregnancy, are not covered under the policy just as complications from non-covered services such as the surgical treatment or dental services set forth above, for example, are not covered. As a result, the policy does not treat "complications of pregnancy differently from any other illness or sickness" under the policy.

b. **MDI Finding:** The following advertisement includes:

- (1) The Company's description of "What is precertification – and do I need it before I receive care?" is contrary to Missouri requirements for coverage. The Company's explanation of precertification states, "Be aware that obtaining precertification is not a guarantee of coverage for the service or treatment."

Missouri requires that a company shall not subsequently retract certification after it has provided the services.

- (2) It also notes the coverage and benefits of the Company's Coventry One policy but fails to mention the limitations and exclusions involved. An advertisement that provides information of the benefits available in a health insurance contract should also include information about the limitations and exclusions. Without this information, these advertisements have the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of any policy benefit payable.

References: 20 CSR 400-10.200(1), 20 CSR 400-5.700(4) and (5)(A)1.

Advertisement Number  
(None)  
Policies

Advertisement Name  
Your Guide to Individual PPO Health Benefit

**CHL-KS Response:**

CHL-KS respectfully disagrees with this Finding for the reasons stated above in Section II.D.1.a. CHL-KS's description of "What is precertification – and do I need it before I receive care?" is part of the same packet of information referenced above that is provided to brokers to review with potential purchasers.

CHL-KS also disagrees that that it has violated 20 CSR 400-10.200(1) in this case because the statement above that precertification is not a guarantee of coverage is on the equivalent of a violation of this regulation. Various circumstances may arise in which coverage may not be provided despite precertification. For example, the member may lose coverage between the precertification date and the date of service. It is circumstances such as these that form the purpose behind the statement above that precertification is not a guarantee of coverage. When combined with the language referenced in the above response in Section II.D.1.a., CHL-KS makes clear the intent behind this statement.

Finally, section 2.6 on page 20 of the CoventryOne Certificate of Coverage states that Pre-Certification only determines medical necessity and appropriateness and that all other terms of the COC are then applied. If CHL-KS pre-certifies covered services, CHL-KS shall not subsequently retract the pre-certification after the covered services have been received, or reduce payment unless: (1) such pre-certification is based on a material misrepresentation or omission about the member's health condition or the cause of the health condition; or (2) coverage terminates before the health care services are provided; or (3) the CHL-KS's coverage under the COC terminates before the health care services are provided. Lastly, CHL-KS disagrees that the sentence cited by the examiners -- "Be aware that obtaining precertification is not a guarantee of coverage. . ." -- violates 20 CSR 400-10.200(1). In fact, CHL-KS will not guarantee coverage, and will retract certification, if any of the three conditions set forth in 20 CSR 400-10.200(1) are satisfied. As such, the sentence cited above not only does not violate 20 CSR 400-10.200(1), it is necessary so that CHL-KS can notify prospective members of grounds for precertification retraction authorized under Missouri law.

c. **MDI Finding:** The following advertisement is misleading for the following reasons:

- (1) It refers to freedom of choice with regard to physicians, but fails to mention the increased cost for being treated by an out of network physician or specialist. The statement of "No referrals for specialists" along with "freedom of choice for specialists" in this advertisement can lead an insured to believe that he may choose a specialist without limitation or additional cost. The advertisement fails to mention pre-certification as defined in the insurance contract or that there is increased cost to receive treatment from an out of network physician or specialist.

An advertisement that provides benefit information in a Preferred Provider Organization (PPO) policy should also include information about the conditions and limitations affecting coverage. Without this information, the advertisement has the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of policy benefits payable.

- (2) This advertisement is also misleading because it includes coverage and benefits of the Coventry One policy but fails to mention the limitations and exclusions involved. Without this information, an advertisement has the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of policy benefits.

References: 20 CSR 400-5.700(4) and (5)(A)1.

Advertisement Number

Advertisement Name

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for the reasons stated above in Section II.D.1.a. The marketing material identified as "Coventry One Individual Health Insurance" is part of the same packet of information referenced above that is provided to brokers to review with potential purchasers.

CHL-KS notes that this marketing material specifically addresses copayment, deductible and coinsurance differentials between Primary Care physicians and Specialist physicians on pages 6 through 13 of the marketing material "CoventryOne Benefit Summaries For Missouri".

d. **MDI Finding:** The following two advertisements are misleading for the following reasons:

- (1) They indicate that the policies specifically do not cover maternity services unless the applicant purchases a maternity benefits rider. They also include an exclusion for medical complications arising directly or indirectly from a non-covered service. When the Company issues this policy without a maternity rider, the exclusion operates to exclude complications of pregnancy. Missouri requires policies to cover complications of pregnancy like any other illness.
- (2) These advertisements also include an exclusion of any service or supply that is not medically necessary. Since the policy does not define "medically necessary," this exclusion has the tendency to mislead prospective purchasers as to the nature or extent of any policy benefit payable.
- (3) The Company excludes dental services in these advertisements without notice of the Missouri requirement of coverage for administration of anesthesia and hospital charges for dental care provided to the following covered persons:
  - A child under age five
  - A person who is severely disabled, or
  - A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

References: Sections 375.995.4(6), and 376.1225, RSMo, and 20 CSR 400-5.700 (5)(A)1

<u>Advertisement Number</u>	<u>Name</u>
(None)	Your Guide to Individual Health Benefit Policies Missouri Coventry One

(None) Your Guide to Individual Health Benefit Policies Missouri

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for the reasons stated above in Section II.D.1.a. The marketing material identified as "Coventry One Individual Health Insurance" is part of the same packet of information referenced above that is provided to brokers to review with potential purchasers.

- e. **MDI Finding:** The following three advertisements are misleading because they note benefits of the policies but fail to mention the limitations and exclusions involved. An advertisement that provides information of the benefits available in a health insurance contract should also include information about the limitations and exclusions. Without information about exclusions and limitations, this advertisement has the tendency, capacity, or effect to mislead prospective purchasers as to the nature or extent of any policy benefit payable. References: 20 CSR 400-5.700(4) and (5)(A)1.

<u>Advertisement Number</u>	<u>Advertisement Name</u>
(None)	Introducing Coventry One Business Reply Mail
(None)	Your Guide to Individual PPO Health Benefit Policies
COBRO-1105 CHKS50644	Coventry One INDIVIDUAL HEALTH INSURANCE

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding. In particular, with respect to items above entitled Introducing Coventry One Business Reply Mail and Your Guide to Individual PPO Health Benefit Policies, CHL-KS disagrees for the reasons stated above in Section II.D.1.a. The marketing material identified as "Coventry One Individual Health Insurance" is part of the same packet of information referenced above that is provided to brokers to review with potential purchasers.

With respect to the advertisement above entitled Coventry One INDIVIDUAL HEALTH INSURANCE, CHL-KS disagrees because this document states that there is more information regarding the policy available and invites the potential purchaser to inquire further. Specifically, this document lists the following disclaimer: "Please refer to the Evidence of Coverage, Group Master Contract, Schedule of Benefits and applicable Riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms." See Exhibit [KS046].

- f. **MDI Finding:** In its utilization review policies and appeal process manual, Coventry lists two services related to breast cancer that require authorization due to

possible benefit limitation or exclusion. These are "Breast implant / breast reconstruction" and "Breast – mastectomy." Because breast reconstruction after a mastectomy is a mandated benefit under Missouri law and under the federal Women's Health and Cancer Rights Act, the Company should clarify in its manual that authorization is not required when breast cancer is involved.

Reference: Section 376.1209, RSMo

**CHL-KS Response:** CHL-KS respectfully disagrees that 376.1209 RSMo. bars an insurance company from requiring prior authorization for breast reconstructive surgery. In fact 376.1209, RSMo. is silent with regard to utilization review of breast reconstructive services, and states in part "Coverage for prosthetic devices and reconstructive surgery shall be subject to the same deductible and coinsurance conditions applied to the mastectomy *and all other terms and conditions applicable to other benefits . . .*" (italics added).

Through the utilization review process, CHL-KS attempts to avoid situations where services are rendered only for the insured to later discover that coverage was not available due to an exclusion or limitation. In fact, CHL-KS has the following language within its benefit policy at the top of the section that includes the authorization requirements for these services: "The following services require prior authorization or precertification as many of these procedures may be viewed as cosmetic surgery and/or may have certain benefit limitations or exclusions."

### **GHP**

- a. **MDI Finding:** GHP used communications including form letters that failed to clearly identify Coventry Health and Life Insurance Company as the insurer of record. Form letters include a GHP logo with the words "A Coventry Health Care Plan" along the bottom of the logo. Coventry Health Care Company is the parent Company of several insurance companies with titles containing the name Coventry. GHP does not make it clear in its communications with insureds and providers that it is administrator and primary contact for Coventry Health and Life Insurance Company, and that CHL-GHP is the Company of record with financial responsibility for the claims presented under its contracts. The Company's files were commingled and/or misidentified causing GHP to provide files to the examiners that were later found to be GHP HMO files having no relevance to the Coventry Health and Life Insurance Company examination.

References: Section 375.936(4), RSMo, and 20 CSR 400-5.700(2), (12)(A), (B), (C) & (D)

**CHL-GHP Response:** CHL-GHP agrees the letters contained the errors as noted above. However, GHP clearly informs members in their member materials and identification cards that GHP is the administrator and primary contact for CHL-GHP and that CHL-GHP is the company of record with financial responsibility for

the claims presented under its contracts.

As corrective action, CHL-GHP will revise its template communications to clarify both points. In addition, CHL-GHP will work to correctly identify GHP vs. CHL-GHP files to prevent future commingling of files.

- b. **MDI Finding:** The Company uses the following 44 advertisements that include premium rates for coverage, which causes them to be invitations to contract as defined by Missouri law. These advertisements failed to include the limitations and exclusions of the policy as Missouri law requires for an invitation to contract. Reference: 20 CSR 400-5.700(5)(B)

<u>Advertisement</u>			<u>Type</u>
2004 Ind Product "Launch"	Insert	8/1/04	Direct Mail Insert
2004 Ind Product "Notebook"	Insert	9/27/04	Newspaper Insert
2004 Ind Product "Notebook"	Insert	12/2/04	Newspaper Insert
2004 Ind Product "Load Off"	Insert	12/13/04	Newspaper Insert
2005 Ind Product "New Years"	Ad	1/2/05	Kraft Wrap
2005 Ind Product "New Years"	Insert	1/10/05	Newspaper Insert
2005 Ind Product "New Years"	Insert	1/12/05	Newspaper Insert
2005 Ind Product "New Years"	Insert	2/7/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	2/17/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	3/7/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	3/16/05	Newspaper Insert
2005 Ind Product "Knight"	Ad	3/27/05	1/4 Page Ad
2005 Ind Product "Knight"	Insert	4/4/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/15/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/28/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/28/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/1/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Cash Register Ad	JuneJuly	2005	Cash Register Receipt Ad
2005 Ind Product "Graduating"	Insert	6/1/05	Handout
2005 Ind Product "Be Thrifty"	Insert	6/6/05	Direct Mail
2005 Ind Product "Notebook"	Insert	6/6/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	6/16/05	Direct Mail
2005 Ind Product "Be Thrifty"	Insert	6/16/05	Direct Mail
2005 Ind Product "Notebook"	Insert	6/22/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	7/11/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	7/20/05	Newspaper Insert
2005 Ind Product "Jogger"	Insert	8/1/05	Newspaper Insert

2005 Ind Product "Jogger"	Insert	8/1/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	8/17/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/1/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/1/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/12/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/21/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	10/31/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	10/3/05	Newspaper Insert
2005 Ind Product "Notebook"	Insert	11/1/05	Newspaper Insert
2005 Ind Product "Thanksgiving"	Insert	11/9/05	Newspaper Insert
2005 Ind Product "Thanksgiving"	Insert	11/15/05	Newspaper Insert

Advertisement

<u>Advertisement</u>			<u>Type</u>
2005 Ind Product "Be Thrifty"	Insert	11/29/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	12/12/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	12/29/05	Newspaper Insert

**CHL-GHP Response:** The Company respectfully disagrees with this Finding. The materials referenced in this Finding are not advertisements under 20 CSR 400-5.700(2)(A). Rather, the materials meet the definition of "lead generation device" under 20 CSR 400-5.700(2)(G). 20 CSR 400-5.700(5)(B) requires an "advertisement which is an invitation to contract" to include policy limitations and exclusions. Since these materials are lead generating devices and not advertisements which are invitations to contract, 20 CSR 400-5.700(5)(B) does not apply and the Company is not violation of this regulation.

Further, 20 CSR 400-5.700(2)(E) defines "invitation to contract" as any advertisement which is not an "invitation to inquire." For purposes of this argument only, assuming that these materials are "advertisements", these materials still fall within the definition of "invitation to inquire" under 20 CSR 400-5.700(2)(F) and not the definition of "invitation to contract." Specifically, the purpose of the materials is to create a desire to inquire further about the product and the materials only include a brief description of the benefit. Please note that the materials titled, "2005 Ind Product 'Be Thrifty', Insert 12/12/05, Newspaper Insert," and "2005 Ind Product 'Be Thrifty', Insert 12/29/05, Newspaper Insert" do not mention the cost of the products. The remaining materials list example rates for the products. However, these materials clearly indicate that the rates are subject to medical underwriting and potential customers are on notice that the actual cost of the products may differ from the example rates provided. In conclusion, even if the Company assumes that the materials are in fact "advertisements", these materials fit within the definition of "invitations to inquire" and not the definition "invitations to contract". Therefore, the Company is not in violation of 20 CSR 400-5.700(5)(B).

c. **MDI Finding:** Missouri requires companies, in connection with the offering for sale of any health benefit plan to a small employer, to make a reasonable disclosure as part of its solicitation and sales materials of all of the following information:

- (1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;
- (2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors for other than claim experience that affect changes in premium rates;
- (3) The provisions relating to renewability of policies and contracts; and
- (4) The provisions relating to any preexisting condition provision.

The Company advised that the information is included in three places: the contingency section of the rate quote, the Group Enrollment Agreement (GEA), and the Broker Manual.

The Company does not provide the information as required because: (i) the Broker Manual is not available to the small employer; (ii) the Enrollment Agreement is not available until after the sale is complete; and (iii) the contingency of the rate quote form does not include all of the information required.

Reference: Section 379.936.4, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. The information required by (1) is set forth Proposal Contingencies section of the Benefit Proposal, which specifically states:

These rates are presented as a preliminary proposal only. Final rates may change based on actual enrollment, review and approval by GHP of Individual Applications and Group Application (Application of Benefits Offering), and verification of data entry.

**See Exhibit [GHP-06].** Therefore, small employers are on notice that the proposed premium rates may change based on variations with respect to claims costs and health status.

The information required by (2) and (3) above is explicitly included in the Group Enrollment Agreement ("GEA"). **See Exhibit [GHP-06].** The GEA is available prior to the sale on the CHL-GHP's website, through the broker or through the Company by request.

Finally, CHL-GHP does not include any preexisting condition provisions in its documents. Therefore, the information required by (4) above does not apply to the CHL-GHP's materials.

- d. **MDI Finding:** The Company used the following policy brochures on its web site that included information about benefits and rates but failed to include the limitations and exclusions. An advertisement that includes the cost of a policy must also include the limitations and exclusions.

Reference: 20 CSR 400-5.700(5)(B)1

Advertisement Form

GHP 8100-01

GHP 8100-01 7/06

GHP 8100-02 8/06

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. 20 CSR 400-5.700 (5)(B)(1) requires invitations to contract, such as the pieces referenced in this Finding, to disclose limitations and exclusions affecting the basic provisions of the policy "without which the advertisement would have the capacity or tendency to mislead or deceive". Each of the advertisements sets forth clear statements that notify the reader that exclusions and limitations apply to the policy. Specifically, advertisements GHP 8100-01 7/06 and GHP 8100-02 8/06 clearly states the following:

1. On the cover "If you have any questions, please contact the GHP Individual Sales Team at 1-866-557-8749.";
2. On the cover, "Note: Final rates are based on medical underwriting." (italics added);
3. On page 1, "Refer to the Certificate of Coverage (COC) for a detailed description of covered services and limitations or exclusions.";
4. On page 1, "All services must be medically necessary as a condition of coverage and not otherwise limited or excluded.";
5. On each Summary of Benefits page, reference to a prior authorization requirement for each applicable benefit requiring such;
6. On each Summary of Benefits page, reference to when a benefit is offered in-network only;
7. On each Rates page, "Final rates will be based on medical underwriting."

Further, advertisement GHP 81000-01 states the following:

1. On the cover "If you have any questions, please contact the GHP Individual Sales Team at 1-866-557-8749.";
2. On the cover, "Note: Final rates are based on medical underwriting." (italics

added);

3. On each Summary of Benefits page, reference to when a benefit is offered in-network only;
4. On each Rates page, "Final rates will be based on medical underwriting."

CHL-GHP does not include all exclusions of the policy in such marketing materials. This would not be feasible given that CHL-GHP has numerous exclusions included in the COC. The repeated, clear notifications referenced above make clear that exclusions and limitations apply to the policy. As such, these advertisements do not mislead or deceive. **See Exhibit [GHP-07].**

## II. UNDERWRITING AND RATING PRACTICES

### A. Forms and Filings

#### CHC-KS

1. **MDI Finding:** The following 17 Coventry Schedules of Benefits failed to include the mandated Childhood Immunization coverage without deductible or co-pay expense. For the childhood immunizations, the Company stated that it programmed its claim payment system to take only co-payment, deductible and/or coinsurance on the office visit charge. However, the Company has not corrected the policy provision to reflect the wording for the mandatory coverage.

References: Sections 376.1215.1 and 2., RSMo

<u>Form Number</u>	<u>Co-Pay</u>
CHC-KC-PPO-M01-00701	\$10.00
CHC-KC-PPO-M02-00701	\$10.00
CHC-KC-PPO-M03-00701	\$10.00
CHC-KC-PPO-M05-00701	\$10.00
CHC-KC-PPO-M06-00701	\$15.00
CHC-KC-PPO-M07-00701	\$15.00
CHC-KC-PPO-M08-00701	\$15.00
CHC-KC-PPO-M09-00701	\$15.00
CHC-KC-PPO-M010-00701	\$20.00
CHC-KC-OOAPPO Spec1-2001	\$10.00
CHC-KC-OOAPPO Spec2	\$10.00
CHC-KC-PPO-M012-00701	\$20.00
CHC-KC-PPO-M013-00701	\$20.00
CHC-KC-PPO-M014-00701	\$20.00
CHC-KC-OOAPPO-spec1-2003	\$10.00
CHC-KC-OOAPPO-spec2	\$10.00
CHC-KC-PPO-M025-00701	\$15.00

**CHL-KS Response:** CHL-KS agrees with this Finding and notes that the above-listed Schedules of Benefits are no longer in use. All Schedules of Benefits filed with the MDI since 2004 list Pediatric Immunization separately with no cost-sharing or member responsibility. CHL has completed a review which confirms that for the period 2003 - 2005 no co-pays, co-insurance or deductibles were collected for childhood immunizations.

2. **MDI Finding:** The rider form CHL-KS-MO-RID-005-11.03 was not provided for review within the 10 calendar day requirement.

References: Section 374.205.2(2), RSMo, and 20 CSR 300-2.200(5) & (6)(2005)

**CHL-KS Response:** CHL-KS agrees with this Finding. Unfortunately, this oversight was due to human error. CHL-KS apologizes for the oversight.

3. **MDI Finding:** The following policy includes these exclusions:

(41) Medical Services involves expenses incurred for any condition of or related to pregnancy, childbirth, routine pregnancy visits, nursery care charges, expenses associated with Cesarean section, voluntary induced abortion or selective reduction during pregnancy.

(45) Medical complications arising directly or indirectly from a non-covered service.

The policy does not include maternity benefits, except, when the member purchases a Maternity Benefits Rider. When the Maternity Benefits Rider is not attached, exclusion (45) would operate to exclude all medical complications of pregnancy arising directly or indirectly from a pregnancy, which is a non-covered condition. Exclusion (41) acts to exclude Cesarean Section or other expenses that may result from a complication of pregnancy.

Missouri requires policies to consider complications of pregnancy as any other illness. The Company's composition of this policy with regard to maternity benefits operates to exclude complications of pregnancy.

Reference: Section 375.995.4(6), RSMo

Policy Form

CHL-KS-MO-COC-074.05.05

**CHL-KS Response:** CHL-KS respectfully disagrees that above-referenced policy violates Section 375.995.4(6), RSMo. Section 375.995.4(6), RSMo., prohibits an insurer from "Treating complications of pregnancy differently from any other illness or sickness under the contract." CHL-KS's policy, in fact, does not treat complications of pregnancy any differently from any other illness under the policy.

To clarify, CHL-KS's individual policies did not and do not offer a maternity benefits rider, contrary to this Finding's statement. Although the policy excludes coverage for Maternity Services including services related to pregnancy, as permitted by Missouri law, the policy also excludes coverage for services to treat certain other illness or sickness – for example, the surgical treatment for morbid obesity or dental services for certain diseases of the gums and oral cavity.

CHL-KS's policy applies Exclusion #45 – "Medical complications arising directly

or indirectly from a non-Covered Service” – consistently with regard to all non-Covered Services or benefit exclusions. As a result, complications from non-covered services such as Maternity Services, including services related to pregnancy, are not covered under the policy just as complications from non-covered services such as the surgical treatment or dental services set forth above, for example, are not covered. As a result, the policy does not treat “complications of pregnancy differently from any other illness or sickness” under the policy.

### GHP

1. **MDI Finding:** The Company used the following forms that include the wording “...in the Plan’s sole and absolute discretion...” This wording is also used in its member appeals process when denying approval for treatment that has been suggested by the health care provider. This term is not allowed in contract language or in communications to claimants.

The use of this language can only be interpreted to expand on what is explicit in the contract that the insurer will make coverage and benefit decisions. This interpretation may lead the insured or any one else to believe that no action on the part of the insured or anyone else is contractually available to modify the insurer’s decision. This cannot be the case because it would conflict with several provisions of law. This interpretation eliminates the insured’s right to seek legal action to enforce the contract and make any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. This language effectively serves to confuse and mislead insured persons.

Reference: Section 375.936, RSMo

#### Policy Form

MO\_OPEN\_ACCESS\_POS\_COC\_08.03\_CHL-GHP  
MO\_OA\_POS\_NDED\_COC\_05.04\_GHP  
MO\_OA\_POS\_IND\_COC\_01.05\_CHL-GHP

#### Policy Form

MO\_PPO\_Individual\_COC\_07.03\_CHL-GHP  
MO\_GROUP\_PPO\_COC\_07.04\_CHL-GHP  
MO\_PPO\_IND\_ND\_COC\_0104\_CHL-GHP

**CHL-GHP Response:** CHL-GHP respectfully disagrees with Finding. First, CHL-GHP notes that the Policy Form MO\_OA\_POS\_NDED\_COC\_05.04\_GHP CHL-GHP referenced above is not a CHL Policy Form. As a result, it falls outside the scope of this exam and should not be cited above.

Nonetheless, these Certificates of Coverage (“COCs”) referenced above do not

misrepresent the coverage terms of the policy. CHL-GHP makes it clear to its members numerous times throughout the claims and appeals processes that a member may in fact question or challenge CHL-GHP as follows:

1. Each COC contains an entire section entitled "Resolving Complaints and Grievances". In this section, the various avenues a member could use to challenge CHL-GHP's determinations – complaints, appeals, contacting the MO-DOI – is explained complete with timeframes.
2. In "Utilization Review Policy and Procedures" section of each COC, CHL-GHP's members are specifically informed of their right to request a reconsideration of various adverse benefit determinations and their right to appeal.
3. A document entitled "Your Right to Review the Plan's Determination" is included with every EOB. This document provides detail on the process provided to its members to challenge the adverse determinations and how to utilize the MDI to affect such a challenge. This document is also sent as an attachment to member denial letters for adverse determinations.
4. "Appeal and Grievance Process and Member Rights" is provided to members at the conclusion of the first level and second level appeals processes.
5. The Member Handbook also informs the member of their right to file a complaint or grievance.
6. If a member calls the Customer Service Organization (CSO) with a complaint or grievance, a representative of the CSO will explain to the member the process for filing such complaint or grievance.

**See Exhibit [GHP-08].**

In light of the information above, it is difficult to understand that the COC's one-time use of the words "sole and absolute discretion" gives the impression that "no action on the part of the insured or anyone else is contractually available to modify the insurer's decision".

Notwithstanding CHL-GHP's disagreement with this Finding, CHL-GHP has already removed references to its "sole and absolute discretion" from all COCs.

2. **MDI Finding:** The Company's policy form

MO\_OA\_POS\_IND\_COC\_01.05\_CHL-GHP does not include maternity benefits unless the Maternity Rider is purchased. In the policy exclusions number 47) Medical Complications means complications arising directly or indirectly from a non-covered service. Missouri requires a policy to cover complications of pregnancy as any other illness. This means that a complication of pregnancy will be covered even when the policy does not include maternity benefits. The policy exclusion 47) allows the Company to exclude complications of pregnancy when maternity coverage is not added with the inclusion of the Maternity Rider

Reference: Section 375.995, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees that above-referenced policy violates Section 375.995, RSMo. Section 375.995.4(6), RSMo., prohibits an insurer from "Treating complications of pregnancy differently from any other illness or sickness under the contract." CHL-GHP's policy, in fact, does not treat complications of pregnancy any differently from any other illness under the policy.

Although the policy excludes coverage for Maternity Services including services related to pregnancy, as permitted by Missouri law, the policy also excludes coverage for services to treat certain other illness or sickness – for example, the surgical treatment for morbid obesity or dental services for certain diseases of the gums and oral cavity.

CHL-GHP's policy applies Exclusion #47 – "Medical complications arising directly or indirectly from a non-Covered Service" – consistently with regard to all non-Covered Services or benefit exclusions. As a result, complications from non-covered services such as Maternity Services, including services related to pregnancy, are not covered under the policy just as complications from non-covered services such as the surgical treatment or dental services set forth above, for example, are not covered. As a result, the policy does not treat "complications of pregnancy differently from any other illness or sickness" under the policy.

3. **MDI Finding:** The Company used policy form OPEN ACCESS POS COC 08.03 that included the following definition of Chiropractic Services:

Coverage is provided for basic Chiropractic Services (i.e., spinal manipulation) if the service is medically necessary and rendered by a licensed provider. Additional Chiropractic Services are available through a rider.

The policy also indicates that prior authorization is required for Chiropractic Services. The Company advised that the form was not filed for use in Missouri.

By using this form and the rider form MO(PPO) – CHIRO (02/02) during the period August 28, 2003, through April 2004, when specific chiropractic coverage was required, the Company failed to provide the specified coverage and required authorization when it was not allowed.

Reference: Sections 376.405 and 376.1230, RSMo

**CHL-GHP Response:** CHL-GHP disagrees this Finding.

First, CHL-GHP disagrees that policy form OPEN ACCESS POS COC 08.03 was not filed for use in Missouri. In fact, it was filed with the MDI and approved on April 29, 2004. See Exhibit [GHP-09]. CHL-GHP is unaware of any communication to the MDI examiners to the contrary. As a result, CHL-GHP did not violate section 376.405, RSMo.

Second, CHL-GHP disagrees that it did not provide coverage required under section 376.1230, RSMo. Section 6 of the approved form states: "Medically Necessary and clinically appropriate Chiropractic therapy is Covered." Coverage was not limited in this form to spinal manipulation. See Exhibit [GHP-10]. As a result, GHL provided chiropractic coverage under this policy in compliance with section 376.1230, RSMo.

4. **MDI Finding:** The Company used riders to provide chiropractic coverage in policies that do not include the benefit. Since August 28, 2003, Missouri requires health carriers to provide insurance policies that include chiropractic benefits. The riders used by CHL-GHP did not provide coverage for the correct number of visits.

The riders require prior authorization for services. Missouri law states that after 26 office visits, a company can require the insured to obtain prior approval for additional treatment or follow-up diagnostic tests.

Reference: Section 376.1230.1, RSMo

<u>Rider Forms</u>	<u>Approved Date</u>
MO (PPO) – CHIRO (02/02) CHP01 thru 6	5/2/02

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

Although some policies in effect during the period covered by this examination used riders that limited chiropractic benefits not in compliance with section 376.1230.1, RSMo., CHL-GHP has since revised all policies in effect so that chiropractic treatment is no longer limited as such.

5. **MDI Finding:** The Company used the following form that provides coverage for domestic partners. When a married couple purchases a contract, the coverage

is rated for a husband and a wife and any children. The Company considers each family member and adds each rate to arrive at a total premium. The Company uses the same process to calculate the Domestic Partner coverage but then adds an additional 1% charge to the total group premium for the Domestic Partner rider. Because Domestic Partners family unit is not unlike a married couple unit, the ensuing risk is not different. The Company stated that it has no documentation to support the addition of the 1% premium charge. Missouri does not allow a company to provide less coverage, or charge more premium for persons with essentially same risk, based on a person's marital status. It also does not allow a company to use marital status, living arrangements, or gender to rate an applicant.

Reference: Sections 375.936(11)(e) and 375.995, RSMo, and 20 CSR 400-2.120(2)(E)

Form Number

MO\_DOMPART\_03.05\_CHL-GHP

**CHL-GHP Response:** CHL-GHP agrees with this Finding. In 2006, CHL-GHP ceased charging an additional rate associated with domestic partner coverage and started use of a domestic partner rider.

6. **MDI Finding:** The Company's Application for Benefits Offering forms do not limit the number of hours that an employer-applicant can set as a minimum number of working hours an employee must work to be a full time employee and eligible for benefits. Missouri limits the maximum number of work hours to 30 hours per week. CHL-GHP allows an employer to select more than 30 hours as a limit.

Reference: 379.942, RSMo

Form Numbers

M173 (1/98)  
GHP-7850-15(3/98)  
GHP ENROLL – 603

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP has already revised, filed, and received MDI approval of its Application for Benefit Offering form addressing this issue. Attached is the revised form and evidence of the MDI's approval. **See Exhibit [GHP-11].**

7. **MDI Finding:** The Company's Chiropractic Care Benefits riders fail to provide 26 visits per policy years as required. The forms approved 5-2-2002 included a limitation of benefits which states: "Benefits shall be payable for a maximum of twenty (20) visits per calendar year."

Reference: 376.1230, RSMo

Form Numbers

CHP01

CHP02

**CHL-GHP Response:** CHL-GHP disagrees with this Finding because even though the form numbers referenced above may not have been compliant with section 376.1230, RSMo., CHL-GHP never issued them to any members during the period covered by this examination. Because these documents were never used to govern the terms of any members coverage period covered by this examination, CHL-GHP did not violate section 376.1230, RSMo.

Notwithstanding the above, CHL-GHP would like to note that since the period covered by this examination, CHL-GHP has revised all policies in effect so that chiropractic treatment is no longer limited as such.

**B. Underwriting and Declinations**

**1. Declinations**

**CHC-KS**

- a. **MDI Finding:** The Company failed to maintain complete documentation of the following declined small group applications. The information provided by the Company did not allow the examiners to determine the Company's underwriting and rating standards or to see if CHL-KS offered these groups coverage under a standard or basic small employer group plan. The Company also failed to provide copies of its basic and standard small group plans as well as a copy of its most recent "Actuarial certification" sent to the Missouri director certifying its compliance with the provisions of Section 379.940, RSMo. The Company advised that it used its regularly issued plans instead of a Basic or Standard Policy form. References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (3)(E) (2005), and

Small Group Name

Global Media

Parker Mortuary

Christopher Hanson Ins

Cargan Services Corp

Small Group Name

South Barns

South Barns

Brass Leasing, Inc.

Alliance Energy

Small Group Name

Healthier Cline, DDS

Bi-Lo Market

Small Group Name

Ozark Lazar Systems

Dawson Furniture

Quick Cash of Wisconsin  
Hubbell Mechanical Supply  
All Seasons Energy, LLC  
Branson Meadows Assisted Living  
Datalink, Inc  
Ozark Lazar Systems  
Southwest Audio & Visual  
BMI

Cargan Services Corp  
First Baptist Church of Nixa  
Glendale Christian Church  
All Seasons Energy, LLC  
Community State Bank  
Nations RX  
Professional Builders  
S&R Coach

**CHL-KS Response:** CHL-KS respectfully disagrees that it failed to provide complete underwriting documentation, or documentation that a basic and standard plan was actively offered.

First, it is important to note that the purpose of CHL-KS's initial group evaluation process is to determine whether CHL-KS will proceed with underwriting or quoting a prospective group. For example, during this evaluation process CHL-KS determines factors such as the geographic location of the group and the number of employees. CHL-KS does not use any of the factors yielded during the initial group evaluation process to actually underwrite or provide a quote to a group during the subsequent underwriting or quoting process.

The list of small employers listed above are small employers who failed to qualify as a CHL-KS group pursuant to CHL-KS's group evaluation process. As such, these groups never qualified to enter CHL-KS's group underwriting/quoting process, and CHL-KS did not decline any of these groups for reasons related to the health status, claim experience, or any other reason prohibited by state law.

Second, none of these groups ever completed an application for coverage. Rather, as explained in CHL-KS's response to Criticism #26, the preliminary information forwarded to CHL-KS about these groups may have been notes or a questionnaire that the prospective employer group's broker produced. It is information gleaned from these sources that disqualified these groups' eligibility into CHL\_KS underwriting/quoting process, and thus exempted CHL-KS from the obligation of offering coverage or accepting applications to these groups pursuant to subsection 1 of 379.940 RSMo. For instance, some of the criteria reviewed during the initial evaluation included:

(a) Where the small employer is physically located. If the small employer is not physically located in the carrier's established geographic service area, CHL-KS would have no obligation under 379.940 RSMo, and

(b) The number of employees who do not work or reside within the carrier's established geographic service area. If more than 25% of eligible employees work outside the established geographic area CHL-KS would

have no obligation under 379.940 RSMo.

These criteria among others are permitted by section 379.940.3 and .2(4). CHL-KS's administration of these criteria was compliant with section 379.940.1(2)(b).

Further, CHL-KS contends that it did not violate 20 CSR 300-2.200(2), (3)(A). This regulation required maintenance of records for policy record files and defined "record" as any evidence of coverage proposed for issuance or issued by an insurer. In each of the cases above, however, no group ever even qualified to enter CHL-KS's process to evaluate whether an evidence of coverage could be proposed. As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

In addition, 20 CSR 300-2.200(3)(E) required maintenance of records for declined underwriting record files and defined "declined underwriting file" as all records "concerning a policy for which an *application for insurance coverage has been completed and submitted to the insurer. . . but the insurer has made a determination not to issue a policy. . .*" In each of the cases above, however, no application for coverage was ever even completed by the small groups, let alone submitted to CHL-KS. Further, an "application", as defined in 20 CSR 300-2.200(1)(A), "does not include documents. . . generated in response to a request for a premium quote which did not result in an application for coverage". As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

## GHP

### 2. Small Group Declinations

- a. **MDI Finding:** The Company failed to maintain complete documentation of the following declined small group applications. Although Missouri requires companies to maintain declinations for a minimum of three years, the Company's procedure is to destroy them after 18 months. From the information provided by the Company, the examiners were unable to determine the Company's underwriting standards or check if it offered these groups coverage under a standard or basic small employer group plan.

References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (3)(E) (2005),

<u>Small Group App. No.</u>	<u>Small Group App. No.</u>	<u>Small Group App. No.</u>
24984	24944	39006
26034	39103	38549
25977	25961	23987
34905	25353	25993

25195	35159	23756
25150	37535	35268

<u>Small Group App. No.</u>	<u>Small Group App. No.</u>	<u>Small Group App. No.</u>
37986	25209	24267
26308	35724	37337
35196	24090	24063
26395	23439	25886
25109	35517	25646
35259	35662	26025
23652	38662	24334
27858	38639	26356
23450	38998	38579
39138	23446	38521
35555	25506	

**CHL-GHP Response:** CHL-GHP respectfully disagrees that it failed to provide maintain underwriting documentation, or documentation that a basic and standard plan was actively offered.

First, it is important to note that the purpose of CHL-GHP's initial group evaluation process is to determine whether CHL-GHP will proceed with underwriting or quoting a prospective group. For example, during this evaluation process CHL-GHP determines factors such as the geographic location of the group and the number of employees. CHL-GHP does not use any of the factors yielded during the initial group evaluation process to actually underwrite or provide a quote to a group during the subsequent underwriting or quoting process.

The small groups listed above were small employers who failed to qualify as a CHL-GHP group pursuant to CHL-GHP's group evaluation process. As such, these groups never qualified to enter CHL-GHP's group underwriting/quoting process, and CHL-GHP did not decline any of these groups for reasons related to the health status, claim experience, or any other reason prohibited by state law.

Second, none of these groups ever completed an application for coverage. Rather, the preliminary information forwarded to CHL-GHP about these groups may have been notes or a questionnaire produced by the prospective employer group's broker. It is information gleaned from these sources that disqualified these groups' eligibility into CHL-GHP's underwriting/quoting process, and thus exempted CHL-GHP from the obligation of offering coverage or accepting applications to these groups pursuant to subsection 1 of 379.940 RSMo. For instance, some of the criteria reviewed during the initial evaluation included:

(a) Where the small employer is physically located. If the small employer is

not physically located in the carrier's established geographic service area, CHL-GHP would have no obligation under 379.940 RSMo, and

(b) The number of employees who do not work or reside within the carrier's established geographic service area. If more than 25% of eligible employees work outside the established geographic area CHL-GHP would have no obligation under 379.940 RSMo.

These criteria among others are permitted by section 379.940.3 and .2(4). CHL-GHP's administration of these criteria was compliant with section 379.940.1(2)(b).

Further, CHL-GHP contends that it did not violate 20 CSR 300-2.200(2), (3)(A). This regulation required maintenance of records for policy record files and defined "record" as any evidence of coverage proposed for issuance or issued by an insurer. In each of the cases above, however, no group ever even qualified to enter CHL-GHP's process to evaluate whether an evidence of coverage could be proposed. As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

In addition, 20 CSR 300-2.200(3)(E) required maintenance of records for declined underwriting record files and defined "declined underwriting file" as all records "concerning a policy for which an *application for insurance coverage has been completed and submitted to the insurer. . . but the insurer has made a determination not to issue a policy. . .*" In each of the cases above, however, no application for coverage was ever even completed by the small groups, let alone submitted to CHL-GHP. Further, an "application", as defined in 20 CSR 300-2.200(1)(A), "does not include documents. . . generated in response to a request for a premium quote which did not result in an application for coverage". As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

### 3. Large Group Declinations

- a. **MDI Finding:** The Company failed to maintain complete documentation of the following declined large group applications for the mandated three years because it is the Company's procedure to destroy them after 18 months.  
References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (3)(E) (2005)

<u>Large Group App. No.</u>	<u>Large Group App. No.</u>	<u>Large Group App. No.</u>
38517	35581	24099
36581	38827	23377
38600	24900	25311

23482	23669	24910
38183	35493	24737
23969	38667	35660
23898	35091	38727
35427	25368	39105
23919	35164	25534
26571	26054	38587
25498	38873	25408

<u>Large Group App. No.</u>	<u>Large Group App. No.</u>	<u>Large Group App. No.</u>
38482	23774	35276
35573	26075	24589
35951	24818	35035
38202	25514	35820
36613	26430	38589
26466	26117	

**CHL-GHP Response:** CHL-GHP respectfully disagrees that it failed to provide maintain underwriting documentation and thus violated 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (3)(E) (2005).

First, it is important to note that the purpose of CHL-GHP's initial group evaluation process is to determine whether CHL-GHP will proceed with underwriting or quoting a prospective group. For example, during this evaluation process CHL-GHP determines factors such as the geographic location of the group and the number of employees. CHL-GHP does not use any of the factors yielded during the initial group evaluation process to actually underwrite or provide a quote to a group during the subsequent underwriting or quoting process.

The large groups listed above were large employers who failed to qualify as a CHL-GHP group pursuant to CHL-GHP's group evaluation process. As such, these groups never qualified to enter CHL-GHP's group underwriting/quoting process, and CHL-GHP did not decline any of these groups for reasons related to the health status, claim experience, or any other reason prohibited by state law.

Second, none of these groups ever completed an application for coverage. Rather, the preliminary information forwarded to CHL-GHP about these groups may have been notes or a questionnaire produced by the prospective employer group's broker. It is information gleaned from these sources that disqualified these groups' eligibility into CHL-GHP's underwriting/quoting process, and thus exempted CHL-GHP from the obligations set forth in 20 CSR 300-2.200(2), (3)(A), and (3)(E).

20 CSR 300-2.200(2), (3)(A) required maintenance of records for policy record

files and defined "record" as any evidence of coverage proposed for issuance or issued by an insurer. In each of the cases above, however, no group ever even qualified to enter CHL-GHP's process to evaluate whether an evidence of coverage could be proposed. As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

20 CSR 300-2.200(3)(E) required maintenance of records for declined underwriting record files and defined "declined underwriting file" as all records "concerning a policy for which an *application for insurance coverage has been completed and submitted to the insurer. . . but the insurer has made a determination not to issue a policy. . .*" In each of the cases above, however, no application for coverage was ever even completed by the small groups, let alone submitted to CHL-GHP. Further, an "application", as defined in 20 CSR 300-2.200(1)(A), "does not include documents. . . generated in response to a request for a premium quote which did not result in an application for coverage". As a result, 20 CSR 300-2.200(2), (3)(A) did not apply to the above cases.

Finally, as section 379.940, RSMo. governs small group health plans and the above-listed employers are small groups, section 379.940, RSMo. does not apply.

#### **4. Underwriting and Rating**

##### **a. Current New Issues**

###### **GHP**

The examiners noted no errors in this review.

###### **CHC=KS**

The examiners noted no errors in this review.

##### **b. Individual Health Insurance**

###### **CHC-KS**

The examiners found no errors in this review.

###### **GHP**

- (1) **MDI Finding**: The Company accepted an application for certificate 901071932-01 in group 6600001005 that included a response to a pertinent question that was changed without the authorization of the applicant. Missouri law and the Company underwriting procedures require an applicant

to place their initials in close proximity of any changes to an application.  
Reference: Section 376.783.2, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding. It is CHL-GHP's policy to return to the applicant any applications reflecting an answer change that is unaccompanied by the applicant's initials. **See Exhibit [GHP-12].**

- (2) **MDI Finding:** The Company accepted an application for certificate 901165125-01 of group 6600001001 although the applicant dated the signature on the application after the date of receipt. The file documentation failed to indicate the reason for this contradiction. The Company advised that the inconsistency may be an inadvertent error by the applicant.  
Reference: 20 CSR 300-2.200 (2005)

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding as the regulation cited above does not require CHL-GHP to indicate the reason for this contradiction.

- (3) **MDI Finding:** The Company provided files for the following 14 certificates that did not include documentation of the date of delivery. The rating information was not included in seven of the files – indicated by an asterisk. Without this information, the examiners could not perform a comprehensive audit of the Company's underwriting process. The files failed to include underwriting information and the notification letter to show the date of delivery.  
Reference: 20 CSR 300-2.200 (2005)

<u>Group</u>	<u>Certificate</u>	<u>Group</u>	<u>Certificate</u>
6600001001	901067207-01	6600001001	901145725-01
6600001001	901096864-01	6600001001	901155099-01
6600001001	901097017-01	6600001001	901096960-01
6600001001	901105093-01	6600001001	901437949-01*
6600001001	901223791-01*	6600004501	901236828-01*
6600002005	901123657-01*	6600001003	900643462-01*
6600003001	901236676-01*	6600001001	901105472-01*

**CHL-GHP Response:** CHL-GHP respectfully disagrees has violated 20 CSR 300-2.200. CHL-GHP's policy record files contain all information required by this regulation; among the regulation's numerous requirements, it does not mandate date of delivery. As a result, CHL-GHP disagrees that it violated this regulation.

Nonetheless, in 2008, GHP has incorporated the practice of recording in its

database the date of delivery. Such information will become a part of each group's policy record file.

c. **Small Employer Group Health Insurance – State Defined**

**CHC-KS**

The examiners found no errors in this review.

**GHP**

- (1) **MDI Finding:** The Company allowed small employers to stipulate a minimum of more than 30 hours per week to be eligible for health care benefits, thus reducing the number of eligible employees. Missouri's small employer health insurance law states that an eligible employee normally works 30 or more hours per week. This limit attempts to assure a fair standard for employers and to increase the availability of healthcare for small employer groups. By allowing the following 32 small employer groups to select more than 30 hours as the normal work-week eligibility standard, CHL-GHP diminishes the intent of the law.

Reference: Section 379.930.2(15), RSMo

<u>Group Number</u>	<u>Hours</u>	<u>Group Number</u>	<u>Hours</u>
6411505001	40	6410775999	40
6411765001	35	6425640001	32
6406365999	40	6426260001	40
6421360001	32	6404045001	40
6412005001	32	6410385001	40
6411095001	35	6210992999	40
6424640001	32	6402295001	40
6402415001	40	6421790001	40
6230855001	40	6218142001	40
6414125001	40	6415805001	40
6230572001	40	6419125001	40
6424960001	40	6407295001	40
6417385001	40	6410145001	32
6224895999	32	6302735999	40
6225602001	40	6401045001	40
6405405001	40	6404585001	40

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP has already revised, filed, and received MDI approval of its Application for Benefit Offering form addressing this issue. Attached is the revised form and

evidence of the MDI's approval. See Exhibit [GHP-11].

- (2) **MDI Finding:** The Company's Broker Manual and Field Underwriting Guidelines included a reference to a \$500 reinstatement fee. The Company provided the following responses to inquiries presented during the examination:
- i. The Company explains the reinstatement fee to the member in page 4 of the DOI approved application.
  - ii. The Company advised that it did not charge the fee to any members in 2003, 2004 or 2005.
  - iii. The Request for Reinstatement Form is available for members to request reinstatement of the plan.

The Company did not include notice of the reinstatement fee in the policy provisions. An application is not appropriate to amend or make additional requirements to policy provisions. The Company may attach the application to a policy to document the underwriting information, but it cannot act as an amendment, endorsement, rider or addendum to a policy.

Reference: 20 CSR 400-8.200(2)(B)

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP will remove this information from future Broker Manual and Field Underwriting Guidelines as well as CHL-GHP's Individual Enrollment Application/Change Form.

- (3) **MDI Finding:** The Company's Broker Manual and Field Underwriting Guidelines includes "Pregnancy – Currently (either male or female)" within a list of conditions that will be automatically declined. Pregnancy is a condition that is unique to the female gender. The inclusion of the male gender under Pregnancy is not proper and not applicable. It is unfair discrimination to use the medical condition of another to underwrite or approve a policy. Missouri law does not allow unfair discrimination concerning gender or marital status. Reference: Section 375.936(11)(e)&(g), RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. The inclusion of the word "male" in the above document was a mistake made during CHL-GHP's revision of this document from its intentional purpose: use with a family plan individual product. Unfortunately, when CHL-GHP changed the purpose of the document – use with an individual-only individual product – it neglected to omit the word "male". CHL-GHP will remove this term from its Broker Manual and Field Underwriting Guidelines. However, CHL-GHP did not violate Section 375.936(11)(e)&(g), RSMo.

because it did not discriminate based on gender or marital status.

- (4) **MDI Finding:** The Company's Broker Manual and Field Underwriting Guidelines include a notice in the Rates and Medical Underwriting section of the manual stating: "Any costs associated with the collection of medical records are the sole responsibility of the applicant." Underwriting costs are the expense of the Company and should not be passed on to the applicant. Reference: Section 375.936, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. Although it is correct that CHL-GHP should bear the expenses of its own underwriting, the language quoted above does not address any scenario whatsoever in which CHL-GHP passes on such expense to an applicant. Rather, this language addresses the situation where an applicant does not agree with the CHL-GHP's proposed premium for policy coverage. If the applicant wishes to appeal CHL-GHP's proposed premium rate and chooses to supply medical records to support his/her appeal, the quoted language notifies the applicant that the costs for obtaining such records is the applicant's responsibility.

In addition, even if CHL-GHP did require an applicant to pay for record collection costs -- which it does not -- this practice does not constitute a violation of any unfair practice defined in section 375.936, RSMo. CHL-GHP respectfully requests that the MDI provide specific citation to the applicable subsection of this statute so that CHL-GHP may respond.

d. **Large Group and Non Defined Small Group Health Insurance**

**CHC-KS**

The examiners found no errors in this review.

**GHP**

- (1) **MDI Finding:** The Company used an application that allowed the employers of the following two groups to stipulate more than the allowed 30 hours as the minimum number of hours required to be eligible for health insurance coverage. Missouri's small employer health insurance law states that an eligible employee works 30 or more hours per week. Reference: Section 379.930.2(15), RSMo

<u>Group Number</u>	<u>Hours</u>
6216625001	32

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP has already revised, filed, and received MDI approval of its Application for Benefit Offering form addressing this issue. Attached is the revised form and evidence of the MDI's approval. **See Exhibit [GHP-11].**

- (2) **MDI Finding:** The Company's practice when adding newborns is to collect premium for the first 31 days coverage of a newborn. Missouri requires a policy to cover a newborn from the date of birth for 31 days. If the member adds the newborn to the policy, the Company may charge premium to continue the coverage beyond the first 31 days.

Reference: Section 376.406, RSMo

**CHL-GHP Response:** The Company respectfully disagrees with this Finding. Although section 376.406, RSMo. sets forth that a carrier may request payment of an additional premium for coverage to extend "beyond" the first thirty-one day period", this statute does not prohibit a carrier from charging a premium for the first thirty-one days. MDI Bulletin 07-10 supports this position, stating that insurers must provide special enrollment period for newborns effective from thirty-one days from birth. As a result, CHL-GHP disagrees that it has violated section 376.406, RSMo.

### III. CLAIM PRACTICES

#### A. Claims Time Studies

##### 1. Paid Group Health Claims

###### CHC-KS

###### Acknowledgement Time

The examiners noted no errors in this review.

###### Investigation Time

The examiners noted no errors in this review.

###### Determination Time

**MDI Finding:** The Company failed to deny the following, non-electronic claim, within 15 working days from the date that it completed its investigation.  
Reference: 20 CSR100-1.050(1)(A)

<u>Claim Number</u>	<u>Date Investigation Completed</u>	<u>Date Co. Denied Claim</u>	<u>Working Days</u>
1517122622*	06/23/2005	07/18/2005	16

\* Adjusted claim number 10762543

**CHL-KS Response:** CHL-KS respectfully disagrees that it failed to deny the above claim within 15 working days after it completed its investigation. CHL-KS completed its investigation on June 12, 2005 and then adjudicated the claim 4 working days later on July 18, 2005. See Exhibit [KS003]. As a result, CHL-KS complied with 20 CSR 100-1.050(1)(A).

###### GHP

###### Acknowledgement Time

The examiners noted no errors in this review.

###### Investigation Time

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**2. Denied Group Health Claims**

**CHC-KS**

**Acknowledgement Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**GHP**

**Acknowledgement Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**3. Claims Denied for Re-Pricing**

**CHC-KS**

**Acknowledgment Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

**MDI Finding:** The Company failed to pay the following paper claims, including 12 line numbers, within 15 working days from the dates the Company completed the investigations.

Reference: 20 CSR 100-1.050(1)(A)

<u>Claim Number</u>	<u>Line /#’s</u>	<u>Date of Service</u>	<u>Date Invest. Completed</u>	<u>Date Co. Paid Claim</u>	<u>Working Days</u>
1501345303* 9759024**	/2	12/27/2005	01/13/2005	03/09/2005	40
1523401398* 10917597**	/1	05/09/2005	08/22/2005	10/05/2005	32
1535423392* 11619081**	/1	09/29/2005	12/20/2005	02/06/2006	33
1524500130* 10961502**	/2	08/08/2005	09/02/2005	10/12/2005	28
1431345803* 9619572**	/2	09/24/2004	11/09/2004	02/09/2005	64
1502122848* 9759051**	/1	11/01/2004	01/21/2005	03/09/2005	34
1516623005* 11721758**	/2	05/04/2005	06/15/2005	02/20/2006	174
1530423287**	/1	10/02/2005	10/31/2005	12/07/2005	27

\* Original Claim Number

\*\* Paid Amount on Original Claim Number

**CHL-KS Response:** CHL-KS agrees that it failed to pay only one of the above claims. CHL-KS failed to pay claim 1535423392 within 15 days of completing its investigation. CHL-KS received paper claim – claim number 1535423392 – on December 21, 2005. See Exhibit [KS008]. CHL-KS denied this claim back to the provider 5 working days later through the Remittance Advice Summary dated

December 28, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS009]. This denial was for additional repricing information. On January 10<sup>th</sup>, 2006 additional information was provided. CHL-KS reprocessed the claim 27 days later and made payment. See Exhibit [KS009a]. A total of twenty seven days passed between the end of our investigation and payment (Claim #11619081)

However, CHL-KS respectfully disagrees that it failed to pay the rest of the claims listed above within 15 days of completing its investigation. When requested additional information was made available to CHL-KS in the form of re-pricing sheets, CHL-KS paid these claims within statutory 15 days of completion of its investigation. It also appears that this Finding has incorrectly listed the date the claim was received as the date our investigation was completed.

- CHL-KS received paper claim – claim number 1501345303 – on January 13, 2005. See Exhibit [KS004]. CHL-KS denied this claim back to the provider 4 working days later through the Remittance Advice Summary dated January 19, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS005]. This denial was for additional repricing information. On March 7, 2005 additional information was provided. CHL-KS reprocessed the claim 2 days later and made payment. See Exhibit [KS005a]. A total of 2 days passed between the end of CHL-KS's investigation and payment (Claim #9759024).
- CHL-KS received paper claim – claim number 1523401398 – on August 23, 2005. See Exhibit [KS006]. CHL-KS denied his claim to the provider 1 working day later through the Remittance Advice Summary dated August 24, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS007]. This denial was for additional repricing information. On October 3, 2005, additional information was provided. CHL-KS reprocessed the claim 2 days later and made payment. See Exhibit [KS007a]. A total of 2 days passed between the end of CHL-KS's investigation and payment (Claim #10917597).
- CHL-KS received paper claim – claim number 1524500130 – on September 2, 2005. See Exhibit [KS010]. Following CHL-KS's denial for additional repricing information, on October 10, 2005 additional information was provided. CHL-KS reprocessed the claim 2 days later and made payment. See Exhibit [KS011a]. A total of 2 days passed between the end of CHL-KS's investigation and payment (Claim #10961502).
- CHL-KS received paper claim – claim number 1431345803 – on November 8, 2004. See Exhibit [KS012]. CHL-KS denied this claim to the provider 2 working days later through the Remittance Advice Summary dated November 10, 2004, in accordance with 20 CSR 100-030(1). See Exhibit [KS013]. This denial was for additional repricing information. On February 7, 2005, additional information was provided. CHL-KS reprocessed the claim 2 days later and made payment. See Exhibit [KS013a]. A total of two days passed

between the end of CHL-KS's investigation and payment (Claim #9619572).

- CHL-KS received paper claim – claim number 1502122848 – on January 21, 2005. See Exhibit [KS014]. CHL-KS denied this claim back to the provider 1 working day later through the Remittance Advice Summary dated January 24, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS015]. This denial was for additional repricing information. On March 7, 2005, additional information was provided. CHL-KS reprocessed the claim 2 days later and made payment. See Exhibit [KS015a]. A total of 2 days passed between the end of CHL-KS's investigation and payment (Claim #9759051).
- CHL-KS received paper claim – claim number 1516623005 – on June 16, 2005. See Exhibit [KS016]. CHL-KS denied this claim back to the provider 2 working days later through the Remittance Advice Summary dated June 20, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS017]. This denial was for additional repricing information. On February 13, 2006, additional information was provided. CHL-KS reprocessed the claim 7 days later and made payment. See Exhibit [KS017a]. A total of 7 days passed between the end of CHL-KS's investigation and payment (Claim #11721758).
- CHL-KS received paper claim – claim number 1530423287 – on October 31, 2005. See Exhibit [KS018]. CHL-KS acknowledged this claim back to the provider 7 working days later through the Remittance Advice Summary dated November 9, 2005, in accordance with 20 CSR 100-030(1). See Exhibit [KS019]. CHL-KS processed the claim and made payment on 12/07/05. See Exhibit [KS019a] A total of 39 days passed between CHL-KS's receipt of the claim and payment.

### GHP

There were no files to review in this category.

#### 4. Denied Group Claims with Complication of Pregnancy ICD-9 Codes

##### CHC-KS

##### Acknowledgment Time

The examiners noted no errors in this review.

##### Investigation Time

The examiners noted no errors in this review.

**Determination Time**

**MDI Finding:** The Company failed to pay the following paper claim within 15 working days from the date the Company completed its investigation.  
Reference: 20 CSR 100-1.050(1)(A)

<u>Claim Number</u>	<u>Date Invest. Completed</u>	<u>Date Co. Denied Claim</u>	<u>Working Days</u>
1523597717	08/23/2005	09/21/2005	20

**CHL-KS Finding:** The Company respectfully disagrees that it failed to pay the paper claim – claim number 1523597717 – within 15 working days from the date it completed its investigation.

CHL-KS actually paid this claim timely, adjudicating it 12 working days from the date of *receipt* on September 19, 2005. See Exhibit [KS020]. As 15 working days never elapsed from the date of receipt, let alone from the completion of CHL-KS's investigation, CHL-KS paid this claim timely in compliance with 20 CSR 100-1.050(1)(A).

**GHP**

**Acknowledgment Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**5. Denied Group Health Claims with Incorrect Effective Dates**

**CHC-KS**

**Acknowledgment Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**6. Denied Group Health Claims with Missing Information**

**CHC-KS**

The following are the results of the time studies.

**Acknowledgment Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**7. Denied Group Health Claims Because of a Non-Credentialed Provider**

**CHC-KS**

**Acknowledgment Time**

The examiners noted no errors in this review.

**Investigation Time**

The examiners noted no errors in this review.

**Determination Time**

The examiners noted no errors in this review.

**B. Unfair Settlement and General Handling Practices**

## 1. Paid Group Health Claims

### CHC-KS

- a. **MDI Finding:** The Company failed to maintain its books, records, documents and other business records in a manner so examiners can readily ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and that it issued a confirmation of receipt within one working day. The following claim files did not contain documentation of the dates of service and billed amounts, copies of the Explanation of Benefits including billed and allowed amounts to the members, and Remittance Advice Summaries including copies of the checks with the amounts of payment to the providers.

References: 20 CSR 300-2.100 (1991) and 20 CSR 300-2.200(2) & (3)(B)1 (2005)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Paid</u>	<u>Type of Submission</u>
2526403634	09/15/2004	09/21/2004	10/10/2005	Electronic
2503404434	01/24/2005	02/03/2005	02/09/2005	Electronic
2521501596	?	08/03/2005	08/08/2005	Electronic
1513624941	04/29/2005	05/16/2005	05/23/2005	Paper
1525800163	08/18/2005	09/15/2005	09/19/2005	Paper
2520009561	?	07/19/2005	07/20/2005	Electronic

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #33 on which this Finding is based.

Request #33 stated that the information it requested was specific to the medical information, notes, internal memos, letters and phone call records regarding the claims referenced herein. It was this information that CHL-KS provided as a response to Request #33.

Request #33 did not reference 20 CSR 300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 300-2.100 and 20 CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

- b. **MDI Finding:** After the Company processed the original claim on July 18, 2005, Saint Luke's Health System sent a correspondence on August 1, 2005, disputing the Company's processing and payment on this claim. The Company failed to record the "Provider Reconsideration" or grievance on its complaint register. The Company is required to record any written communication primarily expressing a grievance on the Company's complaint register and maintain them for review. Reference: Section 376.936(3), RSMo, and 20 CSR 300-2.200 (2005)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Provider Sent Complaint</u>
1517122622*	05/31/05-06/01/05	06/23/2005	08/01/2005

\* Adjusted claim number 10762543

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding.

First, CHL-KS disagrees that section 375.936(3), RSMo. requires the above letter to be recorded in CHL-KS's complaint register. Section 375.936(3), RSMo. states specifically that "complaint" shall mean "any written communication primarily expressing a *grievance*". Section 376.1350(17), RSMo. in turn defines grievance as "a written complaint submitted by or on behalf of an enrollee regarding the: (a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) Claims payment, handling or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between an enrollee and a health carrier".

St. Luke's letter was not submitted by or on behalf of the enrollee and did not meet any of the 376.1350(17), RSMo. criteria listed above. Rather, the letter was submitted by and on behalf of St. Luke's Health System and was strictly in regards to the contractual relationship between St. Luke's Health System (a provider) and CHL-KS. As such, CHL-KS did not violate section 375.936(3), RSMo.

With regard to the citation to 20 CSR 300-2.200 (2005), for the reasons previously stated, the St. Luke's correspondence did not meet the definition of Grievance in Section 376.1350(17), RSMo. and thus did not have to be included in the Complaint Register required to be kept for Market Conduct Examination purposes.

### **GHP**

- a. **MDI Finding:** The Company provides internet access for each medical provider to a Provider Manual. The manual includes rules and procedures regarding claims

submission, prior authorizations, referrals and other required procedures. Within this manual, the Company also includes a section that lists the GHP Member Rights and Responsibilities. The responsibilities include requirements that are not contained in the insurance contract/certificate. The manual does not specifically state, but a provider could infer that the members are contractually required to abide by these responsibilities. A provider may believe that s/he is able to mandate these responsibilities or charge a fee for the patient's lack of cooperation. The responsibilities are prudent, but they are not contractual.

**CHL-GHP Response:** CHL-GHP disagrees that the content in the Provider Manual section entitled "GHP Member Rights and Responsibilities" is not also in each member's policy. To the contrary, each bulleted member right and responsibility is set forth in CHL-GHP's Member Handbook. **See Exhibit [GHP-13]**. The Member Handbook is specifically referenced and incorporated into the member's policy in the introductory section of the member's Certificate of Coverage. In particular, this section states: "The Agreement between Coventry Health and Life Insurance Company as the underwriter and Group Health Plan, Inc. as the administrator (hereafter called "Plan") and You and between the Plan and Your Dependents as Members of the Plan is made up of:

- This Certificate of Coverage (COC) and Amendments;
- The Enrollment/Change Form;
- Applicable Riders;
- Enrollment Agreement;
- Member Handbook & Provider Directory; and
- Schedule of Benefits."

**See Exhibit [GHP-14]**.

- b. **MDI Finding:** The Provider Manual issued by the Company requires a provider to request approval prior to enrolling a member in a clinical trial or providing services related to a clinical trial. Missouri requires coverage for services related to certain clinical trials. The Company failed to advise the provider of the mandated benefit specifications. The Company should not require a provider to obtain approval for mandated benefits.

Reference: Section 376.429, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. Section 376.1219, RSMo. does not prohibit preauthorization of services. However, it does require coverage of phase II, III, and IV clinical trials "undertaken for the purposes of the prevention, early detection, or treatment of cancer". It also requires that Phase II trials be sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or NCI Center. It also requires that Phase II and IV trials be approved by NIH, an NIH cooperative group or center, the FDA in the form of an

investigational new drug application, the federal Departments of Veterans' Affairs or Defense; an institutional review board in Missouri that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects; or a qualified research entity that meets the criteria for NIH Center support grant eligibility. CHL-GHP can only monitor adherence to the criteria if authorization is required.

- c. **MDI Finding:** The Provider manual includes a note to providers that: "In accordance with Missouri law, an acknowledgement must be sent to the provider within ten (10) days of the receipt of the claim. If you have not received an acknowledgement, contact the provider hotline to verify receipt of the claim."

This note fails to include the information concerning electronic claim submissions requirement for acknowledgement within one day. Since the Company allows electronic claim submissions, this information should be included.

Reference: Section 376.384.4, RSMo

**CHL-GHP Response:** Although it is correct that the Provider manual does not include information regarding acknowledgment of electronic claims, CHL-GHP respectfully disagrees that this constitutes a violation of section 376.384.4, RSMo. Section 376.384.4, RSMo. does not require inclusion of such information in an insurer's Provider Manual.

Nonetheless, CHL-GHP has already revised its Provider Manuals to provide notification of its electronic claim acknowledgement timeframe.

## 2. Denied Group Health Claims

### CHC-KS

- a. **MDI Finding:** The Company failed to pay electronic claim number 10266177, which was an adjustment to the following denied claim, within 45 days from the date of original receipt. Therefore, interest is due beginning on the 46<sup>th</sup> day after receipt for this claim.

Reference: Section 376.383.5, RSMo

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>Days</u>	<u>Amount of Payment</u>	<u>Amount Interest</u>
2510512769-15	04/15/2005	06/13/2005	59	\$2,983.04	\$13.73

**CHL-KS Response:** CHL-KS respectfully disagrees that it failed to pay this claim in compliance with section 376.383.5, RSMo.

CHL-KS received the initial claim – claim number 2510512769 – through EDI on April 15, 2005. See Exhibit [KS020A]. The claim was acknowledged through the Remittance Advice Summary on April 18, 2005. See Exhibit [KS020B]. The claim was adjudicated 5 days later on April 20, 2005. See Exhibit [KS020C]. This claim was paid timely, in accordance with 376.383.5 RSMo., and rejected because additional information was need. In addition, the claim was rejected because it was improperly submitted according to the terms of the provider’s contract. Under this provider’s contract, the provider was to first submit the claim to the provider’s independent physician association (“Health Choice”). Health Choice would reprice the claim and submit the claim to CHL-KS.

Following CHL-KS’s rejection of claim number 2510512769, CHL-KS then received a paper claim – claim number 1512422644 – for the same date of service on May 5, 2005. See Exhibit [KS020D]. This paper claim was a repriced claim from Health Choice. (Apparently, the provider correctly submitted the claim to Health Choice pursuant to its contract.) This paper claim was partially denied 4 days later on May 9, 2005. See Exhibit [KS020E].

CHL-KS then received a new claim on June 9, 2005 regarding the same date of service – claim number 10266177. See Exhibit. [KS020F] With new repricing information, CHL-KS paid an additional amount for thie services rendered. This claim was adjusted 4 days later on June 13, 2005. See Exhibit [KS020G].

CHL-KS paid the initial claim and the adjusted claim in 39 days from the date that the paper claim was received. Further, the adjusted claim – claim number 10266177 – was an adjustment to the paper claim– claim number 1512422644 –, and as such no interest owed for the reason that 376.383.5 RSMo. does not apply to paper claims.

- b. **MDI Finding:** The Company failed to maintain its books, records, documents and other business records in a manner to allow examiners to ascertain its procedures. The Company failed to provide source documentation of the insureds effective dates of coverage for all files listed and of the dates of service for the billed amounts from the claims designated with an asterisk. A file shall contain all notes and work papers pertaining to the claim in such detail to allow examiners to reconstruct the pertinent events.

References: 20 CSR 300-2.100 (1991) and 20 CSR 300-2.200(2)&(3)(B)1 (2005)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Billed Amount</u>	<u>Type of Submission</u>
2525102024-7	08/30/2005	09/08/2005	\$125.00	Electronic*
9619561-8	09/17/2004	11/18/2004	36.00	Electronic
1505223269-15	01/19/2005	02/21/2005	78.00	Electronic*

2510512769-15	12/27/2004	04/15/2005	5,115.00	Electronic
1523697430	01/09/2005	08/24/2005	4,544.00	PAPER*

\* No Date of Service Documentation

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #32 on which this Finding is based.

Request #32 stated that the information it requested was specific to the medical information, notes, internal memos, letters and phone call records regarding the claims referenced herein. It was this information that CHL-KS provided as a response to Request #32.

Request #32 did not reference 20 CSR 300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

**GHP**

The examiners found no errors in this review.

**3. Denied Group Health Claims for Repricing**

**CHC-KS**

The examiners found no errors in this review

**4. Denied Group Claims with Complication of Pregnancy ICD-9 Codes**

**CHC-KS**

- a. **MDI Finding:** The Company failed to maintain its books, records, documents and other business records in a manner so examiners could ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and proof that it issued a confirmation of receipt within one working day for the applicable

electronically filed claims. The following claim files did not contain documentation of the Explanation of Benefits with the dates denied along with the written reason for the denials to the member in file. A file shall contain all notes and work papers pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100 (1991), and 20 CSR 300-2.200(2)&(3)(B)1 (2005)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Denied</u>	<u>Type of Submission</u>
1529923505	09/08/2005	10/26/2005	11/02/2005	PAPER
9686166	06/12/2004	06/22/2004	06/28/2004	ELECTRONIC
1523597717	08/01/2003	08/23/2005	09/25/2004	PAPER 2516400760
01/08/2005	06/13/2005	06/15/2005	ELECTRONIC	

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #41 on which this Finding is based.

Request #41 stated that the information it requested was specific to documentation that showed the following regarding the claim numbers referenced therein: (a) Services Rendered; (b) Claim Submission; (c) Medical Information; (d) All Correspondence; (e) Supporting Documentation for Denial; (f) Denial Notification; (g) All appeal or complaint documentation (if any) related to the claim numbers referenced. It was this information that CHL-KS provided as a response to Request #41.

Request #41 did not reference 20 CSR300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

- b. **MDI Finding:** The Company failed to maintain its books, records, documents and other business records in a manner so that examiners could readily ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and proof that it issued a confirmation of receipt within one working day for the applicable electronically filed claims. A file shall contain all notes and work papers

pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events.

References: 20 CSR 300-2.100 (1991) and 20 CSR 300-2.200(2)&(3)(B)1 (2005)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Denied</u>	<u>Type of Submission</u>
1523597636	08/03/2004	08/23/2005	09/01/2005	ELECTRONIC
2502816165	01/10/2005	01/28/2005	02/02/2005	ELECTRONIC
11038354	08/24/2005	09/02/2005	09/07/2005	ELECTRONIC
2524501554	08/24/2005	09/02/2005	09/07/2005	ELECTRONIC

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #41 on which this Finding is based.

Request #41 stated that the information it requested was specific to documentation that showed the following regarding the claim numbers referenced therein: (a) Services Rendered; (b) Claim Submission; (c) Medical Information; (d) All Correspondence; (e) Supporting Documentation for Denial; (f) Denial Notification; (g) All appeal or complaint documentation (if any) related to the claim numbers referenced. It was this information that CHL-KS provided as a response to Request #41.

Request #41 did not reference 20 CSR300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 300-2.100 and CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

### **GHP**

The examiners found no errors in this review.

## **5. Denied Group Health Claims for Incorrect Effective Dates**

### **CHC-KS**

The examiners found no errors in this review.

## GHP

The examiners found no errors in this review.

### 6. Denied Group Health Claims for Missing Information

#### CHC-KS

- a. **MDI Finding:** The Company failed to maintain its books, records, documents and other business records in a manner so examiners could readily ascertain the claims handling practices of the insurer. The following 16 claim files did not include adequate documentation to reconstruct the Company's claim procedures. A file shall contain all notes and work papers pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events. The documentation provided by the Company did not include its documents to show that it notified the provider about missing or incorrect information. The Company's practice is to deny benefits with a coded denial reason and a brief statement of the reason.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100 (1991), and 20 CSR 300-2.200(2)&(3)(B)1(2005)

<u>Group Policy Number</u>	<u>Subscriber Number</u>	<u>Claim Number</u>
543690001	2175468	1509422895
5346241001	2343687	1517245949
5301730041	73419	2533401677
5301730041	73419	2533405924
5301730041	73429	2530522241
5346241001	2343571	1522700326
5346241001	2343571	1522700505
5346241001	2343571	1523645390
5346241001	2343571	1523800095
5325370999	1154144	10256335
5325370999	1154144	1519522612
5325370999	1154144	1525600067

<u>Group Policy Number</u>	<u>Subscriber Number</u>	<u>Claim Number</u>
5325370999	1260635	1510200110
5325370999	1260635	2512309419
5342631001	2157865	1505300748
5343690001	2175468	1503345300

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #30 on which this Finding is based.

Request #30 stated that the information it requested was specific to documentation that showed what information was not provided or was incorrect, the method used to collect the information, and any other documentation CHL-KS determined was necessary to show appropriate handling of all claim numbers referenced therein. It was this information that CHL-KS provided as a response to Request #30.

Request number 30 did not reference 20 CSR 300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, paper claim forms, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

Finally, contrary to this Finding's assertion that CHL-KS did not include documents to show that it notified the provider about missing or incorrect information, the remittance advice in each file contain the denial codes as well as a brief statement of the missing or incorrect information. As such, CHL-KS did not violate 20 CSR 100-1.050(1)(A).

## **GHP**

- a. **MDI Finding:** A Medicare supplement policy or group policy customarily pays the balance of claims where Medicare has paid as the primary insurer. This file does not contain documentation to confirm that the Company determined existence of secondary liability and has not made payment as needed. The claimant is an 89 year old having Medicare as primary coverage. In the absence of payment by the insurer, it is possible that the provider collected the balance from the member, who may not be cognizant of her actual financial liability. The file does not indicate that CHL-GHP paid the remaining balance. The explanations of benefits (EOB) sent to the member indicates Member Responsibility of \$744 and \$12,856.50 respectively. CHL-GHP states that there is no actual member liability, since the Company does not allow a participating provider to bill a member for the balance. The EOB is confusing and not accurate. CHL-GHP cannot confirm that a member would not voluntarily pay the provider the amount shown as Member Responsibility nor does it assure that a provider will refund a payment collected in

error.

Reference: 20 CSR 100-1.020(1)

Claim Numbers for Claimant

2506815181

1521425082

1510823142

**CHL-GHP Response:** CHL-GHP disagrees with this Finding for two reasons. First, for claim numbers 2506815181 and 1521425082, CHL-GHP does not understand how Medicare is relevant. CHL-GHP has no indication that each member had Medicare. CHL-GHP paid this claim as the primary insurer, contrary to this Finding's allegation to the contrary. **See Exhibit [GHP-15].**

With respect to the remaining claim, CHL-GHP disagrees that EOB is confusing and not accurate. The EOB states clearly "This is a statement of benefits only" and does not tell the member to pay any amount. It also instructs the member to contact the provider, not pay the provider.

Although it is true that the EOB does not indicate that CHL-GHP paid the remaining balance, this is because CHL-GHP, as a secondary insurer, cannot properly pay/process a claim until the primary carrier does so. CHL-GHP's remittance advice for the provider regarding this claim indicates this. **See Exhibit [GHP-16].**

It is the member's responsibility to provide the primary and secondary coverage information to the provider so that the provider can properly bill its services. The members COC tells the member how coordination of benefit claims such as this claim 1510823142 are processed and it is the member's responsibility to notify the provider of all insurance coverage. **See Exhibit [GHP-17].**

**7. Denied Group Health Claims Because of a Non-Credentialed Provider**

**CHC-KS**

- a. **MDI Finding:** In the following 12 claim files, the Company failed to include complete documentation consisting of notes and work papers pertaining to the claim in such detail so examiners could reconstruct the pertinent events and the dates of these events.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100 (1991), and 20 CSR 300-2.200(2)&(3)(B)1 (2005)

Group Policy	Subscriber	Claim
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<u>Number</u>	<u>Number</u>	<u>Number</u>
5308000012	657788	2501303481
5308140001	1148918	2503811852
5308210001	1216507	2501303487
5308210001	1216507	2504902190
5408360001	2284049	2524400622
5408360001	22084049	2531802358
5346060001	2315364	2506606263
5346060001	2315364	2510401254
5346060001	2315364	2510503641
5346060001	2315364	2523703495
5346060001	2315364	2523703502
5413540001	2419064	2524903343

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding because it did provide all information requested by the MDI in connection with the Request #31 on which this Finding is based.

When the MDI examiners provided Request #31 to CHL-KS, it was CHL-KS's understanding as well as Request #31 itself that the information being requested was specific to documentation to show what the services provided, the reason the provider was ineligible to provide those services, and which type provider would be regarding all claim numbers referenced therein. It was this information that CHL-KS provided as a response to Request #31.

Request #31 did not reference 20 CSR 300-2.100 and 2.200(2)&(3)(B)1., or provide any context to its request for a "complete claim file".

CHL-KS does maintain complete claim files including notification of the claim, paper claim forms, explanation of benefits, remittance advice, documentary material which is pertinent to the investigation and/or denial of a claim in compliance with 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and CSR 300-2.200 (2)&(3)(B)1. CHL-KS is confident these files comply with the above-referenced regulations. The complete claim files are available for the MDI's review.

**GHP**

The examiners noted no errors in this review.

**8. Denied Claims Because of Incorrect Claim Submissions**

**GHP**

The examiners noted no errors in this review.

9. **Denied Claims Pre-Authorization Requirements**

**GHP**

- a. **MDI Finding:** The Company requires its providers to use a specific service to perform PSA tests unless the provider obtains prior authorization. Since the provider performed the test without prior authorization, GHP denied the cost. The Company should not require participating providers to obtain prior authorization for mandated benefits.

Reference: Section 408.020, RSMo

Claim Number

1527346149

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding for three reasons.

First, section 408.020, RSMo does not prohibit preauthorization of services.

Second, the statute governing the PSA testing benefit, section 376.1250, RSMo, also does not prohibit preauthorization of these services.

Third, CHL-GHP's Provider Manual sets forth the procedure that providers must follow for laboratory services. In particular, the Provider Manual instructs that providers must send members to Quest Diagnostics ("Quest") for such services or providers may collect the needed specimen in their office and then send to Quest. The only services which providers may perform in their offices without prior authorization are listed in the Provider Manual. CPT 84153 – the service at issue in claim number 1527346149 – is not on this list. The provider submitting this claim did not obtain prior authorization for this service, as he/she was contractually obligated to do.

- b. **MDI Finding:** Although a mammogram is a mandated benefit in Missouri, the Company denied coverage for them in the following nine claims because the provider coded the mammogram as a secondary test to one that required prior authorization. The Company agreed it should have paid the mammogram portion of the billing, but then would not pay the benefit because the contract with the providers requires them to appeal incorrect payments within one year. The Company should not punish a provider for failing to contest the denial of coverage for a mandated service.

Reference: Section 376.782, RSMo

Claim Number

2521405372  
2520011191  
2517204841  
2501835863  
12448211

Claim Number

2520113468  
2517804732  
2504208237  
1520746705

**CHL-GHP Response:** CHL-GHP disagrees that it should pay these claims even though the rendering provider failed to notify CHL-GHP that it incorrectly processed them. Although CHL-GHP would have covered the services otherwise, the provider is contractually bound to notify CHL-GHP of any claims incorrectly processed if it wishes them to be reprocessed, regardless of the nature of the services –mandated or otherwise – on the claim. Section 376.782, RSMo does not set forth that an insurer must exempt a participating provider from its contractual obligations owed to the insurer because of the mandated nature of this benefit.

- c. **MDI Finding:** The Company requires prior authorization for bone density tests. Missouri law requires coverage for bone density tests for services related to diagnosis, treatment, and appropriate management of osteoporosis. The Company should not require a participating provider to obtain prior authorization for mandated treatments.

Reference: Section 376.1199(3), RSMo

Claim Number

2521405372

**CHL-GHP Response:**

CHL-GHP respectfully disagrees with this Finding. Section 376.1199 (3), RSMo does not prohibit preauthorization of services. However, it does require “coverage for services....for individuals with a condition or medical history for which bone mass measurement is medically indicated for such individual” (underline added). CHL-GHP can only monitor adherence to the criteria if authorization of bone density testing is required.

It is important to note in 2007 CHL-GHP eliminated prior authorization requirement for bone mass measurement services regardless of medical indication.

- d. **MDI Finding:** The Company’s Utilization Review Manual requires that a provider must obtain prior approval before prescribing PKU formula. The Company should not require prior approval for mandated benefits.

Reference: Section 376.1219.1, RSMo.

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. Section 376.1219, RSMo. does not prohibit preauthorization of services. However, the statute does establish several criteria for the provision of PKU formula and food to members. In addition, 376.1219.4, RSMo. sets forth “Nothing in this section shall prohibit a carrier from using individual case management or from contracting with vendors of the formula and food products.” However, CHL-GHP can only monitor adherence to these criteria, perform individual case management, and direct members to contracted providers if authorization of PKU formula and food is required.

- e. **MDI Finding:** The Company requires participating chiropractors to submit a treatment plan for approval before providing chiropractic care. If the provider does not submit and obtain approval of a treatment plan prior to care, CHL-GHP will not pay benefits. Missouri does not require prior authorization for the first 26 visits. The requirement for a Treatment Plan is no more than a method to maintain control by demanding approval of a chiropractic treatment plan. Some policies allow benefits for spinal manipulation only and cover other treatment when the member purchases an additional rider. Missouri does not restrict care to spinal manipulation during the first 26 visits. The Company denied the following claims inappropriately for the lack of an approved treatment plan.

Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Numbers</u>
900861665*01	25043610836 1178274 250813265 11978584 11978583
900844587*01	1508145120
900761294*01	2505002494
900678025*01	1502522731
900753702*01	2528015345

**CHL-GHP Response:** CHL-GHP respectfully disagrees that its treatment plan requirement constitutes a prior authorization requirement and that it used this requirement to “maintain control by demanding approval of a chiropractic treatment plan”. Also, as explained below, this MDI Finding is incorrect in its statement “[i]f the provider does not submit and obtain approval of a treatment plan prior to care, CHL-GHP will not pay benefits.”

First, although CHL-GHP did impose prior authorization requirements on non-network chiropractor claims listed above, section 376.1230.1 specifically permits it. In particular, section 376.1230.1 RSMo., states “nor shall a carrier be required to

reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee.”

Second, CHL-GHP did not impose prior authorization requirements on any in-network chiropractor claim listed above. Section 376.1230.1 RSMo requires that that CHL-GHP’s chiropractic coverage should be “clinically appropriate and medically necessary.”

For the period examined by the MDI, CHL-GHP’s contracts with in-network chiropractors required submission of a treatment plan so that it could determine medical necessity, not so that CHL-GHP could impose a prior authorization barrier to coverage. Under this process, in the event an in-network chiropractor failed to submit any treatment plan prior to rendering a service, or did submit a treatment plan prior to rendering a service that did not establish medical necessity, CHL-GHP would deny claims for such services. However, as further evidence that CHL-GHP did not use the treatment plan requirement as a prior authorization barrier to coverage, CHL-GHP would reprocess and pay any claims previously denied for lack of a treatment plan establishing medical necessity upon submission of a treatment plan establishing such medical necessity, even if such submission occurred after services were already rendered. CHL-GHP, of course, would not require any treatment plan for a member’s initial visit to in-network chiropractor’s evaluation; CHL-GHP covered all claims for such initial visits in accordance with the terms of the member’s policy. As such, this MDI Finding is incorrect in its statement “If the provider does not submit and obtain approval of a treatment plan prior to care, CHL-GHP will not pay benefits.”

CHL-GHP did not use the treatment plan requirement to “maintain control by demanding approval of a chiropractic treatment plan”, as alleged in this Finding. As stated above, CHL-GHP used the treatment plan to establish medical necessity of an in-network chiropractor’s care. The MDI has not provided any clinical evidence that the number of visits deemed medically necessary by CHL-GHP in response to a submitted treatment plan was unsupported by medical literature. And certainly, a provider was free to provide treatment beyond that deemed medically necessary by CHL-GHP; CHL-GHP did not prevent how much care an in-network chiropractor provided. CHL-GHP’s treatment plan requirement merely set forth what treatments would be considered medically necessary under the member’s policy.

Finally, it is important to note the following:

- (a) in 2008 CHL-GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity,

- (b) although some policies in effect during the period covered by this examination limited chiropractic benefits to spinal manipulation unless the member purchased an additional rider, CHL-GHP has revised all policies in effect so that chiropractic treatment is no longer limited as such.

**10. Denied Claims Because the Claims were not Filed Timely**

**GHP**

The examiners noted no errors in this review.

**11. Denied Claims Because the Claims were Bundled**

**GHP**

The examiners found no errors in this review.

**12. Mandated Benefit Claims**

**CHC-KS**

The examiner found no problems with the information provided.

**GHP**

**MDI Finding:** The Company provided a list of claims involving mandated benefits that it previously denied. Prior to the review of these claims, the Company performed a self-audit to determine if the denials were appropriate. The Company paid those that it deemed payable and provided documentation of those payments. The Company's review resulted in additional claim payments totaling \$251.00, plus \$62.22 of interest.

**CHL-GHP Response:** CHL-GHP agrees with is Finding.

**13. First Steps Claims**

**CHL-KS**

The examiners found no problems with the information provided.

**GHP**

**MDI Finding:** The Company provided claim information for First Steps claims that it

settled during the timeframe. Coventry performed a self-audit of these claims and provided a report of this process. The information included 425 claims that were either paid or denied. The denials consisted of 231 where the member was not effective, 128 that were not timely filed, 54 needed additional information, nine were the primary carrier's liability and the balance for various reasons. The Company failed to reimburse Medicaid in four instances.

<u>Member Number</u>	<u>Claim Number</u>
901168885*03	1604101700
901216395*03	1631167523
901210874*04	1604102124
901229148*03	1625545669

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding for three reasons.

First, this MDI Finding does not cite the statute or regulation allegedly violated.

Second, although this Finding appears under the heading "First Steps Claims", the above claims are not for services that fall under the First Steps program. The First Steps statute (section 376.1218, RSMo.) mandates coverage of early intervention services, whereas the above claims are for immunization services.

Third, in this case, Medicaid submitted a claim to be reimbursed for its payment of immunization claims that it paid to the provider who rendered the immunization services. Section 376.819, RSMo. states that Medicaid acquires the rights of a Medicaid-eligible individual to payment by an insurer -- CHL-GHP, in this case -- obligated to cover health care items or services.

CHL-GHP's obligation of coverage of this member's health services is based on the member's Certificate of Coverage ("COC"). Each COC sets forth the terms and conditions of coverage, such as prior authorization and varying levels of coverage based on a provider's network participation status.

For each of the above claims, CHL-GHP rightfully requested additional information necessary to determine coverage so that it could process the claim. Each COC sets forth the terms and conditions of coverage, such as prior authorization and varying levels of coverage based on a provider's network participation status. Medicaid's failure to provide the name/credentials of the rendering provider on the claim prevented CHL-GHP from determining the appropriate coverage level under the COC because CHL-GHP did not know whether the rendering provider was participating or non-participating. This fact, in turn, affected whether CHL-GHP should have paid each claim based on a contracted rate or Out-of-Network Rate (as defined in the

COC).

CHL-GHP's denial of each claim for failure to provide information necessary to process each claim does not circumvent Medicaid's assumption of the Medicaid-eligible individual's rights under the COC. Rather, it is consistent with the COC itself.

In addition, even though it could be argued that claims 1604101700, 1604102124, and 1625545669 contained the name and address of Drs. McCaul and Vo, the information on these claims was still not sufficient to pay the claims. Box 31, which requests the name and credentials of the provider who actually rendered the services, was left blank on claims these three claims. As required for any other provider submitting claims to CHL-GHP, this field of information is necessary to process a claim so as to ensure that a provider with appropriate credentials has rendered the service and that appropriate reimbursement is paid. For example, CHL-GHP will not cover a service required to be provided by a doctor if such service is provided by a physician assistant. Also, a provider's contract with CHL-GHP may pay different reimbursement for a covered service based on the credentials of the person who rendered the service. As a result, without Box 31's information, CHL-GHP was reasonably unable to pay the claim.

Finally, claim 1631167523 indicated Pike County Health Department as the provider, but this name does not appear to be a specific name or entity. Medicaid has never resubmitted the claim with additional information.

#### **14. Claims Denied**

##### **CHC-KS**

The Company's policy form limited chiropractic services to 26 visits within a calendar year. Missouri law requires 26 visits during each policy period. The examiners asked the Company to correct the form and pay any claims that it denied because of the incorrect limitation. The Company advised it did not deny any claims due to the limitation. The examiners found no problems with the information provided.

##### **GHP**

- a. **MDI Finding:** As noted in the Policy Forms section of this report, the Company's policy form limited chiropractic services to spinal manipulations. Missouri law requires coverage for chiropractic treatment including initial diagnosis and medically necessary services and supplies required to treat the diagnosed disorder.

**CHL-GHP Response:** CHL-GHP agrees with this Finding. Although some policies in effect during the period covered by this examination limited

chiropractic benefits to spinal manipulation only, CHL-GHP has revised all policies in effect so that chiropractic treatment is no longer limited as such.

- b. **MDI Finding:** The Company requires its participating providers to submit a treatment plan after the initial treatment date to obtain approval for the follow-up treatments. Missouri law requires companies to provide 26 visits for chiropractic treatment. The law allows a company to require prior approval for visits after the first 26 visits. The Company's requirement for a treatment plan circumvents the requirements of law.

The Company required prior authorization for chiropractic care in the Provider Manual published for 2003.

The 2004 Provider Manual contains two different requirements for chiropractic treatment. The Company required prior notification before chiropractic treatment could begin, but under the special services section, it also included a requirement for a treatment plan after the initial visit before it would consider the additional services medically necessary. Medical necessity can be determined during the claim process, after the doctor provides treatment.

The 2005 Provider Manual included chiropractic services in its list of services that required prior authorization but limited the requirement to prior notification only. The manual also includes a requirement for the provider to submit a treatment plan prior to treatment. The Company states that it uses this plan as a means to determine medical necessity. Medical necessity can be determined during the claim process, after the doctor provides treatment.

The Company's requirements contradict Section 376.1230, RSMo. The law specifically states that 26 visits are payable before a company has the option to require prior authorization for additional visits. Since companies adjudicate claims, which allows them to determine whether a provider has used the proper type and level of treatment and to make a determination of payment or denial, the requirement for a treatment plan to base its determination of acceptable or necessary care can only be seen as a means to compel providers to seek prior authorization. The Company denied the following claims because the provider either failed to submit a treatment plan or exceeded the submitted-treatment plan specifications.

Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1508300175	2507310340	1604546027
2532620033	2528719588	2509407074
2510215505	2605213623	2516710176

2509113796	2513717714	2536419425
2507615539	2509015801	1525546432
2613216705	2502715321	2532211394
2517314863	2503309545	2530616775
1509700674	1507745141	2536120108
2534317339	1508146131	

**CHL-GHP Response:** CHL-GHP respectfully disagrees that its treatment plan requirement constitutes a prior authorization requirement and that it used this requirement to “maintain control by demanding approval of a chiropractic treatment plan”. Also, as explained below, this MDI Finding is incorrect in its statement that CHL-GHP uses the treatment plan requirement “as a means to compel providers to seek prior authorization.”

First, although CHL-GHP did impose prior authorization requirements on non-network chiropractor claims listed above, section 376.1230.1 specifically permits it. In particular, section 376.1230.1 RSMo., states “nor shall a carrier be required to reimburse for services rendered by a nonnetwork chiropractor unless prior approval has been obtained from the carrier by the enrollee.”

Second, CHL-GHP did not impose prior authorization requirements on any in-network chiropractor claim listed above. Section 376.1230.1 RSMo requires that that CHL-GHP’s chiropractic coverage should be “clinically appropriate and medically necessary.”

For the period examined by the MDI, CHL-GHP’s contracts with in-network chiropractors required submission of a treatment plan so that it could determine medical necessity, not so that CHL-GHP could impose a prior authorization barrier to coverage. Under this process, in the event an in-network chiropractor failed to submit any treatment plan prior to rendering a service, or did submit a treatment plan prior to rendering a service that did not establish medical necessity, CHL-GHP would deny claims for such services. However, as further evidence that CHL-GHP did not use the treatment plan requirement as a prior authorization barrier to coverage, CHL-GHP would reprocess and pay any claims previously denied for lack of a treatment plan establishing medical necessity upon submission of a treatment plan establishing such medical necessity, even if such submission occurred after services were already rendered. CHL-GHP, of course, would not require any treatment plan for a member’s initial visit to in-network chiropractor’s evaluation; CHL-GHP covered all claims for such initial visits in accordance with the terms of the member’s policy. As such, this MDI Finding is incorrect in its statement that CHL-GHP uses the treatment plan requirement “as a means to compel providers to seek prior authorization.”

CHL-GHP did not use the treatment plan requirement to “maintain control by demanding approval of a chiropractic treatment plan”, as alleged in this Finding. As stated above, CHL-GHP used the treatment plan to establish medical necessity of an in-network chiropractor’s care. The MDI has not provided any clinical evidence that the number of visits deemed medically necessary by CHL-GHP in response to a submitted treatment plan was unsupported by medical literature. And certainly, a provider was free to provide treatment beyond that deemed medically necessary by CHL-GHP; CHL-GHP did not prevent how much care an in-network chiropractor provided. CHL-GHP’s treatment plan requirement merely set forth what treatments would be considered medically necessary under the member’s policy.

Finally, it is important to note that in 2008 CHL-GHP eliminated the treatment plan requirement that in-network chiropractors submit a treatment plan so that it could determine medical necessity.

- c. **MDI Finding:** The Company denied benefits for claims submitted for member 901085952\*01 because the chiropractor provided more treatment sessions than the number authorized, although there were fewer than 26 visits during the period. Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1501345311	11592412	11532743
11532744	11592413	11592416
11592417	1501723768	1501145377

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding for several reasons.

First, CHL-GHP did not initially deny three of the above claims (#1501345311, #1501723768, and #1501723768) for exceeding the number of treatments sessions *authorized*. Rather, it initially denied them for sessions that exceeded the number for which medical necessity was established. As stated in the CHL-GHP response to the Finding immediately above, CHL-GHP did not impose prior authorization requirements on any in-network chiropractor claim.

Second, even though CHL-GHP did inadvertently deny claim #1501345311 and #1501723768 for visits exceeded the number authorized, upon learning of the break from its procedures, CHL-GHP backed out both claims (#11592412 and #11592416), then paid the claims (#11592413 and #11592417). **See Exhibit [GHP-18].**

Third, claim #1501145377 was paid without any authorization requirement

contrary to this Finding's assertion that CHL-GHP required authorization prior to payment. Claims #11532743 and #11532744 are merely back out and repayment of the claim. See Exhibit [GHP-19].

- d. **MDI Finding:** The Company denied benefits for claims submitted for member 900858424\*01 because the chiropractor was not a participating provider. After further review the Company decided that one treatment was payable and paid \$30.00 for the initial visit.  
Reference: Section 376.1230, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- e. **MDI Finding:** The Company denied benefits for several claims submitted for member 901165936\*01 because of the lack of information about other coverage. Because the information was on the claim form, the Company paid the claims after reviewing the claim. Because the Company did not pay interest for the delayed payments, it paid the chiropractor \$5.91 interest for the period of delay.  
Reference: Section 376.1230, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- f. **MDI Finding:** The Company denied benefits for claim 4525047511 submitted for member 900683463\*01 because of "Rej - Invalid Code Combination or other error identified." The Company determined that the three diagnoses were not all related to chiropractic care. One or more of the diagnoses were conditions normally treated by chiropractic manipulation. Therefore, the Company paid the claim, \$41.34.  
Reference: Section 376.1230, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- g. **MDI Finding:** The Company denied benefits for the following claims submitted for two members because the chiropractor delayed submitting the claim to the Company. File documentation indicated that the provider submitted the claim in a timely manner. In addition, the provider was not a network provider so he was not subject to the limitations required of in-network providers. The Company reversed its decision and paid the claims a total of \$250.96.  
Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Numbers</u>
900627349*02	2600324786
	2600324794
	2600324788

	2600324783
	2600324800
900627349*01	2525914726
	2526615253
	2526319622
	2525502629
	2526907703

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- h. **MDI Finding:** CHL-GHP denied benefits for claim 1504546508 for member 900862524\*01 because the chiropractor provided more treatment sessions than the number authorized. The Company reviewed the claims for this member and paid the following claims a total of \$206.00.  
Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Reprocessed Claim Number</u>
1504546508	19224380
1505523251	19224382
1505523205	19224384

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- i. **MDI Finding:** The Company denied benefits for the following claims submitted for member 900860156\*01 because the Company needed the Medicare EOB. The EOB was submitted with subsequent claims. As a result, the Company reprocessed the claims and made payments of \$12.07 and \$8.82 respectively.  
Reference: Section 376.1230, RSMo

<u>Claim Numbers</u>
1503801386
1524400267

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- j. **MDI Finding:** The Company denied benefits for claims submitted for members 901085952\*01 and 900846543\*01 because the chiropractor failed to submit a treatment plan. The Company reprocessed the claims and made payments of \$34.00 and \$126.00 respectively.  
Reference: Section 376.1230, RSMo

<u>Claim Numbers</u>
1532500077

1506800087

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- k. **MDI Finding:** The Company denied benefits for the following claim submitted for member 900655613\*01 because the chiropractor provided more treatment sessions than the number authorized. The Company paid additional benefit of \$7.00.

Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Number</u>
900655613*01	19539370
	19539369

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- l. **MDI Finding:** The Company denied benefits for claim number 2531116205 because the provider failed to submit a treatment plan. The file included a referral, which included the date of service for this claim. The Company paid additional benefits of \$35.00.

Reference: Section 376.1230, RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- m. **MDI Finding:** The Company determined that it did not pay claim 1518945681 correctly and remitted an additional \$17.30 including interest.

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

## **15. Childhood Immunizations Claims Denied**

### **CHC-KS**

The examiners found no errors in this review.

### **GHP**

- a. The examiners found no problems with this information.

## **16. Denied Mental Health Claims**

The Company provided 27 denied claims for members who received treatment for mental health problems.

- a. **MDI Finding:** The Company denied benefits because the level of care stipulated by the managed care TPA was less intensive than that recommended or provided by the provider. The Company paid \$315.00 on claim 0530800581 because the initial care provided to the member on admission was considered necessary due to the perceived emergent factors.

Reference: Sections 354.442.1(3), 375.1007, (3) & (4), and 376.1350(12), RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- b. **MDI Finding:** The Company denied benefits for claim 0516800344 when the member was admitted for detoxification but he was not experiencing suicidal ideation or homicidal ideation. The records indicate that the member presented with vague suicidal thoughts but was not experiencing them when interviewed by the Company. Since the Company's interview did not indicate serious symptoms, CHL-GHP denied the claim. The perceived emergent factors upon arrival were not considered in this claim.

Reference: Sections 375.1007, (3) & (4), and 376.827, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees that it failed to comply with section 376.827, RSMo and that it did not promptly and fairly investigate and settle the above claim.

Section 376.827, RSMo. supports that medical necessity is a prerequisite for substance abuse coverage. In particular, section 376.827(2), RSMo. states that CHL-GHP shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to evaluation and treatment for mental illness than for access to evaluation and treatment for physical conditions. As such, CHL-GHP's TPA MHNNet justifiably investigated the above claim to determine medical necessity.

MHNNet promptly and fairly investigated the above claim to determine medical necessity of the requested inpatient detoxification so that it could settle the claim. On 5/11/05, MHNNet received a call from the provider requesting certification for a member's inpatient detoxification. The request reflected that the member had no suicidal ideation, no current withdrawal symptoms, vital signs normal (BP 144/80, pulse 84, resp 16, temp 97.7), and a long history of substance abuse (last usage was on 5/6 (one marijuana joint) and heroin 1 gm 5/8/05). The member's record reflected that the member has already been detoxified. Based on medical necessity criteria and member's presenting symptoms, the request for inpatient detoxification was denied during that call because the member failed to meet the medical necessity criteria for inpatient detoxification.

Although MHNet offered a peer-to-peer consult in order to determine whether any other data would help establish medical necessity as well as to specifically coordinate with the attending physician the recovery goals and discharge plans, the attending physician and the facility declined. MHNet's reviewing physician then informed the provider that Intensive Outpatient Services (IOP) would be authorized, if requested, as the member appeared to meet the medical necessity criteria for such treatment. Based on medical necessity criteria, IOP treatment (if requested) would have met the clinical needs to deal with repetitive addictive behaviors, and patients unresponsive or non-compliant to traditional 12-Step treatment programs. No request for IOP authorization was ever received though.

Although this MDI Finding states that "the perceived emergent factors upon arrival were not considered in this claim", MHNet and CHL-GHP never received any information about this member from the provider, or the MDI, that established satisfaction of medical necessity criteria for the member's inpatient detoxification.

As a result, the Company did not violate Section 376.827, RSMo, and did, in fact, promptly and fairly investigate, settle, and the above claim.

- c. **MDI Finding:** The Company denied benefits for claim 0533204429 in error. Medicare, the primary carrier, paid its portion of the claim, leaving CHL-GHP responsible for the balance of \$54.48.  
Reference: Section 375.1007, (3) & (4), RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

## **17. Denied Emergency Care and Ambulance Claims**

### **GHP**

- a. **MDI Finding:** The Company did not pay all benefits for claim number 13871740. It did re-adjudicate the benefits in claim 20089890 paying an additional \$511.57.  
Reference: Section 375.1007(3) & (4), RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

- b. **MDI Finding:** The Company denied emergency room care claim 0533204429 in error. CHL-GHP re-opened the claim under claim 0805350059 and paid \$53.17.  
Reference: Section 375.1007(3) & (4), RSMo

**CHL-GHP Response:** CHL-GHP agrees with this Finding.

## 18. Claim Processing Issues

### GHP

- a. The Company's claim procedures, manuals, agreements and contracts do not always contain sufficient continuity and conformity to allow a fair and equitable process. Individual provider contracts do not always include complimentary requirements and procedures to allow fair and equitable claim reimbursement.

**CHL-GHP Introductory Response:** CHL-GHP disagrees strongly with this Finding's characterization of its procedures, manuals, and agreements. CHL-GHP's claims processing practices are in fact fair and equitable, and CHL-GHP claims practices are held in high regard, as evidenced by Medical Group Management Association survey results, claims reviews conducted by CHL-GHP clients such as AT&T, and feedback provided directly to CHL-GHP by its providers. CHL-GHP would object to the statement of these characterizations in any document to be made available to the public.

Where CHL-GHP was able to locate the Criticism(s) that formed the basis for specific Findings below, CHL-GHP has provided its response. Unfortunately, due to the general nature of certain Findings below, CHL-GHP was not able to do so for all Findings in this section. As a result, CHL-GHP requests that the MDI provide the claims or instances that formed the basis of such Findings. This will clarify for CHL-GHP specifically the issue(s) identified by the MDI and promote a more effective dialogue with the MDI. CHL-GHP did locate some Requests made to GHP that resembled the basis for some Findings. In such cases, the responses below are made on behalf of GHP.

1. **MDI Finding:** The Company uses the term "invisible provider" to specify any provider who provides ancillary services but is not a consideration for the member. Certain providers may be "invisible" providers due to their association with a provider from whom the member has chosen to receive services or who is based in a hospital. The following provider types can be "invisible" providers: radiologists, pathologists, anesthesiologists, and ER physicians. Many "invisible" providers do not contract with insurers. In some claims, the Company denied claims because it did not consider the provider a participating "invisible" provider. If the contract allows coverage for non-participating providers, the Company will pay benefits for them as non-participating even when the member does not have a choice in the matter. The Company advised that "invisible" providers can be participating or non-participating, which is determined by the care provided and/or the contractual relationship to GHP.

**CHL Response:** CHL-GHP could not locate a Criticism or claims/instances on which this Finding is based. However, CHL-GHP would like to clarify that although members could be held responsible for charges made by an invisible provider depending on their benefit plan CHL-GHP held the member harmless if balanced billed by such non-participating invisible provider for any amounts over CHL-GHP's Out of Network Rate.

2. **MDI Finding:** The Company's procedure to identify participating providers allows non-participating providers to be associated with and work within an office where all the other providers are participating. In this scenario, even if a member tries to determine in advance if a provider is participating can end up receiving treatment from a non-participating doctor, resulting in higher deductible and co-pay charges.

**CHL Response:** CHL-GHP's 2005 Provider Directory lists participating providers individually, not under their practice group. CHL-GHP provides members with provider directories to insure that they have access to a list of participating providers from which they can choose to receive services at higher, contracted rates. Members can also check for participating providers on the plan's website. CHL-GHP's Certificates of Coverage state clearly, "Listing a particular Provider in the Provider Directory is not a guarantee that the particular Provider will be Participating at the time You seek Health Services. See Exhibit [GHP-20]. You must verify the participation status of Providers with The Plan before You obtain Health Services." (Section 6 – Covered Services), that it is the member's responsibility to confirm a provider's participating status before receiving treatment. A member may see a participating provider in an office where some providers are non-participating. If the member is offered services from a non-participating provider in the same office, it is the member's responsibility not only to inquire as to the provider's participating status, but also to either insist on seeing only participating providers, or to accept the non-participating provider's billed charges at the non-participating rates.

3. **MDI Finding:** On page 22 of the 2005 Provider Manual there is a requirement for pregnancy related services to submit notification only and not require prior authorization. On page 30 of that manual it states, that the Medical Management Department must be notified when pregnancy is confirmed. The Global OB Authorization Request and the OB Precertification Forms are required for these notifications and are to be completed by a physician. The manual does not include a specific requirement for a hospital facility to notify the Company of the date and

type of pregnancy delivery. The Company advised that all hospitals are required to provide notice of all admissions.

**CHL Response:** CHL-GHP's 2005 Provider Manual as well as its provider contracts with hospitals require the hospital to obtain prior authorization for all hospital admissions, including of course deliveries. **See Exhibit [GHP-21].**

In 2006, CHL-GHP changed slightly its process for delivery claims. In the event a CHL-GHP receives a claim for a delivery before an authorization is requested by the provider and granted by CHL-GHP, CHL-GHP alerts the Medical Management Department so that an authorization can be entered to process the claim.

4. **MDI Finding:** The Company requires providers to complete specified forms for claim submissions. The provider name and identification number are required to be placed on form HCFA1500 in Box 31. If the form is completed and that information is not in Box 31, the Company denies the claim because of the lack of or misplaced information even when the information is elsewhere on the forms.

**CHL Response:** CHL-GHP's 2005 Provider Manual in the Section entitled "Claims Information" informs providers on how to complete the HCFA 1500. With regard to Box 31, the Provider Manual instructs providers that a "Signature of Physician or Supplier" is required along with the physician's credentials. **See Exhibit [GHP-22].** Although CHL-GHP was not able to locate the Criticism on which this Finding is based, it is CHL-GHP's experience that many participating providers submitted claims without providing the rendering/attending physician's signature and credentials. Often, such providers repeatedly submit claims for the same service with listing a physician assistant or nurse practitioner. In such cases, CHL-GHP instructs the provider to "Resubmit with rendering/attending physician's signature". **See Exhibit [GHP-23].**

5. **MDI Finding:** The Company has an unwritten rule that requires lab services to be utilized based on the county of residence of the member. The process requires the participating provider to direct members to a specific lab for processing. Since the county of residence is not always obtained by providers, the medical provider often does not have adequate information to assure proper application of the rule. If a provider misdirects the member to an incorrect lab, the lab is penalized for providing services.

**CHL Response:** CHL-GHP respectfully disagrees with this Finding. Contrary to this first sentence of this Finding, CHL-GHP neither requires laboratory vendors to provide services for members based on the member's county of residence nor requires medical providers to send members to a certain laboratory vendor based on the member's county of residence. Rather, CHL-GHP's contracts with certain laboratory vendors explicitly limit what services will be reimbursed based on the member's county of residence.

CHL-GHP's laboratory vendors agreed to this member-of-county provision in contracts with CHL-GHP in order to gain access to CHL-GHP membership in rural markets, as evidenced by negotiation of the provision and execution of the provider contract.

6. **MDI Finding:** The Company's claim processing requirements in the form of a Provider's Manual requires providers to submit claims within specific time limitations. It also specifies the claim forms that will be acceptable to the Company, the information that must be included on the claim forms, and in which specific boxes or positions on the claim form. Some of this information is designated to be entered in more than one position, but it must be entered in each of those positions. If the provider provides incorrect information, omits a required entry, or in any other manner does not correctly complete the form(s) the claim is denied.

**CHL Response:** Please see CHL's Introductory Response above.

7. **MDI Finding:** If the provider fails to include the correct ICD-9 or CPT code, the claim is automatically denied with the reason that the correct codes was/were not included. If other necessary information is not included or is misplaced on the form, the Company denies the claim with the reason that the information was not submitted as required.

**CHL Response:** Please see CHL's Introductory Response above.

8. **MDI Finding:** The Company's claim procedures do not include a method to correct errors on claim forms or to provide immediate assistance for submission errors made by providers. The denial codes with brief explanations are the only contact made with the provider. The codes provide the denial notice, but the explanation does not fully explain the reason for the denial and does not provide immediate assistance to complete the claim process. The lack of direction causes confusion that often delays or causes a claim denial during the adjudication process. In some instances, more than one piece of information is incorrect or

missing. The Company will identify one problem on the denial. When the provider corrects that part, the Company may deny the claim for one of the other processing errors. The process may result in several separate denials and usually the creation of several different claim numbers for the same episode of service. The Company provides assistance in the form of a toll free telephone number for providers or the insured to call to obtain help completing claim forms, but does not have a process to resolve claim submission issues concerning incorrect or missing information.

**CHL Response:** Please see CHL's Introductory Response above.

9. **MDI Finding:** The Company's agreements, contracts and procedure manuals are not always coordinated to achieve a fair and equitable claim process. When the Company requires providers to forfeit earnings because of procedural incompatibilities, the provider can only correct the situation by increasing prices to compensate for the losses. This results in increasing overall costs rather than the perceived lowering of expenses.

**CHL Response:** Please see CHL's Introductory Response above.

10. **MDI Finding:** It does not appear that the Company performs investigations to obtain correct or missing information. When a provider is non-participating, the same process is used but the member must assume responsibility for the claim submission and corrective actions. The claim reviews have discovered claims being denied because the claim information was not correct or was incomplete.

**CHL Response:** Please see CHL's Introductory Response above.

11. **MDI Finding:** The Company's Provider Agreements and Procedure Manuals include numerous requirements and specifications that providers must follow precisely in order to attain the status of a "clean claim." If a submitted claim is not determined to be a "clean claim," then the Company does not consider it a claim. The claimant must resubmit the claim in the form and manner prescribed by the Company. The Company's Provider Agreement requires participating providers to forfeit their fees when they do not file an acceptable claim within 90 days of the date of treatment. Although some claims were filed timely, they included errors and were ultimately denied because a correctly completed "clean claim" form was received late, and the Company did not consider the original submissions because they were not "clean claims."

**CHL Response:** CHL-GHP acknowledges that it has the responsibility to

begin investigating and request additional information to process incomplete claims. CHL-GHP's claims process does just this. CHL-GHP rejects claims without all necessary information by way of denial codes that indicate a lack of information or the additional information needed. CHL-GHP's denial codes request the particular information needed, such as medical records. It is this additional requested information that constitutes the beginning of CHL-GHP's investigation of incomplete claims.

This Finding alleges that when CHL-GHP determines that a submitted claim is a not "clean claim", then "it does not consider it a claim". In doing so, the Finding alleges that the submitting provider must resubmit the claim in the CHL-GHP required format, resulting in a delay that would cause such claims to be rejected for violating a provider contract requirement that claims must be submitted within 90 days of treatment. Although CHL-GHP strives to process each claim in good faith, mistakes do occur. However, even with such mistakes, CHL-GHP disagrees that these instances constitute CHL-GHP's standard claims practice. In order to respond squarely to this Finding, CHL-GHP requests the claim numbers that constitute these instances.

Nonetheless, even without these specific claim numbers, CHL-GHP's general claims practice is not engineered to reject claims so that claims can be delayed to after 90 days of treatment. Rather, CHL-GHP's Provider Manual instructs that providers have an additional 90 days *from the date of their claim submission* to submit additional information requested. As a result, where a provider submits an initial claim within 90 days of treatment and CHL-GHP requests additional information, so long as a follow-up claim providing such additional information is submitted within 90 days after CHL-GHP requested it, CHL-GHP will process the follow-up claim even if its submission date is more than 90 days after the date of treatment. The fact that CHL-GHP's claims system assigns of a new claim number to the follow-up claim has no bearing on this result.

12. **MDI Finding:** The Company's denials for claims that involve members who have their primary insurance with Medicare may cause an elderly member to pay charges that are actually payable by Medicare or CHL. The denial code used states that the member is not responsible for the particular service, yet the EOB identifies a "total amount covered" and indicates that the member is responsible.

**CHL Response:** CHL-GHP disagrees that its EOB is confusing and not accurate. The EOB states clearly "This is a statement of benefits only"

and does not tell the member to pay any amount. It also instructs the member to contact the provider, not pay the provider.

**MDI Finding:** Section 375.1007, RSMo requires a company to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; to complete its investigation within 30 days; effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. The Company does not appear to have done this.

Regulation 20 CSR 100-1.010 states that an investigation means all activities of an insurer directly or indirectly related to the determination of liabilities under coverage afforded by an insurance policy. The Company does not appear to have done this.

Regulation 20 CSR 100-1.030 states that every insurer, upon receiving notification of claim, promptly shall provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. The Company does not appear to provide reasonable assistance.

Regulation 20 CSR 100-1.030(3) requires that upon notice of a claim, the Company shall provide necessary forms, instructions and reasonable assistance to first party claimants so they can comply with the Company's reasonable requirements. CHL does not maintain a procedure to comply with this requirement because it does not provide assistance instead, it denies the claim while supplying minimal information. The claim reviews have discovered large numbers of claims denied because the claim information was not correct or incomplete when first submitted. Claims that are not complete are not considered to be filed claims by the Company. Re-filed claims are considered new filings if they are "clean claims." If a "clean claim" is not filed timely (within 90 days) the claim is denied. The Provider Manual requires participating providers to forfeit their fees when they do not file an acceptable claim within 90 days of the date of treatment. The Company does not perform investigations to obtain correct or additional information. When a company receives a claim, it must accept, deny or suspend it to get more information.

**CHL-GHP Response:** Please see CHL-GHP's response to Finding 11 directly above.

**IV. COMPLAINTS**

**A. Department of Insurance, Financial Institutions and Professional Regulation Complaints**

**CHC-KS**

1. **MDI Finding:** The Company failed to maintain documentation of the postmark for seven of the 18 DIFP complaints, which the Company received during the review period. Missouri requires companies to mail an adequate written response to a DIFP inquiry within 20 days from the date of postmark. The examiners were unable to readily ascertain the complaint handling practices of the Company because postmarks were not reflected in seven of the files.

Reference: 20 CSR 100-4.100(2)(A), and 20 CSR 300-2.200(2) (2005)

<u>Issue No.</u>	<u>Date Received</u>	<u>DOI File No</u>
5969	01/03/2003	02J003621
6008	01/13/2003	03J000085
7841	03/09/2004	04S000187
7873	04/27/2004	04J000850
14744	09/02/2004	04J001867
14759	10/15/2004	04K000619
14851	05/12/2005	05J001560

**CHL-KS Response:** CHL-KS agrees with this Finding. CHL-KS has revised its policies on MDI complaints to reflect that all postmarked envelopes are retained in each file. See Exhibit [KS021].

2. **MDI Finding:** The Company failed to pay the following seven electronic claims related to the respective Department complaints within 45 days from the dates of receipt. Therefore, interest is due beginning on the 46<sup>th</sup> day after receipt up to the date of full payment on the claim. The Company can exclude days that it waits for requested information from the processing days used to determine if or how much interest is due. The Company reprocessed these claims after the claimants filed complaints with the DIFP, which is not the same as a request for information. The payment of interest is required for all delayed payments without the necessity of the claimant to file an additional claim for that interest.

References: Sections 375.1007(1), (3), (4), and (6), and 376.383.5 RSMo

Department Complaint Number  
05J00096

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>	<u>Interest Due</u>

Provider: Pediatric Assoc of

9626538	12/06/04	02/09/05	01/20/05	20	\$55.00	\$ .36
9626547	12/06/04	02/09/05	01/20/05	20	55.00	<u>.36</u>
						Total: \$ .72

Provider: Obstetrics Gynecol

9969498	01/26/05	04/20/05	03/12/05	39	\$34.00	\$ .44
9969504	01/26/05	04/20/05	03/12/05	39	6.30	<u>.08</u>
						Total: \$ .52

Department Complaint Number

05J000917

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>	<u>Interest Due</u>
10981992	11/29/04	10/17/05	01/22/05	288	\$611.00	\$57.85

Department Complaint Number

04J000467 (The Company paid \$289.90 interest on these two claims and an additional \$109.19 for another insured to the Center for Rheumatic Disease provider for a total of \$399.09 interest during the course of this examination.)

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>
8115104	03/04/03	03/08/04	04/18/03	324	\$1,797.22
8083621	07/03/03	03/01/04	08/17/03	196	1,686.30

**CHL-KS Response Regarding Department Complaint Number 05J00096:**

Pediatric Associates of Springfield

CHL-KS respectfully disagrees that it failed to pay adjusted claim 9626538 within 45 days. CHL-KS first received the initial claim at issue – claim number 2434101229 (Member Dylan Christian) – on December 6, 2004. See Exhibit [KS022]. CHL-KS then adjudicated the claim 15 days later on December 21, 2004. See Exhibit [KS023].

CHL-KS respectfully disagrees that it failed to pay adjusted claim 9626547 within 45 days. CHL-KS first received the initial claim at issue – claim number 2434101227 (Member Halston Christian) – on December 6, 2004. See Exhibit [KS024]. CHL-KS then adjudicated the claim 15 days later on December 21, 2004. See Exhibit [KS025].

CHL-KS then received MDI complaint file 05J000096 on January 26, 2005, and upon investigation determined that claim numbers 2434101229 and 2434101227 needed to be adjusted. The adjusted claim numbers are 9626538 (See Exhibit [KS026]) and 9626547

(See Exhibit [KS027]), and as the explanations of benefits show, an additional amount was paid 12 days later on February 9, 2005.

As such, CHL-KS paid these claims in 27 days (15 days plus 12 days) and thus did not violate 376.383.5, RSMo.

Obstetrics Gynecology

CHL-KS respectfully disagrees that it failed to pay adjusted claim 9969498 within 45 days. CHL-KS first received the initial claim at issue – claim number 2503108030 (Member Tanya Christian) – on January 26, 2005. See Exhibit [KS028]. CHL-KS then adjudicated the claim 20 days later on February 15, 2005. See Exhibit [KS029].

CHL-KS respectfully disagrees that it failed to pay adjusted claim 9969504 within 45 days. CHL-KS first received the initial claim at issue – claim number 2503108035 (Member Tanya Christian) – on January 26, 2005. See Exhibit [KS030]. CHL-KS then adjudicated the claim 20 days later on February 15, 2005. See Exhibit [KS031].

CHL-KS then received an additional correspondence from the DOI regarding complaint file 05J000096 on April 7, 2005, and upon investigation determined that claim numbers 2503108030 and 2503108035 needed to be adjusted. The adjusted claim numbers are 9969498 (See Exhibit [KS032]) and 9969504 (See Exhibit [KS033]), and as the explanations of benefits show, an additional amount was paid 15 days later on April 20, 2005.

As such, CHL-KS paid these claims in 35 days (20 days plus 15 days) and thus did not violate 376.383.5 RSMo.

In addition to the fact that CHL-KS paid the claims within 45 days, our review of the statute indicates that there is no stated requirement for a health carrier to pay interest on a claim that had been adjudicated timely and in good faith, but later is discovered to have been adjudicated incorrectly or for an incorrect amount. Upon notification of an incorrect adjudication, CHL-KS promptly makes any necessary adjustments. We note that as a health carrier, however, we may have certain contractual obligations to pay such interest with specific providers in such cases.

We believe that the original intent of the Prompt Pay Statute was to address the problem of health carriers routinely failing to adjudicate claims in an expeditious manner. We would certainly welcome a citation to any statute, regulation, or legislative history that indicates a contrary position.

Finally, CHL-KS disagrees that it violated section 376.1007(1),(3),(4),(6), RSMo. by failing to conduct a reasonable investigation when these claims were originally processed. The claims were adjudicated correctly based upon the information that the claims examiner had at the time. MDI Complaint Number 05J00096 contained information not previously known to

CHL-KS – namely, representations made by the employer group’s broker to the member – that allowed CHL-KS to determine it would make an exception in this case and reprocess the claim. See Exhibit [KS034].

**CHL-KS Response Regarding Department Complaint Number 05J000917:** CHL-KS respectfully disagrees that it failed to pay adjusted claim 10981992 within 45 days. CHL-KS first received the initial claim at issue – claim number 2433421333– on November 29, 2004. See Exhibit [KS035]. CHL-KS then adjudicated the claim 21 days later on December 20, 2004. See Exhibit [KS036].

CHL-KS then received DOI complaint file 05J001917 on October 10, 2005, and upon investigation determined that claim number 2433421333 needed to be adjusted. The adjusted claim number is 10981992, and as the explanation of benefits shows an additional amount was paid 7 days later on October 17, 2005. See Exhibit [KS037]

As such, CHL-KS paid these claims in 28 days (21 days plus 7 days) and thus did not violate 376.383.5, RSMo.

In addition to the fact that CHL-KS paid the claims within 45 days, our review of the statute presents no stated requirement for a health carrier to pay interest on a claim that had been adjudicated timely and in good faith, but later is discovered to have been adjudicated incorrectly or for an incorrect amount. Upon notification of an incorrect adjudication, we promptly make any necessary adjustments. We note that as a health carrier, however, we may have certain contractual obligations to pay such interest with specific providers in such cases.

We believe that the original intent of the Prompt Pay Statute was to address the problem of health carriers routinely failing to adjudicate claims in an expeditious manner. We would certainly welcome a citation to any statute, regulation, or legislative history that indicates a contrary position.

Finally, CHL-KS disagrees that it violated section 376.1007(1),(3),(4),(6), RSMo. by failing to conduct a reasonable investigation when these claims were originally processed. The claims were adjudicated correctly based upon the information that the claims examiner had at the time. MDI Complaint Number 05J000917 contained information not previously known to CHL-KS – namely, that an authorization had been obtained, not by the billing facility, but by the specific physician who provided the service – that allowed CHL-KS to reprocess the claim. See Exhibit [KS038].

**CHL-KS Response Regarding Department Complaint Number 04J000467:** CHL-KS agrees that it failed to pay original claim numbers 2306302797 and 2318407355 within 45 days, and therefore interest is owed. As such the claims were reprocessed on November 2, 2006 to pay interest to the provider as described in the following chart.

Original Claim No.	Date Received	Adjusted Claim No.	Date Paid	Interest Days	Interest Owed
2306302797	03/04/03	8115104	03/08/04	324	\$181.24
2318407355	07/03/03	8083621	03/01/04	196	\$108.66

The reason for the disparity between the MDI's and CHL-KS's calculation in interest owed for original claim number 2306302797 is that CHL-KS is basing interest on the additional amount of \$1,678.16 that was paid on adjusted claim number 8115104 on March 8, 2004, rather than the total due. CHL-KS's rationale for the difference is that it paid the provider the initial payment timely. Please see the attached Remittance Advice Check dated 03/08.2004. See Exhibit [KS039].

3. **MDI Finding:** The Company did not conduct a reasonable investigation when it originally processed the following 14 claims. The Company only reprocessed these claims after the claimants filed complaints with the DIFP.

Reference: Section 375.1007(1), (3), (4), and (6), RSMo

<u>Complaint Number</u>	<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Initially Processed</u>	<u>Date Co. Paid</u>	<u>Amount of Payment</u>
Provider: Doctors Hosp of Sp					
05J00096	9969458	10/12/04	11/09/04	04/19/05	\$96.00
Provider: Allergy & Asthma					
05J00096	9969440	08/27/04	09/15/04	04/19/05	\$95.10
05J00096	9969450	10/12/04	10/19/04	04/19/05	79.73
05J00096	9969471	10/19/04	10/29/04	04/19/05	8.25
05J00096	9969479	10/29/04	11/12/04	04/19/05	8.25
05J00096	9969484	11/24/04	12/09/04	04/19/05	8.25
05J00096	9969492	12/08/04	12/21/04	04/19/05	8.25
05J00096	9969494	12/22/04	01/12/05	04/19/05	8.25
05J00096	9969507	02/08/05	02/25/05	04/19/05	8.25
05J00096	9969509	03/01/05	02/08/05	04/19/05	8.25
					Total: \$232.58
Provider: Avista Hospital					
05J000915	10104405	12/15/04	12/23/04	05/16/05	\$8,321.26
Provider: Ozarks Medical Center					
05S000284	9767334	01/18/05	01/26/05	04/04/05	\$138.90
05S000284	9767378	02/01/05	02/16/05	04/04/05	<u>\$172.58</u>

Total: \$311.48

Provider: Skaggs Hospital

05J002228 11157715 06/24/05 07/06/05 11/14/05 \$7,149.14

**CHL-KS Response:** CHL-KS disagrees that it violated section 376.1007(1),(3),(4),(6), RSMo. by failing to conduct a reasonable investigation when these claims were originally processed. Each claim was adjudicated correctly based upon the information that the claims examiner had at the time. In each case below, CHL-KS learned new information as a result of the MDI Complaint that it did not have during the original processing of the claim at issue.

**CHL-KS Response Regarding Department Complaint Number 05J00096 – Doctors Hospital of Springfield:** MDI Complaint Number 05J00096 contained information not previously known to CHL-KS – namely, CHL-KS representations made to the member – that allowed CHL-KS to determine it would make an exception in this case and reprocess the claim. See Exhibit [KS040].

**CHL-KS Response Regarding Department Complaint Number 05J00096 – Allergy & Asthma:** As this is the same MDI Complaint Number, please see the paragraph immediately above.

**CHL-KS Response Regarding Department Complaint Number 05J000915 – Avista Hospital:**

MDI Complaint Number 05J000915 alerted CHL-KS to information not previously known to CHL-KS – namely, that CHL-KS had not timely processed the claim originally – that allowed CHL-KS to determine it would make reprocess the claim. See Exhibit [KS041].

**CHL-KS Response Regarding Department Complaint Number 05S000284 – Ozarks Medical Center:** MDI Complaint Number 05S000284 alerted CHL-KS to information not previously known to CHL-KS – namely, new coordination of benefits information – that allowed CHL-KS to determine it would make reprocess the claim. See Exhibit [KS042].

**CHL-KS Response Regarding Department Complaint Number 05J002228 – Skaggs Hospital:** MDI Complaint Number 05J002228 alerted CHL-KS to information not previously known to CHL-KS – namely, that CHL-KS had an incorrect participating status assigned to a provider – that allowed CHL-KS to determine it would make reprocess the claim. See Exhibit [KS043].

### **GHP**

1. The Company denied approval in the following complaint of Vagus Nerve Stimulation (VNS) treatment for Treatment Resistant Depression (TRD). The FDA approved this treatment. The Company used a July 15, 2005, FDA approval for the pre-market use of the treatment. The provider submitted a July 15, 2005, approval from the FDA that did not

include the restriction for pre-market use only. The file included other documentation that showed reports from several tests of the equipment. Some tests of the equipment indicated good results while others failed to determine any benefits. The file did not include documentation to show FDA non-approval for this treatment.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Number</u>	<u>Complaint Number</u>	<u>Company Number</u>
900863850-02	06J000147	DOI10602301MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. On July 15, 2005, the FDA approved the use of the VNS Therapy System™ for the long-term treatment of chronic or recurrent depression that has not responded to usual treatments. The FDA's approval order requires Cyberonics to conduct two post-approval studies:

[T]o further characterize the optimal stimulation dosing and patient selection criteria for the VNS Therapy System for treatment-resistant depression (TRD). The first study is a prospective, multicenter, randomized, double-blind comparison of different output currents in 450 new subjects with TRD.

The order further required these study subjects to be followed:

[F]or at least one year following implantation to further characterize duration of responses as well as safety parameters at these higher doses.

Further, no Medicare carrier had approved VNS therapy for TRD, but several had denied coverage. Arkansas BlueCross BlueShield (CHL-GHP's Medicare carrier) excludes VNS therapy to treat TRD. The coverage policy manual stated that VNS therapy for TRD lacks the necessary randomized controlled clinical studies, and, therefore, Medicare considers the therapy investigational.

When the FDA approved to market VNS therapy to treat TRD, the FDA determined that such a treatment is safe. However, FDA approval does not mean that treatment of TRD with VNS therapy is appropriate. In fact, CHL-GHP found no evidence to support a conclusion that VNS therapy to treat TRD is reasonable or necessary. CHL-GHP's Technology Assessment division reviewed the data and deemed the use of VNS for depression as Investigational/Experimental under the member's policy.

This Finding references Sections 376.1365, 376.1382 and 376.1385, RSMo, which are the statutes governing the reconsideration and appeal of an adverse determination. CHL-GHP adhered to the requirements set forth in these statutes during its review of the complaint, and therefore was not in violation of these laws. Specifically, § 376.1365 requires CHL-GHP to reconsider an adverse benefit determination with one working day of a

reconsideration request. CHL-GHP did not receive such a request for this member, and therefore did not violate this statute.

Section 376.1382, RSMo, requires CHL-GHP to process first level appeals as follows:

- (i) Acknowledge receipt in writing of the appeal within ten working days;
- (ii) Conduct a complete investigation of the appeal within twenty working days after receipt; provided, however, that if investigation cannot be completed within twenty working days after receipt, the enrollee shall be notified in writing on or before the twentieth working day and the investigation shall be completed within thirty working days thereafter.
- (iii) Within five working days after the investigation is completed, have someone not involved in the circumstances giving rise to the appeal decide upon the appropriate resolution of the appeal and notify the enrollee in writing of the decision and of the enrollee's right to file an appeal for a second-level review; and
- (iv) Within fifteen working days after the investigation is completed, notify the person who submitted the grievance of the carrier's resolution of said grievance.

CHL-GHP did not receive a first level appeal letter from the member. Rather, the member filed a complaint with the MDI, which was received by CHL-GHP on January 23, 2006. CHL-GHP processed the member's MDI complaint as a first level appeal request. However, CHL-GHP did not send an acknowledgment letter to the member because the complaint came directly from the MDI and the member did not submit a formal first level appeal request to CHL-GHP. On February 7, 2006, CHL-GHP mailed to the member a request to extend the investigation through March 9, 2006. **See Exhibit [GHP-24]**. A Coventry Medical Director reviewed and upheld the denial based on the Coventry Health Care Technology Assessment for this service, and CHL-GHP sent a closure letter to the member on March 2, 2006. **See Exhibit [GHP-24]**. Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

Section 376.1385, RSMo, requires a second level appeal request to be submitted to a grievance advisory panel and resolved within the timeframes set forth in Section 376.1382, RSMo. On March 24, 2006, the provider submitted a second level appeal request on behalf of the member. **See Exhibit [GHP-24]**. On April 26, 2006, CHL-GHP sent an acknowledgement letter and an authorized representative form to the provider. **See Exhibit [GHP-24]**. CHL-GHP was not statutorily obligated to send an acknowledgment letter to the provider within ten working days, because the provider was not authorized to submit a second level appeal on behalf of the member. CHL-GHP's position is supported by the fact that it never received the completed authorized

representative form from either the provider or the member. However, on May 2, 2006, CHL-GHP received a correspondence from the MDI instructing CHL-GHP to process this second level appeal. CHL-GHP sent an acknowledgment letter to the MDI, and CHL-GHP held a second level appeal hearing held on May 10, 2006. **See Exhibit [GHP-24].** CHL-GHP sent a closure letter to the member on May 17, 2006. **See Exhibit [GHP-24].** Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

2. **MDI Finding:** The Company failed to include the following complaint in its complaint register.

Reference: Section 376.1375, RSMo

<u>Member Number</u>	<u>Complaint Number</u>	<u>Company Number</u>
900793816-02	05S000209	DOI0509004MO

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP's complaint policies instruct that complaints must be maintained in its complaint register in compliance with section 376.1375, RSMo.

3. **MDI Finding:** The administrative contract between CHL-GHP and GHP requires GHP to perform all functions for CHL-GHP. The forms and letters to complainants contain conflicting and misleading information as to what Company is truly responsible for the benefits of the policy. Eleven of the 12 files reviewed indicated the Company's NAIC number 96377 when the correct number for Coventry Health and Life Insurance Company is 81973. The wording placed directly beneath the logo indicates "GHP, a Coventry Health Care Plan." The twelfth file states the NAIC number is 81973 and the underwriting Company is Group Health Plan, which is incorrect. Forms and letters to CHL-GHP members should be very clear as to what Company is ultimately insuring the risk.

References: Sections 375.936(4) and 376.1088, RSMo

<u>DIFP Complaint Number</u>	<u>DIFP Complaint Number</u>
06J000382	05J001945
06J000544	05J002451
05S000209	05J001766
05J002485	05J002498
05J002935	06J000147
05S000065	06J001567

**CHL-GHP Response:** CHL-GHP agrees that forms and letters to complainants contained the errors as noted above. However, GHP clearly informs members in their member materials and identification cards that GHP is the administrator and primary contact for CHL-GHP and that CHL-GHP is the company of record with financial responsibility for the claims presented under its contracts.

As corrective action, CHL-GHP will revise its template communications to clarify all points made above.

4. **MDI Finding:** The Company failed to maintain its complaint register with all the required fields of information. The Company inserted the type of action that was in progress instead of the Type of Coverage in its register.  
Reference: 20 CSR 300-2.200(3)(D) (2005)

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. CHL-GHP by its very nature provides only one type of coverage – indemnity coverage – as it does not provide HMO coverage or any other type of non-health coverage. As such, every entry in the Complaint Register could only have this one type of coverage associated with it.

## B. Consumer Complaints and Appeals

### CHC-KS

#### Consumer Complaints

#### Appeals

1. **MDI Finding:** In the following appeals, the Company paid the claims at non-participating provider rates and allowed the member to be balance billed by the provider. The members were in emergent situations in each case and were unable to select providers. In emergency situations, it is unfair for the Company to pay out-of-network benefits leaving the member responsible for more than the in-network co-pay, coinsurance and deductible. The Company stated that an emergency situation does not require it to hold members harmless in a PPO benefit plan.  
Reference: 20 CSR 400-7.130

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
2644	500668271*01	1317402255
56397	901181169*01	11448201
		11448195
		11448204
		1532545775
		1525023154
		1525023153
47644	901147269*01	1513922658
		10698379
		10578485
		1513922657

46057/43957

901071190\*02

1501422898  
9705058

**CHL-KS Response:** CHL-KS disagrees with this Finding because it did not violate the regulation cited. 20 CSR 400-7.130 applies to health maintenance organizations and, as such, does not apply to CHL-KS.

Nonetheless, CHL-KS would like to note that in September 2006, CHL-KS changed its reimbursement practice for emergency services at non-participating providers to pay 100% of billed charges when necessary to avoid balance billing issues.

2. **MDI Finding:** The Company declined to provide benefits for the drug Provigil that the member was prescribed when covered by a prior carrier. The member's symptoms were similar to those identified for use of this drug by the FDA. The member's condition was not specifically named as approved in the FDA approval but was not specifically named as not permitted. Coventry declined to cover it because it was not specifically named. Since the prior carrier allowed coverage for two years and the doctor prescribed it, the Company should not restrict the member from the medical treatment which provides relief of the symptoms presented.

Reference: Section 376.441, RSMo

Appeal Number  
53570

Member Number  
90124547801

Claim Number  
Authorization Request

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for two reasons. First, CHL-KS agrees that the benefits of the prior carrier and the benefits under CHL-KS are different. However, CHL-KS respectfully disagrees that it is not following succeeding carrier requirements regarding conditions in accordance with the requirements of section 376.441, RSMo.

Section 376.441 RSMo. specifically states "*Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits in respect of classes eligible and activity at work and non-confinement rules shall be covered by that carrier's plan of benefits.*" The member in question became effective with CHL-KS on 10/1/2005 and was covered under the members's CHL-KS benefit plan, in accordance with this statute. In addition, CHL can find no statement in section 376.441, RSMo. that requires a succeeding carrier must match exactly coverage provided by the previous carrier

Second, CHL-KS's review of Section 375.1007 (4) RSMo. indicates that there is no stated preclusion from a health carrier developing a utilization review program using documented clinical review criteria that are based on sound clinical evidence to make prior authorization decisions.

Section 376.1361.11 (2), (3) and (4) RSMo. requires that "A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate" (emphasis added). CHL-KS issued the denial because the member's diagnosis (Ideopathic Hypersomnia) is not a covered indication recognized for treatment in any of the standard reference compendia or in substantially accepted peer-reviewed medical literature. As a result, CHL-KS did not cover this drug. In doing so, however, CHL-KS did not violate Missouri law.

3. **MDI Finding:** The Company denied coverage for a medication that was first prescribed while covered by a prior carrier. The member's doctor had tried several drug combinations to allow her to control her diabetes and found that this combination worked best. When the member's group plan changed to Coventry, it denied coverage.  
Reference: Section 376.441, RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
40555	901099506*02	Authorization Request

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for two reasons.

First, CHL-KS agrees that the benefits of the prior carrier and the benefits under CHL-KS are different. However, CHL-KS respectfully disagrees that it is not following succeeding carrier requirements regarding conditions in accordance with the requirements of section 376.441, RSMo.

Section 376.441 RSMo. specifically states "*Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits in respect of classes eligible and activity at work and non-confinement rules shall be covered by that carrier's plan of benefits.*" The member in question became effective with CHL-KS on 10/1/2004 and was covered under the members' CHL-KS benefit plan, in accordance with this statute. In addition, CHL-KS can find no statement in section 376.441, RSMo. that requires a succeeding carrier must match exactly coverage provided by the previous carrier.

Second, CHL-KS's review of Section 375.1007 (4) RSMo. indicates that there is no stated preclusion from a health carrier developing a utilization review program using documented clinical review criteria that are based on sound clinical evidence to make prior authorization decisions.

Section 376.1361.11 (2), (3) and (4) RSMo. requires that "A health benefit plan that provides coverage for drugs shall provide coverage for any drug prescribed to treat an indication so long as the drug has been approved by the FDA for at least one indication, if

the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature and deemed medically appropriate” (emphasis added). CHL-KS issued the denial because substantially accepted peer-reviewed medical literature established that maximal doses of metformin and sulfonylureas should be used as first-line therapy prior to use of Actos. In this case, the member did not meet this criteria because the member had not yet used maximal doses of metformin and sulfonylureas to treat his diabetes. As a result, CHL-KS did not cover this drug. In doing so, however, CHL-KS did not violate Missouri law.

4. **MDI Finding:** The Company denied coverage for a DJ Iceman machine prescribed and directed for use by the physician to aid the healing process after surgery to correct a knee injury. The provider did not give the member a choice of treatment because it is the doctor’s protocol to use this machine when he performs knee surgery. The Company requires the provider to request authorization prior to use, which he did not do. The doctor requires the machine’s use to allow faster healing and recovery. The Company’s research consisted of inquiries to medical doctors asking whether the DJ Iceman was medically necessary. All doctors indicated that there are other methods to do the job that this machine does. The selected doctors are not asked to take into account the faster healing time or the need for pain medication that is necessary with other treatments. The file failed to include documentation to show that the DJ Iceman was not an appropriate treatment for the member’s condition.

Reference: 375.1007(4), RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
2975	549835	1225601774

**CHL-KS Response:** CHL-KS agrees with this Finding.

5. **MDI Finding:** The Company could not locate the following appeal file. A company is required to maintain documentation of all appeals.

Reference: 20 CSR 300-2.200 (2005), and 20 CSR 400-7.110

<u>Appeal Number</u>
37840

**CHL-KS Response:** CHL-KS agrees with this Finding. It is CHL-KS policy to maintain documentation of all appeals in compliance with the regulations cited above. See Exhibit [KS044].

### GHP

1. **MDI Finding:** When GHP denies prior authorization for treatments, equipment and medications that are not customarily used for the medical condition or are required by the

contract to receive prior authorization, the Company includes the wording from its policies, ...“in the Company’s sole and absolute discretion... .” The Company, due to the unilateral basis of an insurance contract, has the ability to deny coverage. The use of this language can only logically be interpreted to expand on what is explicit in the contract that the insurer will make coverage and benefit decisions. This interpretation must lead the insured to believe that no action on the part of the insured or anyone else is contractually available to modify the insurer’s decision. This interpretation conflicts with several provisions of law, in that it eliminates the insured’s right to seek legal action to enforce the contract and make any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. This language confuses and misleads insured persons. Therefore, policies with this language are not acceptable. The following appeals or complaints are examples of how the Company uses the policy wording in its denial letters.

Reference: Section 375.936, RSMo

<u>Member Number</u>	<u>Appeal Number</u>
900814011-03	RMM0504702MO
900873227-01	RMM0524312MO
901229776-01	RMM0532101MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with Finding. The Certificates of Coverage (“COCs”) referenced above do not misrepresent the coverage terms of the policy. CHL-GHP makes it clear to its members numerous times throughout the claims and appeals processes that a member may in fact question or challenge CHL-GHP as follows:

1. Each COC contains an entire section entitled “Resolving Complaints and Grievances”. In this section, the various avenues a member could use to challenge CHL-GHP’s determinations – complaints, appeals, contacting the MO-DOI – is explained complete with timeframes.
2. In “Utilization Review Policy and Procedures” section of each COC, CHL-GHP’s members are specifically informed of their right to request a reconsideration of various adverse benefit determinations and their right to appeal.
3. A document entitled “Your Right to Review the Plan’s Determination” is included with every EOB. This document provides detail on the process provided to its members to challenge the adverse determinations and how to utilize the MDI to affect such a challenge. This document is also sent as an attachment to member denial letters for adverse determinations.

4. "Appeal and Grievance Process and Member Rights" is provided to members at the conclusion of the first level and second level appeals processes.
5. The Member Handbook also informs the member of their right to file a complaint or grievance.
6. If a member calls the Customer Service Organization (CSO) with a complaint or grievance, a representative of the CSO will explain to the member the process for filing such complaint or grievance.

**See Exhibit [GHP-08].**

In light of the information above, it is difficult to understand that the COC's one-time use of the words "sole and absolute discretion" gives the impression that "no action on the part of the insured or anyone else is contractually available to modify the insurer's decision".

Notwithstanding CHL-GHP's disagreement with this Finding, CHL-GHP will remove references to its "sole and absolute discretion" from its current and future COCs.

2. **MDI Finding:** The Company's appeal process included a second level, which allows the member's claim to be reviewed by a panel that includes a member of the plan. GHP consistently used the same members on all the committees. By using the same members for its second level appeal process, they may develop a relationship with Company personnel which could reduce the objectivity in their decisions. Further review discovered that not all the volunteers were members of the Coventry Health and Life Insurance Company plans. GHP would often include members of the GHP Company plans to be on the committees. This does not comply with Missouri requirements for second level appeals to include members of the plan on the committee.  
Reference: Sections 354.442, and 376.1385, RSMo

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding for two reasons. Group Health Plan, Inc. ("GHP") serves as CHL-GHP's administrative services organization and in this capacity provides an array of services, such as claims processing, medical management, marketing and appeals services. Part of GHP's function, with respect to appeals, is to staff appeal committees appropriately. As a result, the participation of a GHP member on a CHL-GHP appeal committee does not violate 376.1385 and 354.442 RSMo.

Further, although CHL-GHP has made efforts in the past to recruit CHL-GHP members for the CHL-GHP 2nd level appeal committees, so as not to use the same members repeatedly or to rely upon GHP members to serve on the CHL-GHP appeal committees, those efforts often have proven fruitless. These efforts have included a notice in the

member newsletter, letters sent directly to CHL-GHP members, and the Customer Service Department attempting to recruit members when a member called the Department.

Finally, CHL-GHP disagrees that it has violated section 376.1385, RSMo as this statute sets forth the information CHL-GHP must provide to its enrollees and does not address the issue of CHL-GHP members on a second-level appeal panel.

3. **MDI Finding:** The Company refused to pre-authorize Orthotripsy (the use of strong sound waves) as treatment for Plantar Fasciitis in the following appeals. The FDA approved this treatment on August 10, 2005. The Company's original research found that the FDA had not approved this method of treatment at that time. Subsequently the treatment was approved, but the Company did not accept the FDA's approval and again denied authorization. Its latest denial letters were dated July 14, 2005, and November 17, 2005, for member 901180612-01; August 2, 2005, for Member 900830363-01 and September 8, 2005, for Member 900859198701.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Numbers</u>	<u>Appeal or Complaint Number</u>
901180612-01	RMM0530004MO & DOI0530402MO
900830363-01	RMM0519911MO
900859187-01	RMM0523601MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. After evaluating the peer-reviewed medical literature, CHL-GHP concluded that the preponderance of evidence favored the proposed new technology as being unproven (i.e. investigational/experimental). In this case, the recommendation was: "Since efficacy has not been established, inter-vertebral disc replacement continues to be considered investigational/experimental."

As required by MO statutes and URAC standards, any appeal requiring a medical determination is reviewed by a physician of the same or similar specialty as the ordering physician, in this case a Board Certified orthopedic surgeon. The physician reviewing the appeal neither is a subordinate of the original reviewer nor involved in any prior adverse determinations related to this service. All medical records, including any articles provided by the member or treating physician, are included for review by the appeal review physician. CHL-GHP sent this case out for review on November 22, 2005, to a board certified orthopedic surgeon. The appeal review physician, after reviewing the material, agreed that the procedure met the COC's definition of experimental/investigational because no long-term studies have determined the effectiveness of inter-vertebral disc replacement. The appeal review physician upheld CHL-GHP's denial of this service.

Finally, this Finding references Sections 376.1365, 376.1382 and 376.1385, RSMo, which are the statutes governing the reconsideration and appeal of an adverse determination. CHL-GHP adhered to the requirements set forth in these statutes during its review of the complaint, and therefore was not in violation of these laws. Specifically, § 376.1365, sets forth process for reviewing a request to reconsider an adverse benefit determination. CHL-GHP did not receive such a request from any of these members, and therefore did not violate this statute.

Section 376.1382, RSMo, requires CHL-GHP to process first level appeals as follows:

- (i) Acknowledge receipt in writing of the appeal within ten working days;
- (ii) Conduct a complete investigation of the appeal within twenty working days after receipt;
- (iii) Within five working days after the investigation is completed, have someone not involved in the circumstances giving rise to the appeal decide upon the appropriate resolution of the appeal and notify the enrollee in writing of the decision and of the enrollee's right to file an appeal for a second-level review; and
- (iv) Within fifteen working days after the investigation is completed, notify the person who submitted the grievance of the carrier's resolution of said grievance.

With respect to Member Number 901180612-01, CHL-GHP received the member's first level appeal letter on October 27, 2005. **See Exhibit [GHP-25]**. CHL-GHP mailed an acknowledgment letter to the member on October 28, 2005. **See Exhibit [GHP-24]**. CHL-GHP sent the case out for review by a board certified orthopedic surgeon, and completed its investigation on November 15, 2005. CHL-GHP sent a closure letter to the member on November 15, 2005. **See Exhibit [GHP-25]**. Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

With respect to Member Number 900830363-01, CHL-GHP received the member's first level appeal letter on July 19, 2005. **See Exhibit [GHP-26]**. CHL-GHP mailed an acknowledgment letter to the member on July 22, 2005. **See Exhibit [GHP-26]**. CHL-GHP sent the case out for review by a board certified orthopedic surgeon, and completed its investigation on August 2, 2005. CHL-GHP sent a closure letter to the member on August 2, 2005. **See Exhibit [GHP-26]**. Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

With respect to Member Number 900859187-01, CHL-GHP received the member's first level appeal letter on August 24, 2005. **See Exhibit [GHP-27]**. CHL-GHP mailed an

acknowledgment letter to the member on August 25, 2005. See Exhibit [GHP-27]. CHL-GHP sent the case out for review by a board certified orthopedic surgeon, and completed its investigation on September 8, 2005. CHL-GHP sent a closure letter to the member on September 8, 2005. See Exhibit [GHP-27]. Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

Finally, 376.1385, RSMo, sets forth the procedures for processing and adjudicating a second level appeal. CHL-GHP did not receive a second level appeal request from any of these members, and therefore did not violate this statute.

4. **MDI Finding:** On October 13, 2005, the Company received a request for authorization to use an artificial disc to replace one being removed due to degenerative disc disease. The FDA approved the use of the specified artificial disc on October 26, 2004. With the approval of the artificial disc, the FDA advised that the device must continue to be tested with a post-market study to determine its long-term effects. The Company has determined that the post-market study is reason to deem the disc as investigational and deny approval. The FDA used prior tests and studies to base its approval for the artificial disc and asked for input to determine what, if any, long-term effects there would be. References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Numbers</u>	<u>Appeal or Complaint Number</u>
901229976-01	RMM0532101MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. After evaluating the peer-reviewed medical literature, CHL-GHP concluded that the preponderance of evidence favored the proposed new technology as being unproven (i.e. investigational/experimental). In this case, the recommendation was: "Since efficacy has not been established, inter-vertebral disc replacement continues to be considered investigational/experimental."

As required by MO statutes and URAC standards, any appeal requiring a medical determination is reviewed by a physician of the same or similar specialty as the ordering physician, in this case a Board Certified orthopedic surgeon. The physician reviewing the appeal neither is a subordinate of the original reviewer nor involved in any prior adverse determinations related to this service. All medical records, including any articles provided by the member or treating physician, are included for review by the appeal review physician. CHL-GHP sent this case out for review on November 22, 2005, to a board certified orthopedic surgeon. The appeal review physician, after reviewing the material, agreed that the procedure met the COC's definition of experimental/investigational because no long-term studies have determined the effectiveness of inter-vertebral disc replacement. The appeal review physician upheld CHL-GHP's denial of this service.

Finally, this Finding references Sections 376.1365, 376.1382 and 376.1385, RSMo, which are the statutes governing the reconsideration and appeal of an adverse determination. CHL-GHP adhered to the requirements set forth in these statutes during its review of the complaint, and therefore was not in violation of these laws. Specifically, § 376.1365, sets forth process for reviewing a request to reconsider an adverse benefit determination. CHL-GHP did not receive such a request from this member, and therefore did not violate this statute.

Section 376.1382, RSMo, requires CHL-GHP to process first level appeals as follows:

- (i) Acknowledge receipt in writing of the appeal within ten working days;
- (ii) Conduct a complete investigation of the appeal within twenty working days after receipt;
- (iii) Within five working days after the investigation is completed, have someone not involved in the circumstances giving rise to the appeal decide upon the appropriate resolution of the appeal and notify the enrollee in writing of the decision and of the enrollee's right to file an appeal for a second-level review; and
- (iv) Within fifteen working days after the investigation is completed, notify the person who submitted the grievance of the carrier's resolution of said grievance.

CHL-GHP received the member's first level appeal letter on November 17, 2005. See **Exhibit [GHP-28]**. CHL-GHP mailed an acknowledgment letter to the member on November 17, 2005. See **Exhibit [GHP-28]**. CHL-GHP sent the case out for review by a board certified orthopedic surgeon, and completed its investigation on November 22, 2005. CHL-GHP sent a closure letter to the member on November 23, 2005. See **Exhibit [GHP-28]**. Therefore, CHL-GHP processed this appeal in compliance with Section 376.1382, RSMo, and is not in violation of this statute.

Finally, § 376.1385, RSMo, sets forth the procedures for processing and adjudicating a second level appeal. CHL-GHP did not receive a second level appeal request from any of these members, and therefore did not violate this statute.

5. **MDI Finding:** The Company declined the following appeal to pre-certify a surgical excision of the keloid scar tissue from a wound incurred in an accident that occurred while the patient was covered by another Company. The medical records include a picture of the scar on the patient's forehead, a statement from the doctor that the patient had pain and itching and that he had tried other means to treat the problem. The notes from the Company's reviewers indicate that there were no pictures to prove that there

was a scar, that there was no indication of pain or pruritus and that doctors had not attempted any other treatment. The main reasons for denial of approval were that the surgery would provide no functional improvement, was cosmetic because of the delay to request treatment approval and was not medically necessary. The policy's medical necessity definition includes relief of pain. Because some specialists advise to wait a period-of-time prior to having surgery for this problem, the member did not have the surgery earlier. The doctor's patient records did not include a note about the pain and itching at the site but he did include this information in a letter to the Company, which would then be included in the patient records. This claim appears to be payable.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

Member Numbers

901084612-07

Appeal or Complaint Number

RMM0519302MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding because CHL-GHP's treatment of this appeal fully complied with the statutes cited above. As part of the First Level Appeal process, a Board Certified Plastic Surgeon reviewed this case. This physician agreed that the service requested was cosmetic in nature. Similarly, as part of the Second Level Appeal process, three (3) Board Certified Plastic Surgeons reviewed this case (including all medical records and letters, including the physician's letter regarding pain and itching). **See Exhibit [GHP-29].** All three physicians agreed that the service requested was cosmetic in nature.

Although this Finding points to certain reasons why the requesting doctor believed this service should be covered, these reasons do not demonstrate why CHL-GHP violated the statutes cited.

Finally, in the event that the MDI's final sentence of this Finding states that CHL-GHP should pay this claim, CHL-GHP disagrees. The appeal at issue is not an appeal of a claim submitted by the member or a provider. Rather, the appeal relates to CHL-GHP's denied authorization for a requested service. CHL-GHP has not received a claim for reimbursement from either the provider or the member. Therefore, CHL-GHP cannot be obligated to pay any claim for these services since it has not received any claim.

6. **MDI Finding:** The Company denied an exception for a final refill of Valtrax that had to be pre-authorized according to CHL-GHP. The request indicated that the refill was for an ongoing treatment plan, but the notation was overlooked during the process. The Company authorized a new treatment plan because the problem recurred during the appeal process. Since the prior insurer originally authorized the treatment plan, the Company should not have denied or delayed the subsequent refill.

References: Sections 376.441(3), and 376.1365, RSMo

Appeal Number

Member Number

Group Number

**CHL-GHP Response:** CHL-GHP respectfully disagrees this Finding that CHL-GHP did not following succeeding carrier's responsibility regarding pre-existing conditions. In this particular case, CHL-GHP continued the member's benefit and the member received Valtrex. CHL-GHP's policy is to cover 21 Valtrex pills at a time. If the member required additional medication, she would have been able to receive another 21 pills. According to the manufacturer's dosing recommendation, the number of pills of Valtrex required to treat certain conditions is 6-21 pills, depending on the condition. Section 376.441(3) does not prohibit CHL-GHP from taking this action.

Further, CHL-GHP could find no regulation that requires CHL-GHP, as the succeeding plan, to cover the benefit in the exact same manner and level as the prior plan. If the examiner could provide specific citations, CHL-GHP would be happy to review this information.

Finally, 376.1365, RSMo addresses the right of a provider to request the reconsideration of an adverse determination on behalf of the enrollee. CHL-GHP adhered to the requirements of this statute during its review of the claim, and therefore is not in violation of this law.

7. **MDI Finding:** In the following appeal, the Company denied approval for Xanax XR 2 mg to be taken twice per day. GHP reduced the number of pills to 30 and refused to pay for the additional prescribed pills due to its internal dosage rule that allows only one pill per day. This drug is manufactured in 1mg, 2mg and 3mg doses. The doctor found that 4mg was required to treat this patient. Due to this non-contractual rule, the patient was forced to accept an inadequate dosage. The Company applies a limitation that is not specified in the contract to reduce benefit costs without regard for the health issues of the member.

References: Section 375.1007(1), RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Group Number</u>
RMS0522404MO	901179892-01	6410785001

**CHL-GHP Response:** CHL-GHP disagrees with this Finding. "Monthly Supply" is defined, in part, in Section 1.d.(iv) of the member's Prescription Drug Rider (the "Rider") as "an amount defined by the Plan." Further, Section 2.2.A of the Rider states:

The quantity of a Covered Drug dispensed upon payment of a single Copayment shall be limited to a Monthly Supply as defined in Section 1(d).

**See Exhibit [GHP-30].** According to FDA and Pharmaceutical prescribing indications (the "Prescribing Guidelines"), Xanax XR is a once daily medication and CHL-GHP lists

the drug as such on its website. However, the member's physician prescribed Xanax XR twice daily, which exceeds the dosage set forth in the Prescribing Guidelines. CHL-GHP makes prescription drug coverage determinations based on (i) the member's Rider and (ii) medical necessity documentation, including, but not limited to, the Prescribing Guidelines. In this case, CHL-GHP defined "Monthly Supply" as 30 pills in accordance with (i) the definition of "Monthly Supply" and the provisions of Section 2.2.A under the Rider and (ii) the Prescribing Guidelines. Therefore, CHL-GHP did not misrepresent any quantity limitation under the Rider and is in compliance with Section 375.1007(1), RSMo.

8. **MDI Finding:** The Company denied an exception for the following appeal for a final refill for Lamisil that CHL-GHP required to be pre-authorized. The request included a note that the refill was for an on-going treatment plan, but the notation was overlooked during the process. The Company authorized a new treatment plan after the problem recurred during the appeal process that followed the denial. Since the prior insurer authorized the treatment plan, the Company should not then deny or delay the treatment. In addition, although the insured submitted a written appeal, the Company did not enter it into the appeal log. The member was forced to submit a written complaint to obtain the medicine.

References: Sections 376.441(3) and 376.1365, RSMo

Appeal Number  
None

Member Number  
9011835501

**CHL-GHP Response:** CHL-GHP agrees with this Finding, in part, and disagrees in part. CHL-GHP agrees that CHL-GHP should have authorized the Lamisil prescription when originally requested. However, the pharmacy reviewer incorrectly interpreted the request as a request for an additional 12 weeks of treatment and not a request for the final 12 weeks of treatment. CHL-GHP ultimately authorized the treatment.

CHL-GHP disagrees with this Finding that CHL-GHP did not enter the appeal into the appeal log, forcing the member to submit a written complaint to obtain the medicine. CHL-GHP received the member's appeal on 2/28/06. CHL-GHP did, in fact, enter the appeal in its appeal log and appropriately processed the appeal in accordance with the requirements of Section 376.1365, RSMo. **See Exhibit [GHP-31].**

The disconnect in this case may lie in the dates covered by this examination vs. the date of this appeal. The period covered by this examination is 1/1/2003 through 12/31/2005. Because this appeal was received on 2/28/06, it was not included in the log provided to examiners.

9. **MDI Finding:** The Company denied the first level appeal of a request for coverage as in-network for a newly adopted child that received an injury to his head during birth. An

urgent care physician examined him before travel. Coverage for an adopted baby begins at placement. Since the baby, who was born on May 2, 2005, suffered a head injury during birth, the adoptive parents, using the judgment of a prudent layperson, had a local doctor check the baby before the airplane trip home on May 6, 2005. The condition, which was not a risk while in a home setting, could have been problematic during a flight with the change in air pressure. Therefore, with the prospect of travel, the condition was more urgent than it had been in the more dormant setting at the adoption agency. The contract provides for urgent care as in-network when out of the plan's geographic area. The condition appeared to be serious enough to require urgent care in order for the parents to safely transport the baby home.

References: Sections 376.816.2(2), and 376.1367, and 376.1350(12), RSMo

<u>Appeal Number</u>	<u>Identification Number</u>	<u>Group Number</u>
RMS0530003MO	900877438-05	6415845001

**CHL-GHP Response:** CHL-GHP agrees with this Finding. CHL-GHP respectfully disagrees with this Finding. Section 376.150(12), RSMo, defines "emergency medical condition," in part, as:

[T]he sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required.

The Finding states that the member's condition was "not a risk while in the home setting." Therefore, this statement explicitly acknowledges that the member did not have an "emergency medical condition" while in the home setting.

However, the Finding further states that the member's condition "could have been problematic during a flight with the change in air pressure." This statement seems to suggest that the definition of "emergency medical condition" should include potential emergency situations that may occur in the future. However, such an interpretation is inconsistent with the actual definition, which requires a "sudden and, at the time, unexpected onset of a health condition." As the Finding states, the member's condition was not a risk in the home setting, and he did not experience any new sudden onset of a health condition at the time the services were provided. Therefore, such services by definition were not emergent.

Additionally, the definition of "emergency medical condition" is not intended to include a potential urgent condition that may only present itself upon the parents' sole and independent choice to allow the member to fly. In this case, the parents could have decided not to fly, thereby completely avoiding any potential risk of the member requiring urgent care.

Finally, CHL-GHP's position is supported by the diagnosis codes submitted by the provider. Specifically, the service on the claim form is coded as V20.2 (routine infant or child health check) and CPT code 99381 (initial preventive exam, new patient, under 1 year). Therefore, both codes indicate that the service was simply a routine examination and that no emergent service was provided.

In conclusion, CHL-GHP appropriately paid the claim under the member's out of network benefit because the service did not constitute an emergency service for an emergency medical condition under Sections 376.1367 and 376.1350(12). Further, CHL-GHP is in compliance with Section 376.816.2(2), RSMo, because the member's coverage began immediately after the member's birth.

10. **MDI Finding:** The Company provided health insurance coverage for Group 6223567002. The group's coverage included a mental health rider. The rider failed to include benefits to cover at least two visits per contract year to establish a diagnosis. Member 900861998\*01 incurred \$170.00 of expenses for two service dates. The Company denied the claim because the policy benefits did not include the coverage. Reference: Section 376.811.4(2), RSMo and 20 CSR 100-1.050(1)(H)

Appeal Number  
RMS0519908MO

**CHL-GHP Response:** CHL-GHP respectfully disagrees with this Finding. Section 376.811.4(2) RSMo requires CHL-GHP to offer a mental health benefits that meet the requirements of the statute, including at least two visits per contract year to establish a diagnosis ("Two Visits"). However, the statute does not require an employer to purchase such offered benefits. In this particular case, although CHL-GHP offered the employer a rider that included the Two Visits, the employer declined. Instead, the employer purchased a mental health rider that did not include at least two visits per contract year to establish a diagnosis. CHL-GHP could find no statutory or regulatory authority prohibiting CHL-GHP from offering an alternative mental health benefit rider in addition to a rider that includes the benefits required under 376.811.4(2) RSMo.

This Finding references 20 CSR 100-1.050(1)(H), which addresses the prompt settlement of claims by insurers. CHL-GHP is not in violation of this regulation because it appropriately denied the claim within the timeframe required.

### C. Provider Complaints

#### CHC-KS

1. **MDI Finding:** The Company failed to pay electronic claim number 8108922, and adjusted electronic claim number 2400808284, related to a provider complaint, within 45 days from the date of original receipt. Therefore, interest was due after the 45<sup>th</sup> day from the date of claim receipt. The Company paid \$.17 during the course of the examination.  
Reference: Section 376.383.5, RSMo

<u>Claim Number</u>	<u>Interest Days</u>	<u>Payment</u>	<u>Interest Paid</u>
2400808284	14	\$38.00	\$ .17

**CHL-KS Response:** CHL-KS agrees that with Finding and has reprocessed the claim as directed above. See Exhibit [KS045].

2. The Company denied reimbursement for a dose of two 20mg Adderal XR a day to equal 40mg. Coventry reduced the quantity that was approved by the prior plan for Adderal XR from 40mg to 20mg because the lower dose had been approved by the FDA and the higher 40 milligram dose was not yet approved. Coventry considered the two 20mg pills to exceed recommended limits. The provider changed the dose to 30mg as a compromise dosage but this left the patient lacking needed medication. An article about Adderal clinical trials and pharmacokinetic studies only recommends dosage up to the amount used in the trials and studies, it does not state that a doctor cannot use a larger dosage, if necessary. As the succeeding carrier, the Company did not provide the insured continuity of coverage that is usually provided when companies follow HIPPA requirements. The denial also resulted in a restriction in the member's medical treatment.  
Reference: Section 376.441(3), RSMo and Bulletin 97-04

<u>Date MDI Received</u>	<u>Provider</u>	<u>Complainant</u>
02/03/03	Lakeside Pediatrics	T. Murphy

**CHL-KS Response:** CHL-KS respectfully disagrees with this Finding for two reasons.

First, CHL-KS agrees that the benefits of the prior carrier and the benefits under CHL-KS are different. However, CHL-KS respectfully disagrees that it is not following succeeding carrier requirements regarding conditions in accordance with the requirements of section 376.441, RSMo.

Section 376.441 RSMo. specifically states "*Each person who is eligible for coverage in accordance with the succeeding carrier's plan of benefits in respect of classes eligible and activity at work and non-confinement rules shall be covered by that carrier's plan of benefits.*" The member in question became effective with CHL-KS on January 1, 2001 and was covered under the members' CHL-KS benefit plan, in accordance with this statute. In addition, CHL-KS can find no statement in section 376.441, RSMo. that requires a succeeding

carrier must match exactly coverage provided by the previous carrier.

As such, CHL-KS respectfully disagrees that it incorrectly denied coverage for Adderal XR 40 mg for ADHD and aggression.

The decision to deny the quantity limit override request was based on the CHL-KS's policy regarding quantity limits, which states:

"Quantity limits are set on medications for different reasons. [Some] drugs are on the list as a safeguard to make sure that members do not receive a prescription for a quantity that exceeds recommended limits. Limits are set because some medications have . . . a maximum limit recommended by the FDA . . ."

At the time the "Quantity Limit Override Form" was received and reviewed, the CHL-KS used the FDA-approved labeling for guidance on use. The FDA-approved labeling stated:

#### **DOSAGE AND ADMINISTRATION**

Dosage should be individualized according to the therapeutic needs and response of the patient. **ADDERALL XR**® should be administered at the lowest effective dosage.

##### **Children**

In children with ADHD who are 6 years of age and older and are either starting treatment for the first time or switching from another medication, start with 10 mg once daily in the morning; daily dosage may be adjusted in increments of 5 mg or 10 mg at weekly intervals. When in the judgment of the clinician a lower initial dose is appropriate, patients may begin treatment with 5 mg once daily in the morning. The maximum recommended dose for children is 30 mg/day; doses greater than 30 mg/day of **ADDERALL XR**® have not been studied in children. Amphetamines are not recommended for children under 3 years of age. **ADDERALL XR**® has not been studied in children under 6 years of age.

##### **Adolescents**

The recommended starting dose for adolescents who are 13–17 years of age with ADHD is 10 mg/day. The dose may be increased to 20 mg/day after one week if ADHD symptoms are not adequately controlled.

Given that the FDA-approved labeling for guidance on use did not provide for dosages of 40 mg/day and the CHL-KS's policy limited Adderal XR to 30 mg a day, CHL-KS did not incorrectly deny the quantity limit override request.

#### **GHP**

The examiners previously noted the issues for this section in the Claims Handling Section, Part

18 titled Claim Processing Issues.

V. UNCLAIMED PROPERTY

CHC-KS

There were no errors noted in this review.

GHP

There were no errors noted in this review.

VI. FORMAL REQUESTS AND CRITICISMS TIME STUDY

CHC-KS

This study is based upon the time required by CHC-KS to provide the examiners with the requested material or to respond to criticisms.

A. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	58	100.0%

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	64	100.0%

GHP

This study is based upon the time required by GHP to provide the examiners with the requested material or to respond to criticisms.

C. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	136	100%

D. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	170	100

STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL  
INSTITUTIONS AND PROFESSIONAL REGISTRATION

FINAL MARKET CONDUCT EXAMINATION REPORT

OF THE  
LIFE, ACCIDENT AND HEALTH INSURANCE BUSINESS  
OF

**Coventry Health and Life Insurance Company**

NAIC NUMBER: 81973

6705 Rockledge Drive  
Bethesda, MD 64126

STATE OF DOMICILE: DE

October 16, 2009

REPORT NUMBER: 0609-32-LAH

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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 Missouri Department of Insurance, Financial Institutions and Professional Registration. In performing this examination, the DIFP selected a small portion of the Company's operations for its review. As such, this report may not fully 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 Missouri Department of Insurance, Financial Institutions and Professional Registration.

Wherever used in the report:

"Company" or "The Company" refers to The Coventry Health and Life Insurance Company;

"CHL" refers to The Coventry Health and Life Insurance Company;

"GHP" refers to Group Health Plan, Inc who administers coverage in Mid-Missouri and Metro St Louis, MO area;

"CHC-KS" refers to Coventry Health Care of Kansas, Inc., which administers coverage in the Kansas City, MO area;

"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; and

"RSMo" refers to the Revised Statutes of Missouri.

## SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, Sections 374.110, 374.190, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, Section 447.572, RSMo, grants authority to the DIFP to determine the Company's compliance with the Uniform Disposition of Unclaimed Property Act.

The examiners reviewed The Coventry Health and Life Insurance Company. Two affiliated insurance companies operate as administrators of the Coventry Health and Life Insurance Company business in Missouri under separate contracts. They are Group Health Plan (GHP) in the Eastern Section of the State and Coventry Healthcare of Kansas (CHC-KS) in the Western Section of the State. Although the two administrator contracts are with one Company, they operate independently within their respective marketing areas.

The period covered by this examination is primarily from January 1, 2003, through December 31, 2005, unless otherwise noted.

Prior to this examination, the State of Delaware performed the last Market Conduct Examination in conjunction with a Financial Examination dated December 31, 2003.

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

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 ten 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 in excess of these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business:  
Health.

The examination included, unless otherwise noted, a review of the following areas of the Company's operations for the lines of business reviewed: Sales and Marketing, Underwriting and Rating, Claims, Complaints, and Unclaimed Property.

## EXECUTIVE SUMMARY

This examination revealed the following principal areas of concern.

- The Company failed to properly maintain its producer appointment register. The register did not include a method to verify that the Company entered the information within the statutory time limits. The Company did not always enter all of the information required. This included the producer license number, and for producer entities, the names of all producers who are associated with each producer entity were not entered nor were they appointed.
- The Company contracted with two producers who were not licensed. It also failed to advise the DIFP of the termination of three producers.
- The Company maintained contractual relationships with two entities to perform as Third Party Administrators which were not licensed as Third Party Administrators during the time they were contracted.
- The Company used advertisements that include coverage and/or rate information, which qualifies them as offers to purchase, but failed to include the limitations and exclusions of the policy.
- The Company requires members to obtain authorization before receiving chiropractic services. An authorization sets a treatment plan with a specified number of visits. This requirement does not comply with Missouri law, which requires a policy to provide up to 26 visits before the member would be required to obtain authorization for additional treatments or re-evaluation of the condition.
- The Company charges an additional premium when it includes coverage for domestic partners. The Company's documentation indicates that it had not determined that an additional premium was necessary. Since the Company underwrites and charges premium for each individual insured, the addition of a premium charge for domestic partners without an actuarial justification indicates that the Company bases its premium rating and coverage availability on the marital status of the domestic-partners-insured rather than medical issues.
- The Company failed to maintain complete documentation for 48 of the claims requested.
- The Company failed to settle 15 claims within the time parameters required by law.
- The Company failed to maintain and/or provide complete documentation for seven of the 18 DIFP complaints requested for review.
- The Company failed to record one complaint or grievance in its complaint register.

- The Company denied payment for nine mammograms, for which Missouri mandates coverage.
- The Company denied payment for one PSA test, for which Missouri mandates coverage.
- The Company required network providers to obtain prior authorization for treatments for which Missouri law mandates coverage.
- The Company requires network chiropractors to submit a treatment plan and receive approval of the plan before beginning treatment. The Company denies benefits for chiropractic care when the provider does not submit a treatment plan, it does not approve the plan, or if the treatment continues beyond the limits of an approved treatment plan specifications. Missouri requires coverage for the first 26 visits without authorization. The Company appears to use the treatment plan requirement as a method to require authorization.
- During claim reviews, the examiners discovered some providers, whom the Company identified as “invisible” providers. These providers are those who perform ancillary services and are not selected by a member for care or treatment. In some instances, the Company denies benefits for these providers because the member did not receive authorization for their services.
- The Company contracted with several laboratory facilities. Providers are required by an unwritten rule to refer members to a specific lab based upon the member’s county of residence, while another provider can only use the same lab to analyze a specimen. This is based on the contractual relationship between the Company and the facility. This results in an inequitable situation when the provider does not have access to the members’ county of residence information. The lab is required to forfeit its charges when it provides services for members who do not reside in the specified counties, and the Company makes no effort to coordinate the referral system to assure compliance.
- The Company’s Provider Contracts and Provider Manuals contain requirements and specifications that make the claim submission process complicated and cumbersome. The claim reviews discovered that providers are required to forfeit charges because of certain requirements and specifications. In some instances, providers were required to forfeit large numbers of claim charges due to these procedural requirements.
- The Company uses a number of limitations when authorizing medical appliances and medications. In several cases, the Company either limited or refused to authorize maintenance or healing drugs, which a new member had been taking for a period of time and were performing as desired. The Company also refused to authorize medical appliances for members that were ordered by the provider to promote the healing of a medical condition. In some cases, the FDA approved the appliance, but the Company did not approve it for that particular health condition.

# EXAMINATION FINDINGS

For

Coventry Health and Life Insurance Company

NAIC NUMBER: 81973

I. **SALES AND MARKETING**

This section of the report details the examination findings regarding the Company's compliance with the laws that monitor marketing practices. Examiners reviewed the Company's Certificate of Authority for Missouri, its licensing records pertaining to the Company's sales personnel, and product marketing/advertising materials.

Two insurance companies, which are subsidiaries of Coventry Health and Life Insurance Company and which sell and service insurance in their own names, administer the business operations of Coventry Health and Life Insurance Company. They are Coventry Health Care of Kansas (CHC-KS) and Group Health Plan (GHP).

A. **Company Authorization**

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

Coventry Health and Life Insurance Company, a Delaware corporation, has current authority to transact business in the following lines of insurance:

Life, Accident and Health

Regarding the Company's operation in Missouri, the examiners found CHL within the scope of its Certificate of Authority.

**B. Licensing of Producers and Producer Entities**

Missouri law requires companies to sell their insurance products through individuals and entities, which the DIFP licenses. The Missouri licensing process intends to protect the public interest by requiring sales persons to pass examinations in order to qualify for a license. This process ensures that the prospective producer is competent and trustworthy.

DIFP's Insurance, Licensing Section, maintains a database of current licensing information accessible through the Department's website. The DIFP requires companies to maintain a Producer Appointment Register and produce it when asked. A discrepancy occurs whenever a company fails to enter a producer in its Register, enters an inaccurate appointment or termination date, fails to make entries within thirty days of a specified event, or fails to appoint all producers who are associated with a producer entity when the entity is appointed.

The examiners found that the licensing records contained the following discrepancies.

**CHC-KS**

1. The Company provided its Producer Appointment Register to the DIFP with incorrect information and without a method to show when it entered the information. The Company entered a number for 144 producers that was not the producer license number assigned by the DIFP. Furthermore, the date that the Company added the appointment information to the register could not be determined.

Reference: Section 375.022, RSMo, 20 CSR 300-2.200(2) and (3)(C) (as amended 20 CSR 100-8.040(2) and (3)(C), eff. 7/30/08), and 20 CSR 700-1.130

**GHP**

1. The Company provided a list represented as its Producer Appointment Register to the DIFP for review. The examiners could not accept the list as a Producer Appointment Register because it included appointment dates that did not reflect the actual date CHL appointed the producer, the producer license number was not always the one assigned

by the DIFP, and the date that the Company entered the appointment in the register could not be determined.

Reference: Section 375.022, RSMo, 20 CSR 300-2.200(2) and (3)(C) (as amended 20 CSR 100-8.040(2) and (3)(C), eff. 7/30/08), and 20 CSR 700-1.130

2. The Company failed to report termination dates for three producers who were not shown as active in the DIFP records.

Reference: Sections 375.012(4), 375.014, RSMo, and 20 CSR 700-1.020

<u>Producer Number</u>	<u>Company ID</u>	<u>Termination Date</u>
PR155263	22109	12/4/2002
PR160477	18370	12/6/2003
PR165483	20348	1/23/2004

3. The Company continued contracts with two producers after they had terminated their license in Missouri. The producers signed contract forms after the suspension of their license.

References: Sections 375.141.1(12), and 375.071.1, RSMo

<u>Producer Number</u>	<u>Company Number</u>
PR327168	25422
PR225943	18725

4. The Company allowed the following two persons to solicit for the Company before they obtained their license.

References: Sections 375.071.1, and 375.014.1, RSMo

<u>Producer Number</u>	<u>Company Number</u>
PR342398	24405
PR350513	9270

5. The Company accepted applications written by producers who indicated associations with specific producer entities. DIFP records did not reflect these associations. A producer entity must advise the DIFP of all producers with whom it is associated. Missouri requires that a producer entity must report any changes to the DIFP within 20 days. The Company allowed the following producer entities to associate with producers who the entity did not report to the DIFP.

References: Sections 375.015.5, and 375.226, RSMo, and 20 CSR 700-1.130(2)

<u>Producer Number</u>	<u>Producer Entity</u>	<u>Certificate Number</u>
PR288915	Spetner Associates, Inc.	901164455-01
PR278685	Conrad Consulting	901146217801
PR128891	Daniel & Henry Ins Co	6600001001
PR285663	Eagle Insurance Services	9011153696-01

6. The Company contracted with Producer # 331125, Company # 23570 on November 28, 2005. However, the date of appointment noted in the Company's Appointment Register was June 21, 2004. The Company entered an incorrect date into its Appointment Register for this producer.

Reference: Section 375.022.1, RSMo

### **C. Third Party Administrators**

Missouri allows insurance companies to use Third Party Administrators (TPAs) to perform administrative functions. A TPA must obtain authorization in the form of a certificate of authority from the DIFP prior to performing these functions. Additionally, an insurance Company must periodically verify that the TPA operates within the specifications of its contract and complies with Missouri's laws and regulations.

### **CHC-KS & GHP**

1. The administrators, GHP and CHC-KS, entered into a contract with CareMark, Inc. to manage the CHL prescription drug program. This contract was first signed in 1999 and has renewed to this current date. On December 12, 1996, prior to its contract with GHP, CareMark, Inc. caused its TPA license to be inactive and did not renew its license in Missouri. It continued operating without a license until June 19, 2006. Because CareMark, Inc. did not maintain a TPA license, it also did not submit all required reports and forms. An insurance Company is required to operate within Missouri law when dealing with Missouri residents, which includes contracting with companies who are properly licensed.

References: Section 376.1092.1, RSMo, and 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800

2. The administrator GHP maintained a relationship with Cole Vision Services, Inc. d/b/a Cole Managed Vision to provide vision care as a TPA for its members from at least January 1, 2002. Missouri issued a TPA Certificate of Authority to Cole Vision Services, Inc. d/b/a/ Cole Managed Vision on June 20, 1995, but that license became inactive on May 19, 2006. As noted in the Company's GHP Network Connection, Cole Managed Vision began integrating into Eye Med Vision Care on July 1, 2005. It continues to operate under the EyeMed name. GHP stated that it maintained its relationship with Cole Managed Vision and continues to contract with EyeMed Vision Care. EyeMed Vision Care is not a TPA in the DIFP records. The Company advised that First America Administrators (FAA), a sister company, was providing the vision care services that are required under the CHL contract with EyeMed Vision Care. However, there is no contract between FAA and CHL.

Missouri requires a business to obtain and maintain a TPA certificate of authority while it operates. Missouri also requires a TPA to have an agreement with an insurer and to notify the DIFP of all insurers and trusts with which it had an agreement during the preceding fiscal year. Since EyeMed Vision Care does not have a TPA certificate of authority and there is no agreement between FAA and CHL, the Company is providing vision care services through a business relationship that does not meet Missouri's specifications.

An insurance Company is required to operate within Missouri law when dealing with its residents, which includes contracting with properly licensed companies.

References: Section 376.1092.1, RSMo, and 20 CSR 200-9.600, 20 CSR 200-9.700, and 20 CSR 200-9.800

#### **D. Marketing Practices**

Missouri law requires companies to be truthful and provide full disclosure in the sale and promotion of its insurance products. The examiners reviewed the Company's marketing and advertising materials, including producer-training practices, for the period January 1, 2003, through present. The Company markets its products through the independent agency system, which consists of producers and producer entities, and an internet website.

## **1. Advertising**

Each of the entities which administer the business of Coventry Health and Life Insurance Company in Missouri create advertising for use in Missouri. The examiners reviewed the advertising that each Company provided to verify compliance with Missouri law.

The following is a report of the examiners' reviews.

### **CHC-KS**

a. The following listed exclusions in the Company's Coventry One BENEFIT SUMMARIES FOR MISSOURI have the tendency or effect of misleading prospective purchasers because the descriptions do not clarify Missouri mandated benefits or required coverage.

- (1) The exclusion, "Any service or supply that is not Medically Necessary," is included without a definition of Medical Necessity.
- (2) The Dental Services exclusion is included without the Missouri requirement of coverage for administration of anesthesia and hospital charges for dental care provided to the following covered persons:
  - (a) A child under age five
  - (b) A person who is severely disabled, or
  - (c) A person who has a medical or behavioral condition, which requires hospitalization or general anesthesia when dental care is provided.
- (3) Maternity Services – Expenses incurred for any condition of or related to pregnancy, unless specifically covered in the Schedule of Benefits. Also excluded are expenses associated with selective reduction during pregnancy. Because the Company's medical insurance policy does not provide maternity benefits except with the purchase of an additional rider, this exclusion operates to exclude coverage for complications of pregnancy. A medical insurance policy must cover complications of pregnancy as any other illness.

References: Sections 376.1225, and 375.995.4(6), RSMo, and 20 CSR 400-5.700 (5)(A)1

b. The following advertisement includes:

- (1) The Company's description of "What is precertification – and do I need it before I receive care?" is contrary to Missouri requirements for coverage. The

Company's explanation of precertification states, "Be aware that obtaining precertification is not a guarantee of coverage for the service or treatment."

Missouri requires that a company shall not subsequently retract certification after it has provided the services.

- (2) It also notes the coverage and benefits of the Company's Coventry One policy but fails to mention the limitations and exclusions involved. An advertisement that provides information of the benefits available in a health insurance contract should also include information about the limitations and exclusions. Without this information, these advertisements have the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of any policy benefit payable.

References: 20 CSR 400-10.200(1), 20 CSR 400-5.700(4) and (5)(A)1.

Advertisement Number

Advertisement Name

(None)  
Policies

Your Guide to Individual PPO Health Benefit

c. The following advertisement is misleading for the following reasons:

- (1) It refers to freedom of choice with regard to physicians, but fails to mention the increased cost for being treated by an out of network physician or specialist. The statement of "No referrals for specialists" along with "freedom of choice for specialists" in this advertisement can lead an insured to believe that he may choose a specialist without limitation or additional cost. The advertisement fails to mention pre-certification as defined in the insurance contract or that there is increased cost to receive treatment from an out of network physician or specialist.

An advertisement that provides benefit information in a Preferred Provider Organization (PPO) policy should also include information about the conditions and limitations affecting coverage. Without this information, the advertisement has the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of policy benefits payable.

- (2) This advertisement is also misleading because it includes coverage and benefits of the Coventry One policy but fails to mention the limitations and exclusions involved. Without this information, an advertisement has the tendency, capacity, or effect of misleading prospective purchasers as to the nature or extent of policy benefits.

References: 20 CSR 400-5.700(4) and (5)(A)1.

<u>Advertisement Number</u>	<u>Advertisement Name</u>
COBRO-1105 CHKS50644	Coventry One INDIVIDUAL HEALTH INSURANCE

d. The following two advertisements are misleading for the following reasons:

- (1) They indicate that the policies specifically do not cover maternity services unless the applicant purchases a maternity benefits rider. They also include an exclusion for medical complications arising directly or indirectly from a non-covered service. When the Company issues this policy without a maternity rider, the exclusion operates to exclude complications of pregnancy. Missouri requires policies to cover complications of pregnancy like any other illness.
- (2) These advertisements also include an exclusion of any service or supply that is not medically necessary. Since the policy does not define "medically necessary," this exclusion has the tendency to mislead prospective purchasers as to the nature or extent of any policy benefit payable.
- (3) The Company excludes dental services in these advertisements without notice of the Missouri requirement of coverage for administration of anesthesia and hospital charges for dental care provided to the following covered persons:
  - A child under age five
  - A person who is severely disabled, or
  - A person who has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.

References: Sections 375.995.4(6), and 376.1225, RSMo, and 20 CSR 400-5.700 (5)(A)1

<u>Advertisement Number</u>	<u>Name</u>
(None)	Your Guide to Individual Health Benefit Policies Missouri Coventry One
(None)	Your Guide to Individual Health Benefit Policies Missouri

e. The following three advertisements are misleading because they note benefits of the policies but fail to mention the limitations and exclusions involved. An advertisement that provides information of the benefits available in a health insurance contract should also include information about the limitations and

exclusions. Without information about exclusions and limitations, this advertisement has the tendency, capacity, or effect to mislead prospective purchasers as to the nature or extent of any policy benefit payable.

References: 20 CSR 400-5.700(4) and (5)(A)1.

<u>Advertisement Number</u>	<u>Advertisement Name</u>
(None)	Introducing Coventry One Business Reply Mail
(None)	Your Guide to Individual PPO Health Benefit Policies
COBRO-1105 CHKS50644	Coventry One INDIVIDUAL HEALTH INSURANCE

- f. In its utilization review policies and appeal process manual, Coventry lists two services related to breast cancer that require authorization due to possible benefit limitation or exclusion. These are "Breast implant / breast reconstruction" and "Breast – mastectomy." Because breast reconstruction after a mastectomy is a mandated benefit under Missouri law and under the federal Women's Health and Cancer Rights Act, the Company should clarify in its manual that authorization is not required when breast cancer is involved.

Reference: Section 376.1209, RSMo

### GHP

- a. GHP used communications including form letters that failed to clearly identify Coventry Health and Life Insurance Company as the insurer of record. Form letters include a GHP logo with the words "A Coventry Health Care Plan" along the bottom of the logo. Coventry Health Care Company is the parent Company of several insurance companies with titles containing the name Coventry. GHP does not make it clear in its communications with insureds and providers that it is administrator and primary contact for Coventry Health and Life Insurance Company, and that CHL is the Company of record with financial responsibility for the claims presented under its contracts. The Company's files were commingled and/or misidentified causing GHP to provide files to the examiners that were later found to be GHP HMO files having no relevance to the Coventry Health and Life Insurance Company examination.

References: Section 375.936(4), RSMo, and 20 CSR 400-5.700(2), (12)(A), (B), (C) & (D)

- b. The Company uses the following 44 advertisements that include premium rates for coverage, which causes them to be invitations to contract as defined by Missouri law. These advertisements failed to include the limitations and exclusions of the policy as Missouri law requires for an invitation to contract.

Reference: 20 CSR 400-5.700(5)(B)

<u>Advertisement</u>			<u>Type</u>
2004 Ind Product "Launch"	Insert	8/1/04	Direct Mail Insert
2004 Ind Product "Notebook"	Insert	9/27/04	Newspaper Insert
2004 Ind Product "Notebook"	Insert	12/2/04	Newspaper Insert
2004 Ind Product "Load Off"	Insert	12/13/04	Newspaper Insert
2005 Ind Product "New Years"	Ad	1/2/05	Kraft Wrap
2005 Ind Product "New Years"	Insert	1/10/05	Newspaper Insert
2005 Ind Product "New Years"	Insert	1/12/05	Newspaper Insert
2005 Ind Product "New Years"	Insert	2/7/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	2/17/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	3/7/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	3/16/05	Newspaper Insert
2005 Ind Product "Knight"	Ad	3/27/05	1/4 Page Ad
2005 Ind Product "Knight"	Insert	4/4/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/15/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/28/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	4/28/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/1/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Ind Product "Graduating"	Insert	5/2/05	Newspaper Insert
2005 Cash Register Ad	JuneJuly	2005	Cash Register Receipt Ad
2005 Ind Product "Graduating"	Insert	6/1/05	Handout
2005 Ind Product "Be Thrifty"	Insert	6/6/05	Direct Mail
2005 Ind Product "Notebook"	Insert	6/6/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	6/16/05	Direct Mail
2005 Ind Product "Be Thrifty"	Insert	6/16/05	Direct Mail
2005 Ind Product "Notebook"	Insert	6/22/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	7/11/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	7/20/05	Newspaper Insert
2005 Ind Product "Jogger"	Insert	8/1/05	Newspaper Insert
2005 Ind Product "Jogger"	Insert	8/1/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	8/17/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/1/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/1/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/12/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	9/21/05	Newspaper Insert
2005 Ind Product "Be Thrifty"	Insert	10/31/05	Newspaper Insert
2005 Ind Product "Be Smart"	Insert	10/3/05	Newspaper Insert
2005 Ind Product "Notebook"	Insert	11/1/05	Newspaper Insert

<u>Advertisement</u>	<u>Type</u>
2005 Ind Product "Thanksgiving" Insert 11/9/05	Newspaper Insert
2005 Ind Product "Thanksgiving" Insert 11/15/05	Newspaper Insert
2005 Ind Product "Be Thrifty" Insert 11/29/05	Newspaper Insert
2005 Ind Product "Be Thrifty" Insert 12/12/05	Newspaper Insert
2005 Ind Product "Be Thrifty" Insert 12/29/05	Newspaper Insert

c. Missouri requires companies, in connection with the offering for sale of any health benefit plan to a small employer, to make a reasonable disclosure as part of its solicitation and sales materials of all of the following information:

- (1) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;
- (2) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors for other than claim experience that affect changes in premium rates;
- (3) The provisions relating to renewability of policies and contracts;  
and
- (4) The provisions relating to any preexisting condition provision.

The Company advised that the information is included in three places: the contingency section of the rate quote, the Group Enrollment Agreement (GEA), and the Broker Manual.

The Company does not provide the information as required because: (i) the Broker Manual is not available to the small employer; (ii) the Enrollment Agreement is not available until after the sale is complete; and (iii) the contingency of the rate quote form does not include all of the information required.

Reference: Section 379.936.4, RSMo

d. The Company used the following policy brochures on its web site that included information about benefits and rates but failed to include the limitations and exclusions. An advertisement that includes the cost of a policy must also include the limitations and exclusions.

Reference: 20 CSR 400-5.700(5)(B)1

Advertisement Form

GHP 8100-01

GHP 8100-01 7/06

GHP 8100-02 8/06

## II. 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 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

Each of the entities which administer the business of Coventry Health and Life Insurance Company in Missouri created the forms used in Missouri. The examiners reviewed the policy forms that the Company provided to assure compliance with Missouri law. 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 following is a report of the examiners' reviews.

CHC-KS

1. The following 17 Coventry Schedules of Benefits failed to include the mandated Childhood Immunization coverage without deductible or co-pay expense. For the childhood immunizations, the Company stated that it programmed its claim payment system to take only co-payment, deductible and/or coinsurance on the office visit charge. However, the Company has not corrected the policy provision to reflect the wording for the mandatory coverage.

References: Sections 376.1215.1 and 2., RSMo

<u>Form Number</u>	<u>Co-Pay</u>
CHC-KC-PPO-M01-00701	\$10.00
CHC-KC-PPO-M02-00701	\$10.00
CHC-KC-PPO-M03-00701	\$10.00
CHC-KC-PPO-M05-00701	\$10.00
CHC-KC-PPO-M06-00701	\$15.00
CHC-KC-PPO-M07-00701	\$15.00
CHC-KC-PPO-M08-00701	\$15.00
CHC-KC-PPO-M09-00701	\$15.00
CHC-KC-PPO-M010-00701	\$20.00
CHC-KC-OOAPPO Spec1-2001	\$10.00
CHC-KC-OOAPPO Spec2	\$10.00
CHC-KC-PPO-M012-00701	\$20.00
CHC-KC-PPO-M013-00701	\$20.00
CHC-KC-PPO-M014-00701	\$20.00
CHC-KC-OOAPPO-spec1-2003	\$10.00
CHC-KC-OOAPPO-spec2	\$10.00
CHC-KC-PPO-M025-00701	\$15.00

2. The rider form CHL-MO-RID-005-11.03 was not provided for review within the 10 calendar day requirement.

References: Section 374.205.2(2), RSMo, and 20 CSR 300-2.200(5) & (6) (2005) (as amended 20 CSR 100-8.040(5) and (6), eff. 7/30/08)

3. The following policy includes these exclusions:

(41) Medical Services involves expenses incurred for any condition of or related to pregnancy, childbirth, routine pregnancy visits, nursery care charges, expenses associated with Cesarean section, voluntary induced abortion or selective reduction during pregnancy.

(45) Medical complications arising directly or indirectly from a non-covered service.

The policy does not include maternity benefits, except, when the member purchases a Maternity Benefits Rider. When the Maternity Benefits Rider is not attached, exclusion (45) would operate to exclude all medical complications of pregnancy arising directly or indirectly from a pregnancy, which is a non-covered condition. Exclusion (41) acts to exclude Cesarean Section or other expenses that may result from a complication of pregnancy.

Missouri requires policies to consider complications of pregnancy as any other illness. The Company's composition of this policy with regard to maternity benefits operates to exclude complications of pregnancy.

Reference: Section 375.995.4(6), RSMo

Policy Form

CHL-MO-COC-074.05.05

GHP

1. The Company used the following forms that include the wording "...in the Plan's sole and absolute discretion..." This wording is also used in its member appeals process when denying approval for treatment that has been suggested by the health care provider. This term is not allowed in contract language or in communications to claimants.

The use of this language can only be interpreted to expand on what is explicit in the contract that the insurer will make coverage and benefit decisions. This interpretation may lead the insured or anyone else to believe that no action on the part of the insured or anyone else is contractually available to modify the insurer's decision. This cannot be the case because it would conflict with several provisions of law. This interpretation eliminates the insured's right to seek legal action to enforce the contract and make any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. This language effectively serves to confuse and mislead insured persons.

Reference: Section 375.936, RSMo

Policy Form

MO OPEN ACCESS POS COC 08.03 CHL  
MO\_OA\_POS\_NDED\_COC\_05.04\_GHP  
MO\_OA\_POS\_IND\_COC\_01.05\_CHL  
MO\_PPO\_Individual\_COC\_07.03\_CHL  
MO\_GROUP\_PPO\_COC\_07.04\_CHL  
MO\_PPO\_IND\_ND\_COC\_0104\_CHL

2. The Company's policy form MO\_OA\_POS\_IND\_COC\_01.05\_CHL does not include maternity benefits unless the Maternity Rider is purchased. In the policy exclusions number 47) Medical Complications means complications arising directly or indirectly from a non-covered service. Missouri requires a policy to cover complications of pregnancy as any other illness. This means that a complication of pregnancy will be covered even when the policy does not include maternity benefits. The policy exclusion 47) allows the Company to exclude complications of pregnancy when maternity coverage is not added with the inclusion of the Maternity Rider

Reference: Section 375.995, RSMo

3. The Company used policy form OPEN ACCESS POS COC 08.03 that included the following definition of Chiropractic Services:

Coverage is provided for basic Chiropractic Services (i.e., spinal manipulation) if the service is medically necessary and rendered by a licensed provider. Additional Chiropractic Services are available through a rider.

The policy also indicates that prior authorization is required for Chiropractic Services. The Company advised that the form was not filed for use in Missouri.

By using this form and the rider form MO(PPO) – CHIRO (02/02) during the period August 28, 2003, through April 2004, when specific chiropractic coverage was required, the Company failed to provide the specified coverage and required authorization when it was not allowed.

Reference: Sections 376.405 and 376.1230, RSMo

4. The Company used riders to provide chiropractic coverage in policies that do not include the benefit. Since August 28, 2003, Missouri requires health carriers to provide insurance policies that include chiropractic benefits. The riders used by CHL did not provide coverage for the correct number of visits.

The riders require prior authorization for services. Missouri law states that after 26 office visits, a company can require the insured to obtain prior approval for additional treatment or follow-up diagnostic tests.

Reference: Section 376.1230.1, RSMo

<u>Rider Forms</u>	<u>Approved Date</u>
MO (PPO) – CHIRO (02/02) CHP01 thru 6	5/2/02

5. The Company used the following form that provides coverage for domestic partners. When a married couple purchases a contract, the coverage is rated for a husband and a wife and any children. The Company considers each family member and adds each rate to arrive at a total premium. The Company uses the same process to calculate the Domestic Partner coverage but then adds an additional 1% charge to the total group premium for the Domestic Partner rider. Because Domestic Partners family unit is not unlike a married couple unit, the ensuing risk is not different. The Company stated that it has no documentation to support the addition of the 1% premium charge. Missouri does not allow a company to provide less coverage, or charge more premium for persons with essentially same risk, based on a person's marital status. It also does not allow a company to use marital status, living arrangements, or gender to rate an applicant.

Reference: Sections 375.936(11)(e) and 375.995, RSMo, and 20 CSR 400-2.120(2)(E)

Form Number  
MO\_DOMPART\_03.05\_CHL

6. The Company's Application for Benefits Offering forms do not limit the number of hours that an employer-applicant can set as a minimum number of working hours an employee must work to be a full time employee and eligible for benefits. Missouri limits the maximum number of work hours to 30 hours per week. CHL allows an employer to select more than 30 hours as a limit.

Reference: 379.930, RSMo

Form Numbers  
M173 (1/98)  
GHP-7850-15(3/98)  
GHP ENROLL - 603

7. The Company's Chiropractic Care Benefits riders fail to provide 26 visits per policy years as required. The forms approved 5-2-2002 included a limitation of benefits which states: "Benefits shall be payable for a maximum of twenty (20) visits per calendar year."

Reference: 376.1230, RSMo

Form Numbers

CHP01  
CHP02

**B. Underwriting and Declinations**

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

**1. Declinations**

**CHC-KS**

Field Size:	28
Type of Sample:	Census
Number of Errors:	28
Error Rate:	100.0%
Within Dept. Guidelines:	No

- a. The Company failed to maintain complete documentation of the following declined small group applications. The information provided by the Company did not allow the examiners to determine the Company's underwriting and rating standards or to see if CHL offered these groups coverage under a standard or basic small employer group plan. The Company also failed to provide copies of its basic and standard small group plans as well as a copy of its most recent "Actuarial certification" sent to the Missouri director certifying its compliance with the provisions of Section 379.940, RSMo. The Company advised that it used its regularly issued plans instead of a Basic or Standard Policy form.

References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (E) (as amended 20 CSR 100-8.040(2), (3)(A) and (E), eff. 7/30/08))

Small Group Name

Global Media  
Parker Mortuary  
Christopher Hanson Ins  
Cargan Services Corp  
Healthier Cline, DDS  
Bi-Lo Market  
Quick Cash of Wisconsin  
Hubbell Mechanical Supply  
All Seasons Energy, LLC  
Branson Meadows Assisted Living  
Datalink, Inc  
Ozark Lazar Systems  
Southwest Audio & Visual  
BMI

Small Group Name

South Barns  
South Barns  
Brass Leasing, Inc.  
Alliance Energy  
Ozark Lazar Systems  
Dawson Furniture  
Cargan Services Corp  
First Baptist Church of Nixa  
Glendale Christian Church  
All Seasons Energy, LLC  
Community State Bank  
Nations RX  
Professional Builders  
S&R Coach

GHP

2. Small Group Declinations

Field Size:	50
Type of Sample:	Census
Number of Errors:	50
Error Rate:	100.0%
Within Dept. Guidelines:	No

- a. The Company failed to maintain complete documentation of the following declined small group applications. Although Missouri requires companies to maintain declinations for a minimum of three years, the Company's procedure is to destroy them after 18 months. From the information provided by the Company, the examiners were unable to determine the Company's underwriting standards or check if it offered these groups coverage under a standard or basic small employer group plan.

References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (E) (as amended 20 CSR 100-8.040(2), (3)(A) and (E), eff. 7/30/08))

Small Group App. No. Small Group App. No. Small Group App. No.

24984	24944	39006
26034	39103	38549
25977	25961	23987
34905	25353	25993
25195	35159	23756
25150	37535	35268
37986	25209	24267
26308	35724	37337
35196	24090	24063
26395	23439	25886
25109	35517	25646
35259	35662	26025
23652	38662	24334
27858	38639	26356
23450	38998	38579
39138	23446	38521
35555	25506	

**3. Large Group Declinations**

Field Size:	50
Type of Sample:	Census
Number of Errors:	50
Error Rate:	100.0%
Within Dept. Guidelines:	No

a. The Company failed to maintain complete documentation of the following declined large group applications for the mandated three years because it is the Company's procedure to destroy them after 18 months.

References: Section 379.940, RSMo, and 20 CSR 300-2.200(2), (3)(A), and (E) (as amended 20 CSR 100-8.040(2), (3)(A) and (E), eff. 7/30/08))

Large Group App. No. Large Group App. No. Large Group App. No.

38517	35581	24099
36581	38827	23377
38600	24900	25311
23482	23669	24910

<u>Large Group App. No.</u>	<u>Large Group App. No.</u>	<u>Large Group App. No.</u>
38183	35493	24737
23969	38667	35660
23898	35091	38727
35427	25368	39105
23919	35164	25534
26571	26054	38587
25498	38873	25408
38482	23774	35276
35573	26075	24589
35951	24818	35035
38202	25514	35820
36613	26430	38589
26466	26117	

#### 4. Underwriting and Rating

The examiners reviewed policies currently issued by the Company to determine the accuracy of rating and adherence to prescribed and acceptable underwriting criteria. The following are the results of the reviews.

Each of the entities who administer the business of Coventry Health and Life Insurance Company in Missouri performed underwriting and rating functions independent of the other. The examiners sampled the available data proportionally.

The following is a report of the examiners' reviews.

##### a. Current New Issues

###### GHP

Field Size:	20
Sample Size:	20
Type of Sample:	Convenience
Number of Errors:	None
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

**CHC of KS**

Field Size:	20
Sample Size:	20
Type of Sample:	Convenience
Number of Errors:	None
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

**b. Individual Health Insurance**

The Company provided a list of business written during the examination period with 2,673 total policies for the two administering companies. The examiners sampled these proportionally.

**CHC-KS**

Field Size:	58
Sample Size:	1
Type of Sample:	Random Proportional
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners found no errors in this review.

**GHP**

Field Size:	2,615
Sample Size:	49
Type of Sample:	Random Proportional
Number of Errors:	16
Error Rate:	32.6%
Within Dept. Guidelines:	No

The examiners found the following errors.

(1) The Company accepted an application for certificate 901071932-01 in group 6600001005 that included a response to a pertinent question that was changed without the authorization of the applicant. Missouri law and the Company underwriting procedures require an applicant to place their initials in close proximity of any changes to an application.

Reference: Section 376.783.2, RSMo

(2) The Company accepted an application for certificate 901165125-01 of group 6600001001 although the applicant dated the signature on the application after the date of receipt. The file documentation failed to indicate the reason for this contradiction. The Company advised that the inconsistency may be an inadvertent error by the applicant.

Reference: 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08))

(3) The Company provided files for the following 14 certificates that did not include documentation of the date of delivery. The rating information was not included in seven of the files – indicated by an asterisk. Without this information, the examiners could not perform a comprehensive audit of the Company’s underwriting process. The files failed to include underwriting information and the notification letter to show the date of delivery.

Reference: 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Group</u>	<u>Certificate</u>	<u>Group</u>	<u>Certificate</u>
6600001001	901067207-01	6600001001	901145725-01
6600001001	901096864-01	6600001001	901155099-01
6600001001	901097017-01	6600001001	901096960-01
6600001001	901105093-01	6600001001	901437949-01*
6600001001	901223791-01*	6600004501	901236828-01*
6600002005	901123657-01*	6600001003	900643462-01*
6600003001	901236676-01*	6600001001	901105472-01*

**c. Small Employer Group Health Insurance – State Defined**

The Company provided a list of business written during the examination period with 1,352 total policies for the two administering companies. The examiners sampled these files proportionally.

**CHC-KS**

Field Size: 41  
Sample Size: 2  
Type of Sample: Random Proportional  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners found no errors in this review.

**GHP**

Field Size: 1,311  
Sample Size: 48  
Type of Sample: Random Proportional  
Number of Errors: 32  
Error Rate: 66.6%  
Within Dept. Guidelines: No

The examiners found the following errors in this review.

- (1) The Company allowed small employers to stipulate a minimum of more than 30 hours per week to be eligible for health care benefits, thus reducing the number of eligible employees. Missouri's small employer health insurance law states that an eligible employee normally works 30 or more hours per week. This limit attempts to assure a fair standard for employers and to increase the availability of healthcare for small employer groups. By allowing the following 32 small employer groups to select more than 30 hours as the normal work-week eligibility standard, CHL diminishes the intent of the law.

Reference: Section 379.930.2(15), RSMo

<u>Group Number</u>	<u>Hours</u>	<u>Group Number</u>	<u>Hours</u>
6411505001	40	6410775999	40
6411765001	35	6425640001	32
6406365999	40	6426260001	40
6421360001	32	6404045001	40
6412005001	32	6410385001	40

<u>Group Number</u>	<u>Hours</u>	<u>Group Number</u>	<u>Hours</u>
6411095001	35	6210992999	40
6424640001	32	6402295001	40
6402415001	40	6421790001	40
6230855001	40	6218142001	40
6414125001	40	6415805001	40
6230572001	40	6419125001	40
6424960001	40	6407295001	40
6417385001	40	6410145001	32
6224895999	32	6302735999	40
6225602001	40	6401045001	40
6405405001	40	6404585001	40

(2) The Company's Broker Manual and Field Underwriting Guidelines included a reference to a \$500 reinstatement fee. The Company provided the following responses to inquiries presented during the examination:

- i. The Company explains the reinstatement fee to the member in page 4 of the DOI approved application.
- ii. The Company advised that it did not charge the fee to any members in 2003, 2004 or 2005.
- iii. The Request for Reinstatement Form is available for members to request reinstatement of the plan.

The Company did not include notice of the reinstatement fee in the policy provisions. An application is not appropriate to amend or make additional requirements to policy provisions. The Company may attach the application to a policy to document the underwriting information, but it cannot act as an amendment, endorsement, rider or addendum to a policy.

Reference: 20 CSR 400-8.200(2)(B)

(3) The Company's Broker Manual and Field Underwriting Guidelines includes "Pregnancy - Currently (either male or female)" within a list of conditions that will be automatically declined. Pregnancy is a condition that is unique to the female gender. The inclusion of the male gender under Pregnancy is not proper and not applicable.

It is unfair discrimination to use the medical condition of another to underwrite or approve a policy. Missouri law does not allow unfair discrimination concerning gender or marital status.

Reference: Section 375.936(11)(e)&(g), RSMo

d. Large Group and Non Defined Small Group Health Insurance

The Company provided a list of business written during the examination period with 2,673 total policies for the two administering companies. The examiners sampled the files proportionally.

CHC-KS

Field Size:	62
Sample Size:	3
Type of Sample:	Random Proportional
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners found no errors in this review.

GHP

Field Size:	1,149
Sample Size:	47
Type of Sample:	Random Proportional
Number of Errors:	3
Error Ratio:	6.4%
Within Dept. Guidelines:	Yes

The examiners found the following errors in this review.

- (1) The Company used an application that allowed the employers of the following two groups to stipulate more than the allowed 30 hours as the minimum number of hours required to be eligible for health insurance coverage. Missouri's small employer health insurance law states that an eligible employee works 30 or more hours per week.

Reference: Section 379.930.2(15), RSMo

Group Number

Hours

6216625001

32

6421640001

34

- (2) The Company's practice when adding newborns is to collect premium for the first 31 days coverage of a newborn. Missouri requires a policy to cover a newborn from the date of birth for 31 days. If the member adds the newborn to the policy, the Company may charge premium to continue the coverage beyond the first 31 days.

Reference: Section 376.406, RSMo

### III. CLAIM PRACTICES

In this section, the examiners reviewed the claim practices of the Company to determine its accuracy of payment, efficiency in handling claims, adherence to contract provisions and compliance with Missouri law. Because there were a large number of claim files, examining 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 the 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.

#### A. Claims Time Studies

To determine the Company's efficiency in claim handling, the examiners look at how much time the Company used to acknowledge receipt of a claim, how much time the Company used to investigate a claim and how much time the Company took to make payment or provide an explanation of its denial of a claim. Missouri regulations define the reasonable duration of time for claim handling as follows:

- (1) acknowledgment of the receipt of a claim must be made within ten working days, or one working day for claims submitted electronically
- (2) completion of the investigation of a claim must be made within 30 calendar days of receipt of the claim, and
- (3) payment or denial of a claim must be made within 15 working days after submission of all forms necessary to establish the nature and extent of the claim.

If the Company does not pay an electronically filed claim within 45 days, the Company must pay interest of one percent per month in addition to the benefits payable.

Whenever a claim file reflected that the Company failed to meet these standards, the examiners cited it for noncompliance with Missouri law.

Each of the entities, who administer the business of Coventry Health and Life Insurance Company in Missouri, performed claim processing. The examiners sampled the available data proportionally.

The following is a report of the examiners' reviews.

## 1. Paid Group Health Claims

The Company provided a list of claims paid during the examination period with 795,454 total claims for the two administering companies. The examiners sampled them proportionally.

### CHC-KS

Field Size:	115,859
Sample Size:	7
Type of Sample:	Random/Proportional

The following are the results of the time studies.

### Acknowledgement Time

Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

### Investigation Time

Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

### Determination Time

Number of Errors:	1
Error Rate:	14.3%
Within Dept. Guidelines:	No

The examiners noted the following error in this review.

The Company failed to deny the following, non-electronic claim, within 15 working days from the date that it completed its investigation.

Reference: 20 CSR100-1.050(1)(A)

<u>Claim Number</u>	<u>Date Investigation Completed</u>	<u>Date Co. Denied Claim</u>	<u>Working Days</u>
1517122622*	06/23/2005	07/18/2005	16

\* Adjusted claim number 10762543

**GHP**

Field Size: 679,595  
 Sample Size: 43  
 Type of Sample: Random/Proportional

The following are the results of the time studies.

**Acknowledgement Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**2. Denied Group Health Claims**

The Company provided a list of claims denied during the examination period with 90,640 total claims for the two administering companies. The examiners sampled them proportionally.

**CHC-KS**

Field Size: 9,631  
Sample Size: 5  
Type of Sample: Random/Proportional

The following are the results of the time studies.

**Acknowledgement Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**GHP**

Field Size: 89,009  
Sample Size: 45  
Type of Sample: Random/Proportional

The following are the results of the time study.

**Acknowledgement Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

3. **Claims Denied for Re-Pricing**

**CHC-KS**

Sample Size: 118  
Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 12  
Error Rate: 10.2%  
Within Dept. Guidelines: No

The Company failed to pay the following paper claims, including 12 line numbers, within 15 working days from the dates the Company completed the investigations.

Reference: 20 CSR 100-1.050(1)(A)

<u>Claim Number</u>	<u>Line /#’s</u>	<u>Date of Service</u>	<u>Date Invest. Completed</u>	<u>Date Co. Paid Claim</u>	<u>Working Days</u>
1501345303* /2 9759024**	/2	12/27/2005	01/13/2005	03/09/2005	40
1523401398* /1 10917597**	/1	05/09/2005	08/22/2005	10/05/2005	32
1535423392* /1 11619081**	/1	09/29/2005	12/20/2005	02/06/2006	33
1524500130* /2 10961502**	/2	08/08/2005	09/02/2005	10/12/2005	28
1431345803* /2 9619572**	/2	09/24/2004	11/09/2004	02/09/2005	64
1502122848* /1 9759051**	/1	11/01/2004	01/21/2005	03/09/2005	34
1516623005* /2 11721758**	/2	05/04/2005	06/15/2005	02/20/2006	174
1530423287** /1	/1	10/02/2005	10/31/2005	12/07/2005	27

\* Original Claim Number

\*\* Paid Amount on Original Claim Number

**GHP**

There were no files to review in this category.

**4. Denied Group Claims with Complication of Pregnancy ICD-9 Codes**

**CHC-KS**

Sample Size: 15  
Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 1  
Error Rate: 6.7%  
Within Dept. Guidelines: Yes

The Company failed to pay the following paper claim within 15 working days from the date the Company completed its investigation.

Reference: 20 CSR 100-1.050(1)(A)

<u>Claim Number</u>	<u>Date Invest. Completed</u>	<u>Date Co. Denied Claim</u>	<u>Working Days</u>
1523597717	08/23/2005	09/21/2005	20

**GHP**

Sample Size: 51  
 Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
 Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

5. **Denied Group Health Claims with Incorrect Effective Dates**

**CHC-KS**

Sample Size: 32  
 Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

6. **Denied Group Health Claims with Missing Information**

**CHC-KS**

Sample Size: 16  
Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

7. **Denied Group Health Claims Because of a Non-Credentialed Provider**

**CHC-KS**

Sample Size: 12  
Type of Sample: Selective

The following are the results of the time studies.

**Acknowledgment Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Investigation Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**Determination Time**

Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**B. 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 time studies.

**1. Paid Group Health Claims**

**CHC-KS**

The Company provided a list of claims paid during the examination period with 795,454 total claims for the two administering companies. The examiners sampled the available data proportionally.

Field Size:	115,859
Sample Size:	7
Type of Sample:	Random/Proportional
Number of Errors:	7
Error Rate:	100%
Within Dept. Guidelines:	No

The examiners noted the following errors in this review.

- a. The Company failed to maintain its books, records, documents and other business records in a manner so examiners can readily ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and that it issued a confirmation of receipt within one working day. The following claim files did not contain documentation of the dates of service and billed amounts, copies of the Explanation of Benefits including billed and allowed amounts to the members, and Remittance Advice Summaries including copies of the checks with the amounts of payment to the providers.

References: 20 CSR 300-2.100 and 20 CSR 300-2.200(2) & (3)(B)1 (as amended 20 CSR 100-8.040)

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Paid</u>	<u>Type of Submission</u>
2526403634	09/15/2004	09/21/2004	10/10/2005	Electronic
2503404434	01/24/2005	02/03/2005	02/09/2005	Electronic
2521501596	?	08/03/2005	08/08/2005	Electronic
1513624941	04/29/2005	05/16/2005	05/23/2005	Paper
1525800163	08/18/2005	09/15/2005	09/19/2005	Paper
2520009561	?	07/19/2005	07/20/2005	Electronic

- b. After the Company processed the original claim on July 18, 2005, Saint Luke's Health System sent a correspondence on August 1, 2005, disputing the Company's processing and payment on this claim. The Company failed to record the "Provider Reconsideration" or grievance on its complaint register. The Company is required to record any written communication primarily expressing a grievance on the Company's complaint register and maintain them for review.

Reference: Section 376.936(3), RSMo, and 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Provider Sent Complaint</u>
1517122622*	05/31/05-06/01/05	06/23/2005	08/01/2005

\* Adjusted claim number 10762543

### GHP

Field Size:	679,595
Sample Size:	43
Type of Sample:	Random/Proportional

The following are the results of the review.

- a. The Company provides internet access for each medical provider to a Provider Manual. The manual includes rules and procedures regarding claims submission, prior authorizations, referrals and other required procedures. Within this manual, the Company also includes a section that lists the GHP Member Rights and Responsibilities. The responsibilities include requirements that are not contained in the insurance contract/certificate. The manual does not specifically state, but a provider could infer that the members are contractually required to abide by these

responsibilities. A provider may believe that s/he is able to mandate these responsibilities or charge a fee for the patient's lack of cooperation. The responsibilities are prudent, but they are not contractual.

- b. The Provider Manual issued by the Company requires a provider to request approval prior to enrolling a member in a clinical trial or providing services related to a clinical trial. Missouri requires coverage for services related to certain clinical trials. The Company failed to advise the provider of the mandated benefit specifications. The Company should not require a provider to obtain approval for mandated benefits.

Reference: Section 376.429, RSMo

- c. The Provider manual includes a note to providers that:

"In accordance with Missouri law, an acknowledgement must be sent to the provider within ten (10) days of the receipt of the claim. If you have not received an acknowledgement, contact the provider hotline to verify receipt of the claim."

This note fails to include the information concerning electronic claim submissions requirement for acknowledgement within one day. Since the Company allows electronic claim submissions, this information should be included.

## **2. Denied Group Health Claims**

The Company provided a list of claims paid during the examination period with 98,640 total policies for the two administrating companies. The examiners sampled these files proportionally.

### **CHC-KS**

Field Size:	9,631
Sample Size:	5
Type of Sample:	Random/Proportional
Number of Errors:	5
Error Rate:	100%
Within Dept. Guidelines:	No

The following are the results of this review.

- a. The Company failed to pay electronic claim number 10266177, which was an adjustment to the following denied claim, within 45 days from the date of original receipt. Therefore, interest is due beginning on the 46<sup>th</sup> day after receipt for this claim.

Reference: Section 376.383.5, RSMo

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>Days</u>	<u>Amount of Payment</u>	<u>Amount Interest</u>
2510512769-15	04/15/2005	06/13/2005	59	\$2,983.04	\$13.73

- b. The Company failed to maintain its books, records, documents and other business records in a manner to allow examiners to ascertain its procedures. The Company failed to provide source documentation of the insureds effective dates of coverage for all files listed and of the dates of service for the billed amounts from the claims designated with an asterisk. A file shall contain all notes and work papers pertaining to the claim in such detail to allow examiners to reconstruct the pertinent events.

References: 20 CSR 300-2.100 and 20 CSR 300-2.200(2)&(3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Billed Amount</u>	<u>Type of Submission</u>
2525102024-7	08/30/2005	09/08/2005	\$125.00	Electronic*
9619561-8	09/17/2004	11/18/2004	36.00	Electronic
1505223269-15	01/19/2005	02/21/2005	78.00	Electronic*
2510512769-15	12/27/2004	04/15/2005	5,115.00	Electronic
1523697430	01/09/2005	08/24/2005	4,544.00	PAPER*

\* No Date of Service Documentation

**GHP**

Field Size:	89,009
Sample Size:	45
Type of Sample:	Random/Proportional
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners found no errors in this review.

**3. Denied Group Health Claims for Repricing**

**CHC-KS**

Sample Size:	118
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners found no errors in this review

**4. Denied Group Claims with Complication of Pregnancy ICD-9 Codes**

**CHC-KS**

Sample Size:	15
Type of Sample:	Census
Number of Errors:	8
Error Rate:	53.3%
Within Dept. Guidelines:	No

The following are the results of this review.

- a. The Company failed to maintain its books, records, documents and other business records in a manner so examiners could ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and proof that it

issued a confirmation of receipt within one working day for the applicable electronically filed claims. The following claim files did not contain documentation of the Explanation of Benefits with the dates denied along with the written reason for the denials to the member in file. A file shall contain all notes and work papers pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and 20 CSR 300-2.200(2)&(3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Denied</u>	<u>Type of Submission</u>
1529923505	09/08/2005	10/26/2005	11/02/2005	PAPER
9686166	06/12/2004	06/22/2004	06/28/2004	ELECTRONIC
1523597717	08/01/2003	08/23/2005	09/25/2004	PAPER
2516400760	01/08/2005	06/13/2005	06/15/2005	ELECTRONIC

- b. The Company failed to maintain its books, records, documents and other business records in a manner so that examiners could readily ascertain the claims handling practices of the insurer. The Company failed to provide the actual claim-specific documentation to indicate when it received all electronic claims and proof that it issued a confirmation of receipt within one working day for the applicable electronically filed claims. A file shall contain all notes and work papers pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events.

References: 20 CSR 300-2.100 and 20 CSR 300-2.200(2)&(3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Claim Number</u>	<u>Date of Service</u>	<u>Date Co. Received</u>	<u>Date Denied</u>	<u>Type of Submission</u>
1523597636	08/03/2004	08/23/2005	09/01/2005	ELECTRONIC
2502816165	01/10/2005	01/28/2005	02/02/2005	ELECTRONIC
11038354	08/24/2005	09/02/2005	09/07/2005	ELECTRONIC
2524501554	08/24/2005	09/02/2005	09/07/2005	ELECTRONIC

**GHP**

Sample Size: 51  
Type of Sample: Census  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners found no errors in this review.

**5. Denied Group Health Claims for Incorrect Effective Dates**

**CHC-KS**

Sample Size: 32  
Type of Sample: Census  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners found no errors in this review.

**GHP**

Field Size: 440  
Sample Size: 27  
Type of Sample: Systematic  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners found no errors in this review.

6. Denied Group Health Claims for Missing Information

CHC-KS

Sample Size: 16  
Type of Sample: Census  
Number of Errors: 16  
Error Rate: 100%  
Within Dept. Guidelines: No

The following are the results of this review.

- a. The Company failed to maintain its books, records, documents and other business records in a manner so examiners could readily ascertain the claims handling practices of the insurer. The following 16 claim files did not include adequate documentation to reconstruct the Company's claim procedures. A file shall contain all notes and work papers pertaining to the claim in such detail so examiners can reconstruct the pertinent events and the dates of these events. The documentation provided by the Company did not include its documents to show that it notified the provider about missing or incorrect information. The Company's practice is to deny benefits with a coded denial reason and a brief statement of the reason.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and 20 CSR 300-2.200(2)&(3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Group Policy Number</u>	<u>Subscriber Number</u>	<u>Claim Number</u>
543690001	2175468	1509422895
5346241001	2343687	1517245949
5301730041	73419	2533401677
5301730041	73419	2533405924
5301730041	73429	2530522241
5346241001	2343571	1522700326
5346241001	2343571	1522700505
5346241001	2343571	1523645390
5346241001	2343571	1523800095
5325370999	1154144	10256335
5325370999	1154144	1519522612
5325370999	1154144	1525600067

<u>Group Policy Number</u>	<u>Subscriber Number</u>	<u>Claim Number</u>
5325370999	1260635	1510200110
5325370999	1260635	2512309419
5342631001	2157865	1505300748
5343690001	2175468	1503345300

**GHP**

Field Size: 430  
Sample Size: 53  
Type of Sample: Systematic  
Number of Errors: 3  
Error Rate: 5.6%  
Within Dept. Guidelines: Yes

The examiners found the following error in this review.

- a. A Medicare supplement policy or group policy customarily pays the balance of claims where Medicare has paid as the primary insurer. This file does not contain documentation to confirm that the Company determined existence of secondary liability and has not made payment as needed. The claimant is an 89 year old having Medicare as primary coverage. In the absence of payment by the insurer, it is possible that the provider collected the balance from the member, who may not be cognizant of her actual financial liability. The file does not indicate that CHL paid the remaining balance. The explanations of benefits (EOB) sent to the member indicates Member Responsibility of \$744 and \$12,856.50 respectively. CHL states that there is no actual member liability, since the Company does not allow a participating provider to bill a member for the balance. The EOB is confusing and not accurate. CHL cannot confirm that a member would not voluntarily pay the provider the amount shown as Member Responsibility nor does it assure that a provider will refund a payment collected in error.

Reference: 20 CSR 100-1.020(1)

Claim Numbers for Claimant

2506815181  
1521425082  
1510823142

**7. Denied Group Health Claims Because of a Non-Credentialed Provider**

**CHC-KS**

Sample Size: 12  
Type of Sample: Census  
Number of Errors: 12  
Error Rate: 100%  
Within Dept. Guidelines: No

Following are the results of this review.

- a. In the following 12 claim files, the Company failed to include complete documentation consisting of notes and work papers pertaining to the claim in such detail so examiners could reconstruct the pertinent events and the dates of these events.

References: 20 CSR 100-1.050(1)(A), 20 CSR 300-2.100, and 20 CSR 300-2.200(2)&(3)(B)1 (as amended 20 CSR 100-8.040, eff. 7/30/08))

<u>Group Policy Number</u>	<u>Subscriber Number</u>	<u>Claim Number</u>
5308000012	657788	2501303481
5308140001	1148918	2503811852
5308210001	1216507	2501303487
5308210001	1216507	2504902190
5408360001	2284049	2524400622
5408360001	22084049	2531802358
5346060001	2315364	2506606263
5346060001	2315364	2510401254
5346060001	2315364	2510503641
5346060001	2315364	2523703495
5346060001	2315364	2523703502
5413540001	2419064	2524903343

**GHP**

Field Size: 79  
Sample Size: 7  
Type of Sample: Systematic  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**8. Denied Claims Because of Incorrect Claim Submissions**

**GHP**

Field Size: 47  
Sample Size: 10  
Type of Sample: Systematic  
Number of Errors: 0  
Within Dept. Guidelines: Yes

The examiners noted no errors in this review.

**9. Denied Claims Pre-Authorization Requirements**

**GHP**

Field Size: 15  
Sample Size: 15  
Type of Sample: Census  
Number of Errors: 10  
Error Rate: 66.67%  
Within Dept. Guidelines: No

The examiners noted the following errors in this review.

- a. The Company requires its providers to use a specific service to perform PSA tests unless the provider obtains prior authorization. Since the provider performed the test without prior authorization, GHP denied the cost. The Company should not require participating providers to obtain prior authorization for mandated benefits.

Reference: Sections 376.1250 and 408.020, RSMo

Claim Number

1527346149

- b. Although a mammogram is a mandated benefit in Missouri, the Company denied coverage in the following nine claims because the provider coded the mammogram as a secondary test to one that required prior authorization. The Company agreed it should have paid the mammogram portion of the billing, but then would not pay the benefit because the contract with the providers requires them to appeal incorrect payments within one year. The Company should not punish a provider for failing to contest the denial of coverage for a mandated service.

Reference: Section 376.782, RSMo

Claim Number

Claim Number

2521405372

2520113468

2520011191

2517804732

2517204841

2504208237

2501835863

1520746705

12448211

- c. The Company requires prior authorization for bone density tests. Missouri law requires coverage for bone density tests for services related to diagnosis, treatment, and appropriate management of osteoporosis. The Company should not require a participating provider to obtain prior authorization for mandated treatments.

Reference: Section 376.1199(3), RSMo

Claim Number

2521405372

- d. The Company's Utilization Review Manual requires that a provider must obtain prior approval before prescribing PKU formula. The Company should not require prior approval for mandated benefits.

Reference: Section 376.1219.1, RSMo

- e. The Company requires participating chiropractors to submit a treatment plan for approval before providing chiropractic care. If the provider does not submit and obtain approval of a treatment plan prior to care, CHL will not pay benefits. Missouri does not require prior authorization for the first 26 visits. The requirement for a Treatment Plan is no more than a method to maintain control by demanding approval of a chiropractic treatment plan. Some policies allow benefits for spinal manipulation only and cover other treatment when the member purchases an additional rider. Missouri does not restrict care to spinal manipulation during the first 26 visits. The Company denied the following claims inappropriately for the lack of an approved treatment plan.

Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Numbers</u>
900861665*01	25043610836 1178274 250813265 11978584 11978583
900844587*01	1508145120
900761294*01	2505002494
900678025*01	1502522731
900753702*01	2528015345

#### **10. Denied Claims Because the Claims were not Filed Timely**

##### **GHP**

Sample Size:	8
Type of Sample:	Census
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners noted no errors in this review.

## **11. Denied Claims Because the Claims were Bundled**

### **GHP**

Field Size:	70
Sample Size:	32
Type of Sample:	Systematic
Number of Errors:	0
Within Dept. Guidelines:	Yes

The examiners found no errors in this review.

## **12. Mandated Benefit Claims**

Missouri law includes mandates for coverage of medical treatment of specific illnesses or tests to determine the presence of specific illnesses. The following sections report on the Company's progress in the implementation of procedures to comply with these laws.

### **CHC-KS**

The Company performed a self-audit on the claims identified and found them to be previously paid or appropriately denied. The examiner found no problems with the information provided.

### **GHP**

The Company provided a list of claims involving mandated benefits that it previously denied. Prior to the review of these claims, the Company performed a self-audit to determine if the denials were appropriate. The Company paid those that it deemed payable and provided documentation of those payments. The Company's review resulted in additional claim payments totaling \$251.00, plus \$62.22 of interest.

## **13. First Steps Claims**

### **CHL-KS**

The Company provided claim information for First Step claims that it settled during the timeframe. Coventry performed a self-audit of these claims and provided a report of this process. The information included 261 claims that it originally denied. Of those claims, the Company paid 81 claims (\$2,306.25) and settled 21 claims (\$1,712.50) to

the deductible. The Company indicated that it denied the remaining 159 claims appropriately. The examiners found no problems with the information provided.

**GHP**

The Company provided claim information for First Steps claims that it settled during the timeframe. Coventry performed a self-audit of these claims and provided a report of this process. The information included 425 claims that were either paid or denied. The denials consisted of 231 where the member was not effective, 128 that were not timely filed, 54 needed additional information, nine were the primary carrier's liability and the balance for various reasons. The Company failed to reimburse Medicaid in four instances.

<u>Member Number</u>	<u>Claim Number</u>
901168885*03	1604101700
901216395*03	1631167523
901210874*04	1604102124
901229148*03	1625545669

**14. Chiropractic Claims Denied**

**CHL-KS**

The Company's policy form limited chiropractic services to 26 visits within a calendar year. Missouri law requires 26 visits during each policy period. The examiners asked the Company to correct the form and pay any claims that it denied because of the incorrect limitation. The Company advised it did not deny any claims due to the limitation. The examiners found no problems with the information provided.

**GHP**

Field Size:	1,732
Sample Size:	73
Type of Sample:	Systematic
Number of Errors:	59
Error Ratio:	80.8%
Within Dept. Guidelines:	No

The examiners found the following errors in this review.

- a. As noted in the Policy Forms section of this report, the Company's policy form limited chiropractic services to spinal manipulations. Missouri law requires coverage for chiropractic treatment including initial diagnosis and medically necessary services and supplies required to treat the diagnosed disorder.
- b. The Company requires its participating providers to submit a treatment plan after the initial treatment date to obtain approval for the follow-up treatments. Missouri law requires companies to provide 26 visits for chiropractic treatment. The law allows a company to require prior approval for visits after the first 26 visits. The Company's requirement for a treatment plan circumvents the requirements of law.

The Company required prior authorization for chiropractic care in the Provider Manual published for 2003.

The 2004 Provider Manual contains two different requirements for chiropractic treatment. The Company required prior notification before chiropractic treatment could begin, but under the special services section, it also included a requirement for a treatment plan after the initial visit before it would consider the additional services medically necessary. Medical necessity can be determined during the claim process, after the doctor provides treatment.

The 2005 Provider Manual included chiropractic services in its list of services that required prior authorization but limited the requirement to prior notification only. The manual also includes a requirement for the provider to submit a treatment plan prior to treatment. The Company states that it uses this plan as a means to determine medical necessity. Medical necessity can be determined during the claim process, after the doctor provides treatment.

The Company's requirements contradict Section 376.1230, RSMo. The law specifically states that 26 visits are payable before a company has the option to require prior authorization for additional visits. Since companies adjudicate claims, which allows them to determine whether a provider has used the proper type and level of treatment and to make a determination of payment or denial, the requirement for a treatment plan to base its determination of acceptable or necessary care can only be seen as a means to compel providers to seek prior authorization. The Company denied the following claims because the provider either failed to submit a treatment plan or exceeded the submitted-treatment plan specifications.

Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1508300175	2507310340	1604546027
2532620033	2528719588	2509407074
2510215505	2605213623	2516710176
2509113796	2513717714	2536419425
2507615539	2509015801	1525546432
2613216705	2502715321	2532211394
2517314863	2503309545	2530616775
1509700674	1507745141	2536120108
2534317339	1508146131	

- c. The Company denied benefits for claims submitted for member 901085952\*01 because the chiropractor provided more treatment sessions than the number authorized, although there were fewer than 26 visits during the period.

Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Claim Number</u>	<u>Claim Number</u>
1501345311	11592412	11532743
11532744	11592413	11592416
11592417	1501723768	1501145377

- d. The Company denied benefits for claims submitted for member 900858424\*01 because the chiropractor was not a participating provider. After further review the Company decided that one treatment was payable and paid \$30.00 for the initial visit.

Reference: Section 376.1230, RSMo

- e. The Company denied benefits for several claims submitted for member 901165936\*01 because of the lack of information about other coverage. Because the information was on the claim form, the Company paid the claims after reviewing the claim. Because the Company did not pay interest for the delayed payments, it paid the chiropractor \$5.91 interest for the period of delay.

Reference: Section 376.1230, RSMo

- f. The Company denied benefits for claim 4525047511 submitted for member 900683463\*01 because of "Rej - Invalid Code Combination or other error identified." The Company determined that the three diagnoses were not all related

to chiropractic care. One or more of the diagnoses were conditions normally treated by chiropractic manipulation. Therefore, the Company paid the claim, \$41.34.

Reference: Section 376.1230, RSMo

- g. The Company denied benefits for the following claims submitted for two members because the chiropractor delayed submitting the claim to the Company. File documentation indicated that the provider submitted the claim in a timely manner. In addition, the provider was not a network provider so he was not subject to the limitations required of in-network providers. The Company reversed its decision and paid the claims a total of \$250.96.

Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Numbers</u>
900627349*02	2600324786 2600324794 2600324788 2600324783 2600324800
900627349*01	2525914726 2526615253 2526319622 2525502629 2526907703

- h. CHL denied benefits for claim 1504546508 for member 900862524\*01 because the chiropractor provided more treatment sessions than the number authorized. The Company reviewed the claims for this member and paid the following claims a total of \$206.00.

Reference: Section 376.1230, RSMo

<u>Claim Number</u>	<u>Reprocessed Claim Number</u>
1504546508	19224380
1505523251	19224382
1505523205	19224384

- i. The Company denied benefits for the following claims submitted for member 900860156\*01 because the Company needed the Medicare EOB. The EOB was

submitted with subsequent claims. As a result, the Company reprocessed the claims and made payments of \$12.07 and \$8.82 respectively.

Reference: Section 376.1230, RSMo

Claim Numbers

1503801386  
1524400267

- j. The Company denied benefits for claims submitted for members 901085952\*01 and 900846543\*01 because the chiropractor failed to submit a treatment plan. The Company reprocessed the claims and made payments of \$34.00 and \$126.00 respectively.

Reference: Section 376.1230, RSMo

Claim Numbers

1532500077  
1506800087

- k. The Company denied benefits for the following claim submitted for member 900655613\*01 because the chiropractor provided more treatment sessions than the number authorized. The Company paid additional benefit of \$7.00.

Reference: Section 376.1230, RSMo

<u>Member Number</u>	<u>Claim Number</u>
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900655613*01	19539370 19539369
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- l. The Company denied benefits for claim number 2531116205 because the provider failed to submit a treatment plan. The file included a referral, which included the date of service for this claim. The Company paid additional benefits of \$35.00.

Reference: Section 376.1230, RSMo

- m. The Company determined that it did not pay claim 1518945681 correctly and remitted an additional \$17.30 including interest.

## **15. Childhood Immunizations Claims Denied**

### **CHC-KS**

The examiners found no errors in this review.

### **GHP**

- a. The Company performed a self-audit of the claims involving childhood immunizations. The audit found that claims for two members were payable and CHL paid \$566.56, which included interest of \$108.56. The examiners found no problems with this information.

## **16. Denied Mental Health Claims**

The Company provided 27 denied claims for members who received treatment for mental health problems.

- a. The Company denied benefits because the level of care stipulated by the managed care TPA was less intensive than that recommended or provided by the provider. The Company paid \$315.00 on claim 0530800581 because the initial care provided to the member on admission was considered necessary due to the perceived emergent factors.

Reference: Sections 354.442.1(3), 375.1007, (3) & (4), and 376.1350(12), RSMo

- b. The Company denied benefits for claim 0516800344 when the member was admitted for detoxification but he was not experiencing suicidal ideation or homicidal ideation. The records indicate that the member presented with vague suicidal thoughts but was not experiencing them when interviewed by the Company. Since the Company's interview did not indicate serious symptoms, CHL denied the claim. The perceived emergent factors upon arrival were not considered in this claim.

Reference: Sections 375.1007, (3) & (4), and 376.827, RSMo

- c. The Company denied benefits for claim 0533204429 in error. Medicare, the primary carrier, paid its portion of the claim, leaving CHL responsible for the balance of \$54.48.

Reference: Section 375.1007, (3) & (4), RSMo

## **17. Denied Emergency Care and Ambulance Claims**

### **GHP**

- a. The Company did not pay all benefits for claim number 13871740. It did re-adjudicate the benefits in claim 20089890 paying an additional \$511.57.

Reference: Section 375.1007(3) & (4), RSMo

- b. The Company denied emergency room care claim 0533204429 in error. CHL re-opened the claim under claim 0805350059 and paid \$53.17.

Reference: Section 375.1007(3) & (4), RSMo

## **18. Claim Processing Issues**

### **GHP**

- a. The Company's claim procedures, manuals, agreements and contracts do not always contain sufficient continuity and conformity to allow a fair and equitable process. Individual provider contracts do not always include complimentary requirements and procedures to allow fair and equitable claim reimbursement.

1. The Company uses the term "invisible provider" to specify any provider who provides ancillary services but is not a consideration for the member. Certain providers may be "invisible" providers due to their association with a provider from whom the member has chosen to receive services or who is based in a hospital. The following provider types can be "invisible" providers: radiologists, pathologists, anesthesiologists, and ER physicians. Many "invisible" providers do not contract with insurers. In some claims, the Company denied claims because it did not consider the provider a participating "invisible" provider. If the contract allows coverage for non-participating providers, the Company will pay benefits for them as non-participating even when the member does not have a choice in the matter. The Company advised that "invisible" providers can be participating or non-participating, which is determined by the care provided and/or the contractual relationship to GHP.

2. The Company's procedure to identify participating providers allows non-participating providers to be associated with and work within an office where all the other providers are participating. In this scenario, even if a member tries to determine in advance if a provider is participating can end

up receiving treatment from a non-participating doctor, resulting in higher deductible and co-pay charges.

3. On page 22 of the 2005 Provider Manual there is a requirement for pregnancy related services to submit notification only and not require prior authorization. On page 30 of that manual it states, that the Medical Management Department must be notified when pregnancy is confirmed. The Global OB Authorization Request and the OB Precertification Forms are required for these notifications and are to be completed by a physician. The manual does not include a specific requirement for a hospital facility to notify the Company of the date and type of pregnancy delivery. The Company advised that all hospitals are required to provide notice of all admissions.
4. The Company requires providers to complete specified forms for claim submissions. The provider name and identification number are required to be placed on form HCFA1500 in Box 31. If the form is completed and that information is not in Box 31, the Company denies the claim because of the lack of or misplaced information even when the information is elsewhere on the forms.
5. The Company has an unwritten rule that requires lab services to be utilized based on the county of residence of the member. The process requires the participating provider to direct members to a specific lab for processing. Since the county of residence is not always obtained by providers, the medical provider often does not have adequate information to assure proper application of the rule. If a provider misdirects the member to an incorrect lab, the lab is penalized for providing services.
6. The Company's claim processing requirements in the form of a Provider's Manual requires providers to submit claims within specific time limitations. It also specifies the claim forms that will be acceptable to the Company, the information that must be included on the claim forms, and in which specific boxes or positions on the claim form. Some of this information is designated to be entered in more than one position, but it must be entered in each of those positions. If the provider provides incorrect information, omits a required entry, or in any other manner does not correctly complete the form(s) the claim is denied.
7. If the provider fails to include the correct ICD-9 or CPT code, the claim is automatically denied with the reason that the correct codes was/were not included. If other necessary information is not included or is misplaced on

the form, the Company denies the claim with the reason that the information was not submitted as required.

8. The Company's claim procedures do not include a method to correct errors on claim forms or to provide immediate assistance for submission errors made by providers. The denial codes with brief explanations are the only contact made with the provider. The codes provide the denial notice, but the explanation does not fully explain the reason for the denial and does not provide immediate assistance to complete the claim process. The lack of direction causes confusion that often delays or causes a claim denial during the adjudication process. In some instances, more than one piece of information is incorrect or missing. The Company will identify one problem on the denial. When the provider corrects that part, the Company may deny the claim for one of the other processing errors. The process may result in several separate denials and usually the creation of several different claim numbers for the same episode of service. The Company provides assistance in the form of a toll free telephone number for providers or the insured to call to obtain help completing claim forms, but does not have a process to resolve claim submission issues concerning incorrect or missing information.
9. The Company's agreements, contracts and procedure manuals are not always coordinated to achieve a fair and equitable claim process. When the Company requires providers to forfeit earnings because of procedural incompatibilities, the provider can only correct the situation by increasing prices to compensate for the losses. This results in increasing overall costs rather than the perceived lowering of expenses.
10. It does not appear that the Company performs investigations to obtain correct or missing information. When a provider is non-participating, the same process is used but the member must assume responsibility for the claim submission and corrective actions. The claim reviews have discovered claims being denied because the claim information was not correct or was incomplete.
11. The Company's Provider Agreements and Procedure Manuals include numerous requirements and specifications that providers must follow precisely in order to attain the status of a "clean claim." If a submitted claim is not determined to be a "clean claim," then the Company does not consider it a claim. The claimant must resubmit the claim in the form and manner prescribed by the Company. The Company's Provider Agreement requires participating providers to forfeit their fees when they do not file an acceptable claim within 90 days of the date of treatment. Although

some claims were filed timely, they included errors and were ultimately denied because a correctly completed "clean claim" form was received late, and the Company did not consider the original submissions because they were not "clean claims."

12. The Company's denials for claims that involve members who have their primary insurance with Medicare may cause an elderly member to pay charges that are actually payable by Medicare or CHL. The denial code used states that the member is not responsible for the particular service, yet the EOB identifies a "total amount covered" and indicates that the member is responsible.

Section 375.1007, RSMo requires a company to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; to complete its investigation within 30 days; effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. The Company does not appear to have done this.

Regulation 20 CSR 100-1.010 states that an investigation means all activities of an insurer directly or indirectly related to the determination of liabilities under coverage afforded by an insurance policy. The Company does not appear to have done this.

Regulation 20 CSR 100-1.030 states that every insurer, upon receiving notification of claim, promptly shall provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. The Company does not appear to provide reasonable assistance.

Regulation 20 CSR 100-1.030(3) requires that upon notice of a claim, the Company shall provide necessary forms, instructions and reasonable assistance to first party claimants so they can comply with the Company's reasonable requirements. CHL does not maintain a procedure to comply with this requirement because it does not provide assistance instead, it denies the claim while supplying minimal information. The claim reviews have discovered large numbers of claims denied because the claim information was not correct or incomplete when first submitted. Claims that are not complete are not considered to be filed claims by the Company. Re-filed claims are considered new filings if they are "clean claims." If a "clean claim" is not filed timely (within 90 days) the claim is denied. The Provider Manual requires participating providers to forfeit their fees when they do not file an acceptable claim within 90 days of the date of treatment. The Company does not perform investigations to obtain correct or additional information. When a company receives a claim, it must accept, deny or suspend it to get more information.

#### IV. COMPLAINTS

##### A. Department of Insurance, Financial Institutions and Professional Regulation Complaints

###### CHC-KS

The Company provided its complaint register during its examination with a listing of 18 Department Complaints received between January 1, 2003, through June 30, 2006.

The following are the exceptions that examiners found during the DIFP complaint review.

1. The Company failed to maintain documentation of the postmark for seven of the 18 DIFP complaints, which the Company received during the review period. Missouri requires companies to mail an adequate written response to a DIFP inquiry within 20 days from the date of postmark. The examiners were unable to readily ascertain the complaint handling practices of the Company because postmarks were not reflected in seven of the files.

Reference: 20 CSR 100-4.100(2)(A), and 20 CSR 300-2.200(2) (as amended 20 CSR 100-8.040(2), eff. 7/30/08))

<u>Issue No.</u>	<u>Date Received</u>	<u>DOI File No</u>
5969	01/03/2003	02J003621
6008	01/13/2003	03J000085
7841	03/09/2004	04S000187
7873	04/27/2004	04J000850
14744	09/02/2004	04J001867
14759	10/15/2004	04K000619
14851	05/12/2005	05J001560

2. The Company failed to pay the following seven electronic claims related to the respective Department complaints within 45 days from the dates of receipt. Therefore, interest is due beginning on the 46<sup>th</sup> day after receipt up to the date of full payment on the claim. The Company can exclude days that it waits for requested information from the processing days used to determine if or how much interest is due. The Company reprocessed these claims after the claimants filed complaints with the DIFP, which is not the same as a request for information. The payment of interest is required for all delayed payments without the necessity of the claimant to file an additional claim for that interest.

References: Sections 375.1007(1), (3), (4), and (6), and 376.383.5 RSMo

Department Complaint Number

05J00096

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>	<u>Interest Due</u>
Provider: Pediatric Assoc of						
9626538	12/06/04	02/09/05	01/20/05	20	\$55.00	\$.36
9626547	12/06/04	02/09/05	01/20/05	20	55.00	.36
						Total: \$.72

Provider: Obstetrics Gynecol

9969498	01/26/05	04/20/05	03/12/05	39	\$34.00	\$.44
9969504	01/26/05	04/20/05	03/12/05	39	6.30	.08
						Total: \$.52

Department Complaint Number

05J000917

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>	<u>Interest Due</u>
10981992	11/29/04	10/17/05	01/22/05	288	\$611.00	\$57.85

Department Complaint Number

04J000467 (The Company paid \$289.90 interest on these two claims and an additional \$109.19 for another insured to the Center for Rheumatic Disease provider for a total of \$399.09 interest during the course of this examination.)

<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Date Co. Paid</u>	<u>45th Day</u>	<u>Interest Days</u>	<u>Amount of Payment</u>
8115104	03/04/03	03/08/04	04/18/03	324	\$1,797.22
8083621	07/03/03	03/01/04	08/17/03	196	1,686.30

3. The Company did not conduct a reasonable investigation when it originally processed the following 14 claims. The Company only reprocessed these claims after the claimants filed complaints with the DIFP.

Reference: Section 375.1007(1), (3), (4), and (6), RSMo

<u>Complaint Number</u>	<u>Claim Number</u>	<u>Date Co. Received</u>	<u>Initially Processed</u>	<u>Date Co. Paid</u>	<u>Amount of Payment</u>
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Provider: Doctors Hosp of Sp

05J00096	9969458	10/12/04	11/09/04	04/19/05	\$96.00
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Provider: Allergy & Asthma

05J00096	9969440	08/27/04	09/15/04	04/19/05	\$95.10
05J00096	9969450	10/12/04	10/19/04	04/19/05	79.73
05J00096	9969471	10/19/04	10/29/04	04/19/05	8.25
05J00096	9969479	10/29/04	11/12/04	04/19/05	8.25
05J00096	9969484	11/24/04	12/09/04	04/19/05	8.25
05J00096	9969492	12/08/04	12/21/04	04/19/05	8.25
05J00096	9969494	12/22/04	01/12/05	04/19/05	8.25
05J00096	9969507	02/08/05	02/25/05	04/19/05	8.25
05J00096	9969509	03/01/05	02/08/05	04/19/05	8.25

Total: \$232.58

Provider: Avista Hospital

05J000915	10104405	12/15/04	12/23/04	05/16/05	\$8,321.26
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Provider: Ozarks Medical Center

05S000284	9767334	01/18/05	01/26/05	04/04/05	\$138.90
05S000284	9767378	02/01/05	02/16/05	04/04/05	\$172.58

Total: \$311.48

Provider: Skaggs Hospital

05J002228	11157715	06/24/05	07/06/05	11/14/05	\$7,149.14
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**GHP**

The examiners reviewed the Company's handling of 12 DIFP complaints dated January 1, 2003 through June 30, 2006.

The examiners noted the following exceptions in this review.

1. The Company denied approval in the following complaint of Vagus Nerve Stimulation (VNS) treatment for Treatment Resistant Depression (TRD). The FDA approved this treatment. The Company used a July 15, 2005, FDA approval for the pre-market use of the

treatment. The provider submitted a July 15, 2005, approval from the FDA that did not include the restriction for pre-market use only. The file included other documentation that showed reports from several tests of the equipment. Some tests of the equipment indicated good results while others failed to determine any benefits. The file did not include documentation to show FDA non-approval for this treatment.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Number</u>	<u>Complaint Number</u>	<u>Company Number</u>
900863850-02	06J000147	DOI10602301MO

2. The Company failed to include the following complaint in its complaint register.

Reference: Sections 375.936(3) and 376.1375, RSMo

<u>Member Number</u>	<u>Complaint Number</u>	<u>Company Number</u>
900793816-02	05S000209	DOI0509004MO

3. The administrative contract between CHL and GHP requires GHP to perform all functions for CHL. The forms and letters to complainants contain conflicting and misleading information as to what Company is truly responsible for the benefits of the policy. Eleven of the 12 files reviewed indicated the Company's NAIC number 96377 when the correct number for Coventry Health and Life Insurance Company is 81973. The wording placed directly beneath the logo indicates "GHP, a Coventry Health Care Plan." The twelfth file states the NAIC number is 81973 and the underwriting Company is Group Health Plan, which is incorrect. Forms and letters to CHL members should be very clear as to what Company is ultimately insuring the risk.

References: Sections 375.936(4) and 376.1088, RSMo

<u>DIFP Complaint Number</u>	<u>DIFP Complaint Number</u>
06J000382	05J001945
06J000544	05J002451
05S000209	05J001766
05J002485	05J002498
05J002935	06J000147
05S000065	06J001567

4. The Company failed to maintain its complaint register with all the required fields of information. The Company inserted the type of action that was in progress instead of the

Type of Coverage in its register.

Reference: 20 CSR 300-2.200(3)(D) (as amended 20 CSR 100-8.040(3)(D), eff. 7/30/08))

**B. Consumer Complaints and Appeals**

**CHC-KS**

**Consumer Complaints**

The examiners reviewed one complaint that the Company received directly from the consumer.

The examiners found no inconsistency in this review.

**Appeals**

Field Size:	89
Sample Size:	27
Type of Sample:	Census of 2 <sup>nd</sup> Level Appeals Random of 1 <sup>st</sup> Level Appeals
Number of Errors:	4
Error Ratio:	14.8%
Within Dept. Guidelines:	No

The examiners found the following errors in this review.

1. The Company declined to provide benefits for the drug Provigil that the member was prescribed when covered by a prior carrier. The member's symptoms were similar to those identified for use of this drug by the FDA. The member's condition was not specifically named as approved in the FDA approval but was not specifically named as not permitted. Coventry declined to cover it because it was not specifically named. Since the prior carrier allowed coverage for two years and the doctor prescribed it, the Company should not restrict the member from the medical treatment which provides relief of the symptoms presented.

Reference: Section 376.441, RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
53570	90124547801	Authorization Request

2. The Company denied coverage for a medication that was first prescribed while covered by a prior carrier. The member's doctor had tried several drug combinations to allow her to control her diabetes and found that this combination worked best. When the member's group plan changed to Coventry, it denied coverage.

Reference: Section 376.441, RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
40555	901099506*02	Authorization Request

3. The Company denied coverage for a DJ Iceman machine prescribed and directed for use by the physician to aid the healing process after surgery to correct a knee injury. The provider did not give the member a choice of treatment because it is the doctor's protocol to use this machine when he performs knee surgery. The Company requires the provider to request authorization prior to use, which he did not do. The doctor requires the machine's use to allow faster healing and recovery. The Company's research consisted of inquiries to medical doctors asking whether the DJ Iceman was medically necessary. All doctors indicated that there are other methods to do the job that this machine does. The selected doctors are not asked to take into account the faster healing time or the need for pain medication that is necessary with other treatments. The file failed to include documentation to show that the DJ Iceman was not an appropriate treatment for the member's condition.

Reference: 375.1007(4), RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Claim Number</u>
2975	549835	1225601774

4. The Company could not locate the following appeal file. A company is required to maintain documentation of all appeals.

Reference: 20 CSR 300-2.200 (as amended 20 CSR 100-8.040, eff. 7/30/08), and 20 CSR 400-7.110

<u>Appeal Number</u>
37840

GHP

The examiners reviewed 31 consumer complaints and 230 appeals dated January 1, 2003 through June 30, 2006.

The examiners noted the following exceptions in this review.

1. When GHP denies prior authorization for treatments, equipment and medications that are not customarily used for the medical condition or are required by the contract to receive prior authorization, the Company includes the wording from its policies, ...“in the Company’s sole and absolute discretion...” The Company, due to the unilateral basis of an insurance contract, has the ability to deny coverage. The use of this language can only logically be interpreted to expand on what is explicit in the contract that the insurer will make coverage and benefit decisions. This interpretation must lead the insured to believe that no action on the part of the insured or anyone else is contractually available to modify the insurer’s decision. This interpretation conflicts with several provisions of law, in that it eliminates the insured’s right to seek legal action to enforce the contract and make any required right to appeal the decision, file a grievance or seek relief through the DIFP meaningless. This language confuses and misleads insured persons. Therefore, policies with this language are not acceptable. The following appeals or complaints are examples of how the Company uses the policy wording in its denial letters.

Reference: Section 375.936, RSMo

<u>Member Number</u>	<u>Appeal Number</u>
900814011-03	RMM0504702MO
900873227-01	RMM0524312MO
901229776-01	RMM0532101MO

2. The Company’s appeal process included a second level, which allows the member’s claim to be reviewed by a panel that includes a member of the plan. GHP consistently used the same members on all the committees. By using the same members for its second level appeal process, they may develop a relationship with Company personnel which could reduce the objectivity in their decisions. Further review discovered that not all the volunteers were members of the Coventry Health and Life Insurance Company plans. GHP would often include members of the GHP Company plans to be on the committees. This does not comply with Missouri requirements for second level appeals to include members of the plan on the committee.

Reference: Sections 354.442, and 376.1385, RSMo

3. The Company refused to pre-authorize Orthotripsy (the use of strong sound waves) as treatment for Plantar Fasciitis in the following appeals. The FDA approved this treatment on August 10, 2005. The Company's original research found that the FDA had not approved this method of treatment at that time. Subsequently the treatment was approved, but the Company did not accept the FDA's approval and again denied authorization. Its latest denial letters were dated July 14, 2005, and November 17, 2005, for member 901180612-01; August 2, 2005, for Member 900830363-01 and September 8, 2005, for Member 900859198701.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Numbers</u>	<u>Appeal or Complaint Number</u>
901180612-01	RMM0530004MO & DOI0530402MO
900830363-01	RMM0519911MO
900859187-01	RMM0523601MO

4. On October 13, 2005, the Company received a request for authorization to use an artificial disc to replace one being removed due to degenerative disc disease. The FDA approved the use of the specified artificial disc on October 26, 2004. With the approval of the artificial disc, the FDA advised that the device must continue to be tested with a post-market study to determine its long-term effects. The Company has determined that the post-market study is reason to deem the disc as investigational and deny approval. The FDA used prior tests and studies to base its approval for the artificial disc and asked for input to determine what, if any, long-term effects there would be.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Numbers</u>	<u>Appeal or Complaint Number</u>
901229976-01	RMM0532101MO

5. The Company declined the following appeal to pre-certify a surgical excision of the keloid scar tissue from a wound incurred in an accident that occurred while the patient was covered by another Company. The medical records include a picture of the scar on the patient's forehead, a statement from the doctor that the patient had pain and itching and that he had tried other means to treat the problem. The notes from the Company's reviewers indicate that there were no pictures to prove that there was a scar, that there was no indication of pain or pruritus and that doctors had not attempted any other treatment. The main reasons for denial of approval were that the surgery would provide no functional improvement, was cosmetic because of the delay to request treatment approval and was not medically necessary. The policy's medical necessity definition

includes relief of pain. Because some specialists advise to wait a period-of-time prior to having surgery for this problem, the member did not have the surgery earlier. The doctor's patient records did not include a note about the pain and itching at the site but he did include this information in a letter to the Company, which would then be included in the patient records. This claim appears to be payable.

References: Sections 376.1365, 376.1382 and 376.1385, RSMo

<u>Member Numbers</u>	<u>Appeal or Complaint Number</u>
901084612-07	RMM0519302MO

6. The Company denied an exception for a final refill of Valtrax that had to be pre-authorized according to CHL. The request indicated that the refill was for an ongoing treatment plan, but the notation was overlooked during the process. The Company authorized a new treatment plan because the problem recurred during the appeal process. Since the prior insurer originally authorized the treatment plan, the Company should not have denied or delayed the subsequent refill.

References: Sections 376.441(3), and 376.1365, RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Group Number</u>
RMS0525602MO	901157874-01	6420750001

7. In the following appeal, the Company denied approval for Xanax XR 2 mg to be taken twice per day. GHP reduced the number of pills to 30 and refused to pay for the additional prescribed pills due to its internal dosage rule that allows only one pill per day. This drug is manufactured in 1mg, 2mg and 3mg doses. The doctor found that 4mg was required to treat this patient. Due to this non-contractual rule, the patient was forced to accept an inadequate dosage. The Company applies a limitation that is not specified in the contract to reduce benefit costs without regard for the health issues of the member.

References: Section 375.1007(1), RSMo

<u>Appeal Number</u>	<u>Member Number</u>	<u>Group Number</u>
RMS0522404MO	901179892-01	6410785001

8. The Company denied an exception for the following appeal for a final refill for Lamisil that CHL required to be pre-authorized. The request included a note that the refill was for an on-going treatment plan, but the notation was overlooked during the process. The Company authorized a new treatment plan after the problem recurred during the appeal

process that followed the denial. Since the prior insurer authorized the treatment plan, the Company should not then deny or delay the treatment. In addition, although the insured submitted a written appeal, the Company did not enter it into the appeal log. The member was forced to submit a written complaint to obtain the medicine.

References: Sections 376.441(3) and 376.1365, RSMo

<u>Appeal Number</u>	<u>Member Number</u>
None	90118355501

9. The Company denied the first level appeal of a request for coverage as in-network for a newly adopted child that received an injury to his head during birth. An urgent care physician examined him before travel. Coverage for an adopted baby begins at placement. Since the baby, who was born on May 2, 2005, suffered a head injury during birth, the adoptive parents, using the judgment of a prudent layperson, had a local doctor check the baby before the airplane trip home on May 6, 2005. The condition, which was not a risk while in a home setting, could have been problematic during a flight with the change in air pressure. Therefore, with the prospect of travel, the condition was more urgent than it had been in the more dormant setting at the adoption agency. The contract provides for urgent care as in-network when out of the plan's geographic area. The condition appeared to be serious enough to require urgent care in order for the parents to safely transport the baby home.

References: Sections 376.816.2(2), and 376.1367, and 376.1350(12), RSMo

<u>Appeal Number</u>	<u>Identification Number</u>	<u>Group Number</u>
RMS0530003MO	900877438-05	6415845001

10. The Company provided health insurance coverage for Group 6223567002. The group's coverage included a mental health rider. The rider failed to include benefits to cover at least two visits per contract year to establish a diagnosis. Member 900861998\*01 incurred \$170.00 of expenses for two service dates. The Company denied the claim because the policy benefits did not include the coverage.

Reference: Section 376.811.4(2), RSMo and 20 CSR 100-1.050(1)(H)

<u>Appeal Number</u>
RMS0519908MO

C. Provider Complaints

CHC-KS

1. The Company failed to pay electronic claim number 8108922, and adjusted electronic claim number 2400808284, related to a provider complaint, within 45 days from the date of original receipt. Therefore, interest was due after the 45<sup>th</sup> day from the date of claim receipt. The Company paid \$.17 during the course of the examination.

Reference: Section 376.383.5, RSMo

<u>Claim Number</u>	<u>Interest Days</u>	<u>Payment</u>	<u>Interest Paid</u>
2400808284	14	\$38.00	\$ .17

2. The Company denied reimbursement for a dose of two 20mg Adderal XR a day to equal 40mg. Coventry reduced the quantity that was approved by the prior plan for Adderal XR from 40mg to 20mg because the lower dose had been approved by the FDA and the higher 40 milligram dose was not yet approved. Coventry considered the two 20mg pills to exceed recommended limits. The provider changed the dose to 30mg as a compromise dosage but this left the patient lacking needed medication. An article about Adderal clinical trials and pharmacokinetic studies only recommends dosage up to the amount used in the trials and studies, it does not state that a doctor cannot use a larger dosage, if necessary. As the succeeding carrier, the Company did not provide the insured continuity of coverage that is usually provided when companies follow HIPPA requirements. The denial also resulted in a restriction in the member's medical treatment.

Reference: Section 376.441(3), RSMo and Bulletin 97-04

<u>Date MDI Received</u>	<u>Provider</u>	<u>Complainant</u>
02/03/03	Lakeside Pediatrics	T. Murphy

GHP

The examiners previously noted the issues for this section in the Claims Handling Section, Part 18 titled Claim Processing Issues.

V. UNCLAIMED PROPERTY

CHC-KS

CHC-KS provided a response to the examiner's questionnaire indicating its procedures with regard to handling of unclaimed property.

CHC-KS advised that 2006 was the first year that it was required to submit unclaimed property to the State.

Year Submitted	Date Submitted	Amount Submitted
2006	October 30, 2006	\$21,407.95

There were no errors noted in this review.

GHP

GHP provided a response to the examiner's questionnaire indicating its procedures with regard to handling of unclaimed property.

GHP advised that 2007 will be the first year that it is required to submit any funds to the state as unclaimed property.

There were no errors noted in this review.

VI. FORMAL REQUESTS AND CRITICISMS TIME STUDY

CHC-KS

This study is based upon the time required by CHC-KS to provide the examiners with the requested material or to respond to criticisms.

A. Criticism Time Study

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	58	100.0%

B. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	64	100.0%

GHP

This study is based upon the time required by GHP to provide the examiners with the requested material or to respond to criticisms.

C. Criticism Time Study

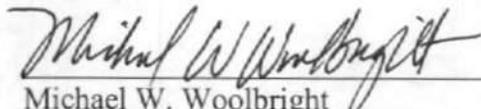
<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
0 to 10	136	100%

D. Formal Request Time Study

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
0 to 10	170	100

## VII. EXAMINATION SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Coventry Health and Life Insurance Company (NAIC #81973), Examination Number 0609-32-LAH. This examination was conducted by Michael Gibbons, Martha (Burton) Long, Wesley Arbeitman, and Walter Guller. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated October 1, 2008. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.

  
Michael W. Woolbright  
Chief Market Conduct Examiner

10/16/09  
Date