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

***In Re*:**	)	
	)	
GOOD HEALTH HMO, INC.	)	**Market Conduct Exam No. 1003-06-TGT**
d/b/a BLUE CARE (NAIC #95315)	)	

ORDER OF THE DIRECTOR

NOW, on this 3rd day of August, 2016, Director, John M. Huff, after consideration and review of the market conduct examination report of Good Health HMO, Inc. d/b/a Blue Care (NAIC #95315) (hereafter referred to as "Good Health"), report number 1003-06-TGT, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), 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 work papers, and any written submissions or rebuttals, the findings and conclusions of such report are deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4).

This order, issued pursuant to §374.205.3(4), §374.280, and §374.046.15. RSMo (Cum. Supp. 2013), is in the public interest.

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

IT IS FURTHER ORDERED that Good Health shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Good Health 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 Good Health shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of $11,000.00 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 3rd day of August, 2016.

John M. Huff
Director

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

***In Re*:**	)	
	)	
GOOD HEALTH HMO, INC.	)	**Market Conduct Exam No. 1003-06-TGT**
d/b/a BLUE CARE (NAIC #95315)	)	

STIPULATION OF SETTLEMENT AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter "the Division") and Good Health HMO, Inc. d/b/a Blue Care (NAIC #95315 (hereinafter "Good Health"), as follows:

WHEREAS, the Division is a unit of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereinafter, "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;

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

WHEREAS, the Division conducted a Market Conduct Examination of Good Health and prepared report number 1003-06-TGT; and

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

1. In forty-nine (49) instances, Good Health utilized unapproved certificate forms on ambulance benefit provisions that were inconsistent with approved forms in violation of §354.410.1 (2) [1], §354.430.3 (1) and 20 CSR 400-7.100.

2. In numerous instances, Good Health utilized unapproved certificate forms on

1 All references, unless otherwise noted, are the Missouri Revised Statutes 2000, as amended.

chiropractic service provisions that were inconsistent with approved forms in violation of §354.405.4 RSMo Supp. 2013, §354.430.2 and 20 CSR 400-7.010.

3. In fifteen (15) instances, Good Health incorrectly denied chiropractic service claims for exceeding a 26 visit limit in violation of §375.1007 (1), (3), (4) and (6), §375.1005 and §376.1230.1, RSMo Supp. 2013.

4. Good Health failed to reprocess and pay chiropractic service claims from 2006-2008 that were incorrectly denied for exceeding a 26 visit limit in violation of §375.1007 (1), (3), (4) and (6), §375.1005 and §376.1230.1, RSMo Supp. 2013.

5. In four (4) instances, Good Health misrepresented to members the reason for the denial of coverage on its explanation of benefits and failed to provide a reasonable and accurate explanation for the denial of ambulance services in violation of §375.1007 (1) and (12) and 20 CSR 100-1.020 (1) (A).

6. In nineteen (19) instances, Good Health imposed a cap on ambulance benefits in violation of §354.410.1 (2), §375.1007 (1), (3) and (4), §375.1005 and 20 CSR 400-7.100.

7. In eight (8) instances, Good Health unlawfully coordinated benefits in violation of §375.1007 (1), (3), (4) and (6), §375.1005, §354.410.1 (2) and 20 CSR 400-2.030 (2) (F) 3 F.

8. In ten (10) instances, Good Health incorrectly denied claims as duplicates when the claims were not duplicates in violation of §375.1007 (1), (3), (4) and (6) and §375.1005.

9. In ten (10) instances, Good Health allowed a provider to collect a co-payment that exceeded the 50% limitation by law, but maintained no documentation showing that the provider made a refund of the excess amount in violation of §375.1007 (3) and (4), §375.1005 and 20 CSR 100-8.040 (3) (B).

10. In numerous instances, Good Health failed to maintain adequate documentation in

its claim files to show clearly the inception, handling, and disposition of its claims in violation of §374.205.2 (2) and 20 CSR 100-8.040 (3) (B).

11. In four (4) instances, Good Health requested a refund or made an offset beyond the twelve month limitation in violation of §376.384.1(3), RSMo Supp. 2013.

12. Good Health failed to pay three (3) claims (one in which its liability was primary and two in which its liability was secondary) in violation of 20 CSR 400-2.030 (4) and (5).

13. In ten (10) instances, Good Health failed to pay interest on appealed claims in violation of §375.1007 (3) and (4), §375.1005 and §376.383.5, RSMo Supp. 2009.

WHEREAS, the Division and Good Health have agreed to resolve the issues raised in the Market Conduct Examination Report as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture embodies the entire agreement and understanding of the signatories with respect to the subject matter contained herein. The signatories hereby declare and represent that no promise, inducement or agreement not herein expressed has been made, and acknowledge that the terms and conditions of this agreement are contractual and not a mere recital.

B. **Remedial Action.** Good Health agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those remedial actions at all times, to reasonably assure that the errors noted in the above-referenced Market Conduct Examination Report do not recur. Such remedial actions shall include, but not be limited to, the following:

1. Good Health agrees to reprocess and pay all chiropractic claims that were denied between 2006 and 2008 because the member exceeded the 26 visit limitation. Interest shall be included as required by §376.383, RSMo Supp. 2009, unless the member is covered under a health

plan subject to ERISA. A letter to the member must be included with the payment, or provided to the member prior to the payment, indicating that "as a result of a Missouri Market Conduct Examination," it was found that a refund was due to the insured.

2. Good Health agrees to review all ambulance benefit claims submitted by members from January 1, 2012 to the date of the Order closing this examination that exceeded the $500 maximum. For those members whose ambulance claims exceeded the $500 benefit maximum, Good Health agrees to pay each member $450. A letter must be included with the payment, or provided to the member prior to the payment, indicating that "as a result of a Missouri Market Conduct Examination," it was found that a refund was due to the insured.

3. Good Health agrees to implement a process for complying with the requirements of 20 CSR 400-7.100 which prohibits HMOs from imposing co-payment charges that exceed 50% of the total cost of providing any single service to its enrollees. That process shall include the following: (1) providing notice to insureds on their Explanation of Benefits that the insured's responsibility for the health services provided is less than the copayment represented in the insured's plan documents and a refund from the provider may be due; (2) providing notice to contracted providers on their Remittance Advice that the insured's responsibility for the health services provided is less than the copayment represented in the insured's plan documents and a refund from the provider may be due; (3) requiring providers to make refunds to members of any copays collected in excess of 50% within 30 days of receipt of remittance advice; and (4) requiring a provider audit and corrective action when Good Health HMO, Inc. receives information that a provider may not be complying. Good Health further agrees to provide evidence that its provider contracts allow Good Health to conduct the audits referenced in this Paragraph B (3), and to amend its Provider Guide to include the procedure set out in this Paragraph B (3).

4. Good Health agrees to maintain adequate documentation, including but not limited to an explanation of benefits and a remittance advice, in its claim files to show clearly the inception, handling, and disposition of its claims pursuant to §374.205.2(2) and 20 CSR 100-8.040(3)(B).

C. **Compliance.** Good Health agrees to file documentation with the Division within 90 days of the entry of a final order of all remedial action taken to implement compliance with the terms of this Stipulation and to document the payment of restitution required by this Stipulation.

D. **Voluntary Forfeiture.** Good Health agrees, voluntarily and knowingly, to surrender and forfeit the sum of $11,000, such sum payable to the Missouri State School Fund, in accordance with §374.049, RSMo Supp. 2013 and §374.280, RSMo Supp. 2013.

E. **Other Penalties.** The Division agrees that it will not seek penalties against Good Health, other than those agreed to in this Stipulation, for the conduct found in Market Conduct Examination No. 1003-06-TGT.

F. **Waivers.** Good Health, 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, and review or appeal by any trial or appellate court, which may have otherwise applied to the above referenced Market Conduct Examination.

G. **Changes.** No changes to this Stipulation shall be effective unless made in writing and agreed to by all signatories to the Stipulation.

H. **Governing Law.** This Stipulation of Settlement and Voluntary Forfeiture shall be governed and construed in accordance with the laws of the State of Missouri.

I. **Authority.** The signatories below represent, acknowledge and warrant that they are authorized to sign this Stipulation of Settlement and Voluntary Forfeiture.

J. **Effect of Stipulation.** This Stipulation of Settlement and Voluntary Forfeiture shall not become effective until entry of a Final Order by the Director of the Department of Insurance, Financial Institutions and Professional Registration (hereinafter the "Director") approving this Stipulation.

K. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation of Settlement and Voluntary Forfeiture and ordering the relief agreed to in the Stipulation, and consent to the issuance of such Order.

DATED: 8/1/2016

Angela L. Nelson
Director, Division of Insurance
Market Regulation

DATED: 7/25/2016

Stewart Freilich
Senior Regulatory Affairs Counsel
Division of Insurance Market Regulation

DATED: 7/13/16

Danette Wilson
President & CEO
Good Health HMO, Inc.
d/b/a Blue Care

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

FINAL MARKET CONDUCT EXAMINATION REPORT

of the Health Maintenance Organization Business of

Good Health HMO d/b/a Blue-Care, Inc.

NAIC # 95315

MISSOURI EXAMINATION # 1003-06-TGT

NAIC EXAM TRACKING SYSTEM # MO341-M5

July 25, 2016

Home Office
2301 Main
Kansas City, MO 64108

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FOREWORD

This is a targeted market conduct examination report of Good Health HMO d.b.a. Blue-Care, Inc. (NAIC Code # 95315). This examination was conducted at the offices of the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). This examination report is generally a report by exception. However, failure to criticize specific practices, procedures, products or files does not constitute approval thereof by the DIFP. During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

When used in this report:

- "ACL®" refers to Audit Command Language – proprietary software;
- "Company" or "Good Health" refers to Good Health HMO d/b/a Blue-Care, Inc.;
- "COB" refers to group Coordination of Benefits;
- "CPT" refers to "Current Procedural Terminology." CPT codes are used to identify medical procedures and are published by the American Medical Association;
- "CSR" refers to the Missouri Code of State Regulations;
- "DIFP" or "Department" refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "Director" refers to the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration;
- "EOB" refers to Explanation of Benefits. A document submitted to an insured or member to explain the amount of payment and/or how a claim was processed;
- "EF" refers to Examiner Finding. A document submitted to the Company by market conduct examiners setting forth errors found in the examiners' review and requesting that the Company agree or disagree and provide an explanation of its position;
- "FR" refers to Formal Request. A document for formalized questions and/or informational requests submitted to the Company by market conduct examiners;
- "HMO" refers to Health Maintenance Organization as defined and described in chapter 354;
- "Diagnostic codes" refers to the ICD-9 (International Classification of Diseases, Ninth Revision) codes used in diagnosis for clinical purposes.
- "NAIC" refers to the National Association of Insurance Commissioners;
- "RA" refers to Remittance Advice. A document submitted to a healthcare provider to explain the amount of payment and/or how a claim was processed;
- "RSMo" refers to the Revised Statutes of Missouri. All citations are to RSMo 2000, unless otherwise specified.

SCOPE OF EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§354.465.1, 374.110, 374.190, 374.205, 375.938, and 375.1009, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and regulations and to consider whether the Company's operations are consistent with the public interest. Unless otherwise noted, the primary period covered by this review is January 1, 2006, through December 31, 2009. Errors uncovered outside the examination time period may also be included in the report. The examination was a targeted examination involving the following business functions:

- Underwriting
- Claims handling
- Complaints

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

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

This market conduct examination was performed as a desk audit at the following DIFP offices:

Harry S Truman State Office Building
301 W. High Street
Jefferson City, MO 65101

COMPANY PROFILE

Good Health HMO, Inc. is a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City. According to the records of the Missouri Secretary of State, Good Health HMO, Inc. was incorporated as a "General Business Corporation" on October 12, 1988. The name under which the Company previously conducted business, Blue-Care, Inc., was registered as a "Fictitious Name" with the Secretary of State's office on February 7, 1990. The name Blue-Care was registered as a "Fictitious Name" with the Secretary of State's office by Blue Cross and Blue Shield of Kansas City on April 20, 2009, and the Blue-Care, Inc. registration was allowed to expire effective October 17, 2009. On June 17, 2014, the Company filed a fictitious name registration for Blue-Care, and the fictitious name registration previously filed by Blue Cross and Blue Shield of Kansas City was allowed to expire effective May 5, 2014. Currently, the Company's status is listed as being in "Good Standing" and its fictitious name registration for Blue-Care is listed as "Fictitious Active" with the Secretary of State's office.

The Company is part of an "Insurance Holding Company System," within the meaning of §382.010, RSMo, along with several other subsidiaries of Blue Cross and Blue Shield of Kansas City (i.e., New Directions Behavioral Health, LLC; The EPOCH Group, LC; Preferred Health Professionals, LLC; Premier Workcomp Management, LLC; Missouri Valley Life and Health Insurance Company; and Blue-Advantage Plus of Kansas City, Inc.). The Company has entered into an agreement with Blue Cross and Blue Shield of Kansas City whereby the parent will provide all administrative services to the Company.

The Company is licensed as a health maintenance organization (HMO) in the states of Missouri and Kansas, and conducts business in an 11 county service area consisting of the Missouri counties of Andrew, Buchanan, Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray, and the Kansas counties of Johnson and Wyandotte. The Company offered its individual practices association HMO product in the individual market, the small employer market and the large employer market in Missouri during the time period covered by this examination, but the Company withdrew from the individual and small employer markets in 2013.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Good Health. The examiners found the following principal areas of concern:

- The Company used forms not as approved by the DIFP;
- The Company limited chiropractic benefits to 26 visits;
- The Company failed to adopt and implement reasonable standards for an investigation and settlement before denying chiropractic claims;
- The Company misrepresented ambulance benefits on EOBs to Members;
- The Company limited ambulance benefits to a per-trip maximum;
- The Company coordinated ambulance benefits with automobile insurance benefits;
- The Company subrogated ambulance benefits with automobile insurance benefits;
- The Company did not maintain proper documentation to verify its members received copayment refunds;
- In some instances, the Company requested refunds and offsets more than 12 months after the original Company payment;
- In some instances, the Company incorrectly processed COB claims;
- In some instances, the Company incorrectly calculated or did not apply interest payments for the re-adjudication of claims after an appeal;
- On one appeal file, the Company incorrectly submitted a claim denial remittance advice to the hospital after the Company overturned the original denial;
- The Company failed to provide three claim files requested by examiners within the time frame prescribed by law.

Examiners requested the Company make refunds concerning claim underpayments and/or interest uncovered during the examination.

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

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report is designed to provide a review of the Company's underwriting and rating practices. These practices include the use of policy forms, adherence to underwriting guidelines, assessment of premium, and procedures to decline or terminate coverage.

An error can include, but is not limited to, any miscalculation of the premium based on the information in the file, an improper acceptance or rejection of an application, misapplication of the Company's underwriting guidelines, incomplete file information preventing the examiners from readily ascertaining the Company's rating and underwriting practices, and any other activity indicating a failure to comply with Missouri statutes and regulations.

The examiners did not conduct specific reviews for compliance with Missouri statutes and regulations regarding underwriting and rating practices in this targeted examination of the Company, but noted the following underwriting and rating errors in the course of conducting other reviews.

A. Forms and Filings – Ambulance Benefit Provisions

In reviewing claim files related to emergency services, the examiners noted provisions in the issued certificate forms that placed maximum payment amounts on ambulance benefits. This prompted the examiners to conduct a review of the Company's certificate forms filed with the Department from 2007 through 2009. In this review, the examiners noted that the "Ambulance" provision in the "Benefit Schedule" (form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09) stated as follows:

> [No Copayment - $500] Air Ambulance Copayment. [*Ground Ambulance limited to $[150 – 10,000] Benefit maximum per use*]

Based upon the "Variable List" filed by the Company with the certificate form filings, the examiners understood this provision to mean:

1. The words "Air Ambulance Copayment," which are not in brackets, will always be in the "Benefit Schedule" of issued certificates since the words are not indicated as a variable.

2. The bracketed variable "[No Copayment - $500]" that precedes the non-variable words "Air Ambulance Copayment" designates the range of air ambulance copayments that will be in the "Benefit Schedule" of issued certificates.

3. The entire bracketed phrase "[*Ground Ambulance limited to $[150 – 10,000] Benefit maximum per use*]" is a variable that can either be in or out of the "Benefit Schedule" of issued certificates, and if it is in an issued certificate, the internal bracketed numbers "*[150 – 10,000]*" represent the variable range for the phrase when it is included in the "Benefit Schedule" of issued certificates.

In reviewing the issued certificates provided in response to FR 25 and FR 47, however, the examiners noted the following:

1. Forty-seven of the certificates provided in response to FR 25 that utilized "Benefit Schedule" form numbers MO-HMO-07 or MO-HMO-09 had the following in the "Ambulance" provision:

   No Copayment
   Ground Ambulance limited to $500 Benefit maximum per use

2. One of the certificates provided in response to FR 47 that utilized "Benefit Schedule" form number MO-HMO-09 (i.e., group number 10994000) had the following in the "Ambulance" provision:

   No Copayment
   Ground Ambulance limited to $5,000 Benefit maximum per use

3. One of the certificates provided in response to FR 47 that utilized "Benefit Schedule" form number MO-HMO-09 (i.e., group number 10638000) had only the words "No Copayment" in the "Ambulance" provision.

In each case, the provision used in the issued certificate differs from the provision filed and approved by the Department in that:

1. None of the issued certificates contain the words "Air Ambulance Copayment," which is required to be included in each certificate since it was not designated as a bracketed variable in the form filings.

2. All of the issued certificates contain the words "No Copayment" without the words "Air Ambulance Copayment" even though the form filings indicate this was part of the bracketed variable for the copayment range to be utilized with the non-variable "Air Ambulance Copayment" language.

By issuing certificates that are inconsistent with the forms filed and approved by the Department, it appears the Company is utilizing unapproved certificate forms contrary to the requirements of §354.405.4, §354.430.2 and 20 CSR 400-7.010.

Reference: §354.405.4, RSMo Supp. 2013, §354.430.2, RSMo, and 20 CSR 400-7.010.

Although the Department's Life and Healthcare Section approved form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09, this approval appears to have been mistaken since the terms applicable to the "Ambulance" benefit do not appear to comply with the requirements for HMOs in that:

1. If the cost sharing being imposed upon members (i.e., all amounts in excess of a cap) is not considered a copayment, the certificate forms appear to be contrary to requirements in §354.410.1(2) and 20 CSR 400-7.100 that limit member cost sharing to copayments.

2. If the cost sharing being imposed upon members is considered a copayment, which would be consistent with the definition of "copayment" in 20 CSR 400-7.150(1)(A), the certificate forms also appear to be contrary to §354.410.1(2) and 20 CSR 400-7.100 since the member cost sharing is not expressed as either a percentage or a flat dollar amount.

3. In either case, the terms applicable to the "Ambulance" benefit appear to be contrary to the requirements for an evidence of coverage in §354.430.3(1).

Reference: §§354.410.1(2) and 354.430.3(1), RSMo, and 20 CSR 400-7.100.

In response to EF 14, the Company acknowledged that it had inadvertently excluded the words "Air Ambulance" from the issued certificates, but it disagreed that differences in the certificate language referenced above constituted the use of unapproved certificate forms contrary to the requirements of §354.405.4, §354.430 and 20 CSR 400-7.010. The Company also disagreed that its certificate forms as filed were contrary to the provisions of §354.410.1(2), §354.430.3(1) and 20 CSR 400-7.100 based upon its position that ambulance benefits were not "basic health care services," so member cost sharing was not limited to copayments.

B. Forms and Filings – Chiropractic Services Provisions

Due to issues in the claim review for chiropractic services, the examiners also reviewed the "Chiropractic Services" provision in the "Benefit Schedule" of the Company's certificate form filings from 2007 through 2009 (form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09). The "Chiropractic Services" provision in these form filings stated as follows:

> [No Copayment - $80 Copayment]
> [*26 – Unlimited Calendar Year Maximum*]

As noted above, the "Variable List" filed by the Company with the certificate form filings indicates that the presence of brackets around these two phrases means that either of the phrases could be in or out of the "Benefit Schedule" of the issued certificate, and if either of the phrases is included in the "Benefit Schedule" of the issued certificate, the phrase would be within the range shown. While the phrase

"[No Copayment - $80 Copayment]" appeared clear to the examiners, since the word "Copayment" is included at both ends of the range, the phrase "[*26 – Unlimited Calendar Year Maximum*]" appeared less clear due to the lack of any additional language after the "26" at the lower end of the range. The examiners suspected the Company intended for the words "*Calendar Year Maximum*" to act as a modifier for the entire range, so they reviewed the issued certificates supplied in response to FR 25. In doing so, the examiners noted that 68 issued certificates had the following in the "Chiropractic Services" provision:

> No Copayment
> *26 visit Calendar Year Maximum*

These issued certificates appear to show the Company intended that the words "*Calendar Year Maximum*" would always appear with "26" when it issued certificates. While this could have been stated more clearly in the form filing by inserting brackets around the internal variable (i.e., "[[*26 – Unlimited*] *Calendar Year Maximum*]") the actual language used in these 68 certificates also contains the word "*visit*" that does not appear in the form filing. By issuing certificates that are inconsistent with the forms filed and approved by the Department, it appears the Company is utilizing unapproved certificate forms contrary to the requirements of §354.405.4, §354.430.2 and 20 CSR 400-7.010.

Reference: §354.405.4, RSMo Supp. 2013, §354.430.2, RSMo, and 20 CSR 400-7.010.

In addition, although the Department's Life and Healthcare Section approved form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09, this approval appears to have been mistaken since §376.1230 (as discussed below in the "Claims Practices" section) does not authorize health carriers to have such a blanket limitation on chiropractic benefits.

Reference: §376.1230, RSMo Supp. 2013, and §354.430.3(1), RSMo

The Company explained in its responses to FR 44 and EF 8 that it believed its certificate provisions and its administration of claims pursuant to those provisions were in compliance with §376.1230 based upon correspondence with the Department's Life and Healthcare Section and the Life and Healthcare Section's approval of the forms with the limitation. When the Company discovered in 2009 that the Department's interpretation of §376.1230 was different than what the Company had previously thought, it modified its processes going forward to allow more than 26 chiropractic visits within a calendar year.

II. CLAIMS PRACTICES

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

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners used ACL® to extract specific populations of claim lines from the claims data provided by the Company. Examiners then requested entire claim files for claim lines extracted. The review consisted of claims submitted, reviewed or processed between January 1, 2009, through December 31, 2009.

A claim file, as a sampling unit, is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g., §§375.1000 – 375.1018 and 375.445.1(3), RSMo) and compared with the NAIC benchmark error rate of seven percent (7%). Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to law. Errors indicating a failure to comply with laws that do not apply the general business practice standard are separately noted as errors and were not included in the error rates.

A claim error includes, but is not limited to, any of the following:

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

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

A mandated health benefit, such as chiropractic visits, must be included in the certificate of coverage. A required policy provision, such as coordination of benefits, is a regulatory requirement similar to a mandate. The person or policyholder buying the insurance coverage cannot choose to leave such benefits or provisions out of a contract.

The examiners requested separate samples of denied or closed without payment claims related to health care benefits and policy provisions mandated by Missouri law as well as certain types of paid claims. Populations of mandated health benefits were identified by using ACL® to identify claim lines with specific claim characteristics, such as CPT codes, diagnostic codes or provider type codes. While the examiners reviewed the

separate claim samples for compliance with the benefits mandated by law, they also reviewed Good Health's standard operating procedures and claim processing manuals.

A. Unfair Claims Practices – Alcoholism Treatment Benefits Denied

Sections 376.779 and 376.811, RSMo Supp. 2013, and §376.827, RSMo, require health carriers to either provide or offer to provide benefits for treatment for alcoholism. The examiners extracted 2,115 claim lines (representing 400 claim numbers) from the data supplied by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to alcohol treatment. Of the 2,115 claim lines, the examiners selected a random sample of 119 claim lines (representing 25 claim numbers) and requested copies of the claim files for the 25 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

B. Unfair Claims Practices – Cancer Screening Benefits Denied

Section 376.1250.1, RSMo, requires health carriers to provide benefits for colorectal cancer screening examinations and prostate cancer screening examinations and laboratory tests. The examiners extracted 15,021 claim lines (representing 4,380 claim numbers) from the data supplied by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to colorectal or prostate exams. Of the 15,021 claim lines, the examiners selected a random sample of 418 claim lines (representing 108 claim numbers) and requested copies of the claim files for the 108 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

C. Unfair Claims Practices – Breast Cancer Treatment Benefits Denied

Section 376.1200, RSMo, requires health carriers to offer to provide benefits for the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. The examiners extracted 2,639 claim lines (representing 767 claim numbers) from the data supplied by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to chemotherapy benefits for the treatment of breast cancer. Of the 2,639 claim lines, the examiners selected a random sample of 500 claim lines (representing 76 claim numbers) and requested copies of the claim files for the 76 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

D. Unfair Claims Practices – Childhood Immunization Benefits Denied

Section 376.1215, RSMo, requires health carriers to provide benefits for immunizations of a child from birth to five years of age. The examiners extracted 3,745 claim lines (representing 1,828 claim numbers) from the data supplied by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to childhood immunizations. Of the 3,745 claim lines, the examiners selected a random sample of 167 claim lines (representing 75 claim numbers) and requested copies of the claim files for the 75 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

E. Unfair Claims Practices – Chiropractic Benefits Denied

Section 376.1230 requires benefits for chiropractic services to be provided in health benefit plans. The examiners extracted 21,114 claim numbers (representing 38,664 claim lines) from the data provided by the Company that were indicated in the data as either being "denied" or "paid" at $0.00 and where the provider code was designated as "chiropractor" and the procedure or diagnostic codes were related to chiropractic care. From this, the examiners selected a random sample of 109 claim numbers (representing 363 claim lines) for review. After determining that the denial codes in the data for 43 claim numbers indicated that the claims appeared to have been properly denied, the examiners requested copies of the claim files for the remaining 66 claim numbers for review.

Field Size:	21,114
Sample Size:	109
Type of Sample	Random
Number of Errors:	15
Error Ratio:	13.8%

The examiners noted the following errors during their review:

1. Section 376.1230, RSMo Supp. 2013, requires health carriers to provide their members with coverage for up to 26 chiropractic office visits per policy period without obtaining a prior authorization. For visits after the 26th, the statute allows a health carrier to require "prior authorization or notification" in order to make a determination as to medical necessity; however, the statute does not permit the limitation of benefits to 26 visits if proof of medical necessity is provided.

   In reviewing the sample claim files, the examiners noted that 15 claims for chiropractic services had been denied because the member had exceeded the maximum number of chiropractic visits allowed. Denial of chiropractic visits in excess of 26 without allowing or considering prior authorization requests by the

member for additional visits is inconsistent with §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013.

Reference: §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013

In response to EF 8, the Company disagreed that its processing of the 15 claims was contrary to §375.1007 and §376.1230.1. As noted above in the "Underwriting and Rating Practices" section, he Company explained that it believed its certificate provisions and its administration of claims pursuant to those provisions were in compliance with §376.1230 based upon correspondence with the Department's Life and Healthcare Section and the Life and Healthcare Section's approval of the forms with the limitation. In September 2009, the Company noted what it termed a "change" in the Department's interpretation of §376.1230 in the market conduct examination report of another HMO, so the Company said it made a "business decision to update its chiropractic benefits, effective January 1, 2009." This involved a change to the Company's claim processing system to allow more than 26 chiropractic visits and a Company "initiative" to "reprocess claims with 2009 dates of service that had been processed prior to the system change." The Company acknowledged that its reprocessing efforts had failed to identify 11 of the 15 claim numbers, and it reprocessed and paid these 11 claim numbers during the course of the examination. The Company declined to pay the remaining four of the 15 claim numbers, however, because their dates of service were prior to 2009.

2. The examiners requested and received from the Company listings of (1) all the claims the Company reprocessed and paid as a result of the 2009 "initiative," and (2) all of the chiropractic claims the Company had denied due to the member exceeding the maximum number of visits in the 2006 through 2009 examination time period. Analysis of this information revealed the following:

   - The Company only reprocessed and paid 22 claim numbers (representing 56 claims lines) as a result of its 2009 "initiative";

   - Of the 5,506 denied claim numbers (representing 14,455 claim lines) in the 2006 through 2009 listing provided by the Company, 1,047 claim numbers had 2009 dates of service.

   - The remaining 4,459 claim numbers had dates of service in 2006 through 2008.

   In EF 9 and EF 10, the examiners criticized the Company for (1) failing to correctly process these 5,506 claim numbers when the claims were first presented, (2) failing to reprocess and pay all 1,047 claim numbers with 2009 dates of service as part of its 2009 "initiative," and (3) failing to reprocess and pay the 4,459 claim numbers with 2006 through 2008 dates of service after learning of the

Department's interpretation of §376.1230 in 2009. In response to EF 9 and EF 10, the Company disagreed with the examiners and reiterated its belief that its actions were reasonable based upon its communications with the Department. The Company reprocessed and paid, with interest, the remaining denied claims with 2009 dates of service during the course of the examination, but it declined to reprocess and pay the declined claims with dates of service from 2006 through 2008.

The Company is required to interpret its certificate and administer claims for benefits under its certificate in a manner consistent with Missouri law as indicated in the certificate's "Conformity with State Laws" provision. When the Company learned in 2009 of its mistake in processing chiropractic claims, it should have taken steps necessary to remedy the situation. The Company's inadequate investigation and reprocessing of denied claims with 2009 dates of service and its refusal to take any action with regard to denied claims with dates of service from 2006 through 2008 appear to be the type of claims settlement practices prohibited by §375.1007(1), (3), (4) and (6), RSMo, and contrary to the requirements of §376.1230.1, RSMo Supp. 2013.

Reference: §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013

F. Unfair Claims Practices – Complications of Pregnancy Benefits Denied

Section 375.995.4(6), RSMo, prohibits health carriers from treating complications of pregnancy differently than any other illness or sickness. The examiners extracted 17,131 claim lines (representing 3,039 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to complications of pregnancy. Of the 17,131 claim lines, the examiners selected a random sample of 378 claim lines (representing 105 claim numbers) and requested copies of the claim files for the 105 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

G. Unfair Claims Practices – Contraceptive Benefits Denied

Section 376.1199.1(4), RSMo Supp. 2011, requires health carriers to provide benefits for contraceptives unless an enrollee requests that such coverage not be included in their plan. The examiners extracted 192 claim lines (representing 137 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to contraceptives. Of the 192 claim lines, the examiners selected a random sample of 47 claim lines (representing 25 claim numbers) and requested copies of the claim files for the 25 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

H. Unfair Claims Practices – Application of Deductibles

The examiners extracted 398 claim numbers from the data provided by the Company that were identified in the data as having deductibles applied to the claims of HMO members. A random sample of 82 claim numbers (representing 225 claim lines) was selected, and copies of the claim files were requested for review.

The examiners found no exceptions during their review.

I. Unfair Claims Practices – Diabetes Benefits Denied

Section 376.385, RSMo, requires health carriers to provide benefits for equipment, supplies and training for the treatment of diabetes. The examiners extracted 13,604 claim lines (representing 5,215 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to diabetes tests and equipment. Of the 13,604 claim lines, the examiners selected a random sample of 326 claim lines (representing 107 claim numbers) and requested copies of the claim files for the 107 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

J. Unfair Claims Practices – Emergency Room and Ambulance Benefits Denied

Emergency medical services are required as part of the "basic health care services" provided by HMOs. In addition, §376.1367, RSMo, requires health carriers to provide benefits for emergency services in managed care plans. The examiners extracted 4,558 claim numbers (representing 4,983 claim lines) from the data provided by the Company that were identified in the data as being "denied" and where the procedure and diagnostic codes were related to emergency room and ambulance services. From the 4,558 claim numbers, the examiners extracted 108 claim numbers (representing 440 claim lines) and requested copies of the claim files for the 108 claims numbers to review for errors in claim processing.

Field Size:	4,558
Sample Size:	108
Type of Sample	Random
Number of Errors:	4
Error Ratio:	3.7%

The examiners noted the following errors during their review.

The explanation given on the EOBs for the denial of some of the claim lines for ambulance services in four claim files was that, "The annual maximum allowed has

been met." In reviewing the corresponding benefit certificates for these four claim numbers, however, the examiners noted that there was no annual maximum benefit limitation for ambulance services, only a $500.00 benefit maximum for each use of ambulance services. Accordingly, the reason for denial given conflicted with the terms of the members' benefit certificates. Providing members with inaccurate explanations for denial of claims that conflict with provisions of their benefit certificates appears to be the type of conduct prohibited by §375.1007(1) and (12), RSMo, and 20 CSR 100-1.020(1)(A).

Reference: §375.1007(1) and (12), 20 CSR 100-1.020(1)(A) and 20 CSR 100-1.010(1)(C).1

In response to EF 4, the Company agreed that the EOB language did not reflect the manner in which ambulance benefits were processed, but it noted that the benefit certificates did accurately describe the benefits and the claim system processed the claims in accordance with the described benefits. The Company indicated that 1,681 of the claim lines for ambulance services in the 2009 claims data provided the examiners had a disposition code that would generate this inaccurate EOB message, but it stated that it would update the EOB language to accurately reflect the benefits in the certificate.

K. Unfair Claims Practices – Ambulance Benefits Paid, Denied or Adjusted

Due to the observed benefit maximums being placed on ambulance services by the Company, the examiners determined that an additional review of ambulance claims should be conducted. The examiners extracted 1,159 claim numbers (representing 4,134 claim lines) from the data provided by the Company with disposition codes of TR2 ("The charge exceeds the covered amount for the service") or TR3 ("Covered Amount greater than Service allowed amount plus related history amount") and a "Place of Service" code of 41 ("Ambulance – Land"). Because the examiners noted that the extracted claim numbers all fell within one of four categories, they selected for review a sample of 103 claims (i.e., the original claim numbers and all adjustments) as follows: (1) the single claim in "Category 1 – Claims Paid at more than $500"; (2) a random sample of 15 claims in "Category 2 – Claims Paid at $500,"; (3) all 26 of the claims in "Category 3 – Claims Paid at less than $500 and more than $0.00"; and (4) all 61 of the claims in "Category 4 – Claims Paid at $0.00."

Field Size:	1159
Sample Size:	103
Type of Sample	Stratified
Number of Errors:	37
Error Ratio:	36%

The examiners noted the following errors during their review.

1. **Category 1 – Claims Paid at more than $500**

According to the Company's response to FR 41, the single claim in this category was initially paid at $500 and subsequently re-adjudicated to pay billed charges. The Company's response indicated the re-adjudication was due to a "benefit exception . . . granted by Company management, [but the] related documentation for this exception was not retained due to clerical error."

As noted above in the "Underwriting and Rating Practices" section, the imposition of a cap for ambulance benefits when this claim was initially adjudicated appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. As indicated in the certificate's "Conformity with State Laws" provision, the Company is required to interpret its certificate and administer claims for benefits under its certificate in a manner consistent with Missouri law. Consequently, the Company's application of a benefit cap when this claim was first adjudicated appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4). While the Company corrected the initial adjudication when it granted a "benefit exception," it failed to maintain adequate documentation of the basis for this "exception" in its claim file as required by §374.205.2(2) and 20 CSR 100-8.040(3)(B). A failure to adopt or implement claim processing standards that appropriately document claim files as required by Missouri law appears to be the type of claim settlement practice prohibited by §375.1007(3).

Reference: §§354.410.1(2), 374.205.2(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

In the Company's response to EF 14, it disagreed that its initial imposition of a cap in processing this claim for ambulance benefits was contrary to §354.410.1(2), §375.1007(1), (3) and (4), and 20 CSR 400-7.100 based upon its position that ambulance benefits were not "basic health care services," so member cost sharing was not limited to copayments. The Company also disagreed that its failure to maintain documentation of the benefit exception for this claim was contrary to the requirements of §374.205.2(2), §375.1007(3), and 20 CSR 100-8.040(3)(B) since this merely represented a single "clerical error" on the Company's part.

2. **Category 2 – Claims Paid at $500**

The Company limited the per-trip benefit to $500 when processing all 15 claims in this category. Again, the imposition of a cap for ambulance benefits when these claims were adjudicated appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100, and the adjudication of these claims in a manner inconsistent with Missouri law appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4). In addition, the amount of cost sharing being imposed upon the member in one of the claims exceeded the 50%

limitation in 20 CSR 400-7.100, which also appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4).

Reference: §§354.410.1(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

The Company's response regarding these 15 claims in EF 14 reiterated its disagreement with the examiners' criticism for the same reasons noted above.

3. **Category 3 – Claims Paid as less than $500 and more than $0**

In reviewing the 26 claims in this category to respond to FR 41, the Company noted that manual processing errors for three of the claims had resulted in payments for the claims in an amount less than the $500 per trip cap specified in the certificate. The Company's response to FR 41 indicated these errors were "based on the inaccurate reflection of a provider discount from the claim's billed charge."

The Company stated that it would re-adjudicate and pay these three claims with interest in its response to FR41, but the re-adjudication would still impose the $500 per trip cap that appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. Consequently, both the Company's initial adjudication of these claims and its subsequent re-adjudication appear to be the type of claims settlement practices prohibited by §375.1007(1), (3) and (4).

Reference: §§354.410.1(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

The Company's response regarding these three claims in EF 14 reiterated its disagreement with the examiners' criticism for the same reasons noted above.

4. **Category 4 – Claims paid at $0**

Of the 61 claims in this category, the examiners noted errors in the processing of the following 18 claims.

A. Claims incorrectly denied as duplicates and re-adjudicated during the course of the examination: In its response to FR 41, the Company indicated that it had found five claims that had been incorrectly denied as duplicates. The Company explained that these errors were due to multiple ambulance trips being provided on the same date of service for the same member to different locations. The Company stated that it would re-adjudicate and pay these five claims with interest in its response to FR41; however, the Company's initial denial of these claims as duplicates when they were not appears to be the type of claims settlement practice prohibited by §375.1007(1), (3), (4) and (6).

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

The Company's response to this criticism in EF 14 expressed the Company's belief that its processing of these five claims did not constitute violations of §375.1007(1), (3), (4) and (6).

B. Claims incorrectly denied as duplicates and re-adjudicated prior to the examination: Information provided by the Company in response to FR 41 indicated that five claims had been initially denied as duplicates, but the Company subsequently re-adjudicated and paid all five claims prior to the examination. In re-adjudicating and paying these claims, however, a $500 per trip cap was applied to the claims resulting in member cost sharing for all but one of the claims that was inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. Additionally, the member cost sharing for two of the claims exceeded the 50% limitation in 20 CSR 400-7.100. The Company's actions in processing these five claims appeared to the examiners to be the kind of claims settlement practices prohibited by §375.1007(1), (3), (4) and (6).

Reference: §§354.410.1(2) and 375.1007(1), (3), (4) and (6), RSMo, and 20 CSR 400-7.100.

As with the five claims noted above, the Company's response to this criticism in EF 14 again expressed the Company's belief that its processing of these five claims did not constitute violations of §375.1007(1), (3), (4) and (6).

C. Claims for which the Company received refunds from providers due to payment by automobile insurance: In the Company's written response to FR 41, the reasons given for no payment on eight claims were either "Unsolicited refund received – Automobile insurance primary" or "Provider request – Automobile insurance primary." Two potential sources of automobile insurance payments that could pay for the medical expenses of the Company's members are:

1. *Medical payments coverage ("Med-Pay Coverage") of the policy covering the automobile in which the member was the driver or passenger*: Under Missouri's "Group Coordination of Benefits" regulation, 20 CSR 400-2.030, health carriers are not permitted to coordinate benefits with Med-Pay Coverage for Missouri residents covered under group health plans due to the exclusion of Med-Pay Coverage provided under "traditional automobile fault contracts" written on an individual basis from the definition of "plan" in 20 CSR 400-2.030(2)(F)3.F.

2. *Bodily injury liability coverage of the policy covering the automobile of a driver other than the member who was at-fault in the accident*: Payments for medical expenses under the bodily injury liability coverage of the at-

fault driver represent compensatory damages that the at-fault driver would be required to pay in response to a tort claim by the Company's member. In addition to this type of insurance coverage not being listed in the definition of "plan" in the "Group Coordination of Benefits" regulation, the regulation also makes it clear that a health carrier may not reduce its benefits by amounts received under bodily injury liability insurance coverage in the prohibition against subrogation contained in 20 CSR 400-2.030(6)(D)3.

In reviewing the claim files for three of the eight claims, the examiners noted documentation indicating that the source of the funds received by the ambulance provider that prompted it to refund money to the Company was Med-Pay Coverage. As such, these funds should have been sent to the Company's member, who was the one entitled to the benefits under the Med-Pay Coverage. By receiving and retaining money attributable to Med-Pay Coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have effectively coordinated its benefits with Med-Pay Coverage in a manner inconsistent with the provisions of 20 CSR 400-2.030(2)(F)3.F. As a result, the Company's actions in processing these three claims appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

In reviewing the claim file for one of the eight claims, examiners noted an EOB from an automobile insurance carrier indicating that payment was made to the ambulance provider under coverage identified as "ABI Auto Bodily Injury." As such, these funds should have been sent to the Company's member, who was the one entitled to the amounts paid under the bodily injury liability coverage provided by the at-fault driver's automobile insurance. By receiving and retaining money attributable to bodily injury liability coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have effectively coordinated its benefits with and subrogated its claim to compensatory damages for a tort claim paid by bodily injury liability coverage in a manner inconsistent with the provisions of 20 CSR 400-2.030(2)(F) and 20 CSR 400-2.030(6)(D)3. As a result, the Company's actions in processing this claim appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

The examiners review of the claim files for four of the eight claims indicated that the source of the funds paid to the ambulance providers that prompted their refund to the Company was automobile insurance, but none of the four files contained any documentation indicating whether this was Med-Pay

Coverage or bodily injury liability coverage. Regardless, these funds should have been sent to the Company's member, who was the one entitled to the amounts paid under either Med-Pay Coverage or the bodily injury liability coverage provided by the at-fault driver's automobile insurance. By receiving and retaining money attributable to either Med-Pay Coverage or bodily injury liability coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have processed these four claims in a manner inconsistent with the provisions of 20 CSR 400-2.030. As a result, the Company's actions in processing these four claims appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

In response to the above criticisms in EF 14, the Company disagreed with the examiners' findings stating that:

- The Company processed the claim, and paid the full extent of ambulance benefits per the certificate to the ambulance provider as is required by §190.205.1, RSMo.

- The Company did not seek to coordinate benefits with another carrier, nor did it engage in any subrogation activity as was referenced by examiners in relation to 20 CSR 400-2.030(6)(D)3. Unsolicited by the Company, the provider refunded or requested the Company recoup amounts it had previously paid. This provider request was based on what would appear to be the receipt of payments in excess of billed charges resulting from its simultaneous billing of the Company and an auto carrier.

L. Unfair Claims Practices – Hospital Dental Anesthesia Benefits Denied

Section 376.1225, RSMo, requires health carriers to provide benefits for general anesthesia and hospital charges for dental care for covered persons under the age of five or who are severely disabled. The examiners extracted 30 claim lines (representing 30 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to hospital dental anesthesia benefits. Of the 30 claim lines, the examiners selected a random sample of eight claim lines (representing eight claim numbers) and requested copies of the claim files for the eight claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

M. Unfair Claims Practices – Lead Testing Benefits Denied

Section 376.1290, RSMo Supp. 2013, requires health carriers to provide benefits for lead poisoning tests for pregnant women. The examiners extracted 123 claim lines (representing 54 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to lead testing benefits. Of the 123 claim lines, the examiners selected a random sample of six claim lines (representing three claim numbers) and requested copies of the claim files for the three claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

N. Unfair Claims Practices – Mammography Benefits Denied

Section 376.782, RSMo, requires health carriers to provide benefits for low-dose mammography screenings. The examiners extracted 1,404 claim lines (representing 1,268 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to mammograms. Of the 1,404 claim lines, the examiners selected a random sample of 280 claim lines (representing 83 claim numbers) and requested copies of the claim files for the 83 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

O. Unfair Claims Practices – Mental Health Benefits Denied

Section 376.1550, RSMo Supp. 2013, requires health carriers to provide benefits for mental health conditions and prohibits health carriers from treating benefits for mental health conditions differently than benefits for physical health conditions. The examiners extracted 7,959 claim lines (representing 4,288 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to mental health. Of the 7,959 claim lines, the examiners selected a random sample of 153 claim lines (representing 108 claim numbers) and requested copies of the claim files for the 108 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

P. Unfair Claims Practices – Newborn Hearing Screening Benefits Denied

Section 376.1220, RSMo, requires health carriers to provide benefits for newborn hearing screenings, necessary rescreening, audiological assessment and follow-up and initial amplification. The examiners extracted 10 claim lines (representing four claim numbers) from the data provided by the Company that were identified in the data as

being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to newborn hearing screenings. Copies of the claim files for the four claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

Q. Unfair Claims Practices – Osteoporosis Benefits Denied

Section 376.1199.1(3), RSMo Supp. 2011, requires health carriers to provide benefits for the covered services related to diagnosis, treatment and appropriate management of osteoporosis. The examiners extracted 230 claim lines (representing 132 claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to osteoporosis benefits. Of the 230 claim lines, the examiners selected a random sample of 59 claim lines (representing 25 claim numbers) and requested copies of the claim files for the 25 claim numbers to review for errors in claim processing.

The examiners found no exceptions during their review.

R. Unfair Claims Practices – PKU Benefits Denied

Section 376.1219, RSMo Supp. 2013, requires health carriers to provide benefits for the treatment of phenylketonuria or any inherited disease of amino and organic acids. The examiners extracted eight claim lines (representing seven claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to PKU benefits. Copies of the claim files for the seven claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

S. Unfair Claims Practices – Denied due to a Pre-existing Condition

The examiners extracted three claim numbers from the data provided by the Company where the disposition code used by the Company indicated that the denial may have been related to a pre-existing condition. Copies of the claim files for the three claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

T. Unfair Claims Practices – Bone Marrow Transplant Testing Benefits Denied

Section 376.1275, RSMo Supp. 2013, requires health carriers to provide benefits for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The

examiners extracted two claim lines (representing two claim numbers) from the data provided by the Company that were identified in the data as being "denied" or "paid" at $0.00 and where the CPT codes or diagnostic codes were related to antigen testing benefits. Copies of the claim files for the two claim numbers were then requested and reviewed for errors in claim processing.

The examiners found no exceptions during their review.

U. Unfair Claims Practices – Copayments

Regulation 20 CSR 400-7.100 prohibits HMOs from "impos[ing] copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees." The Company's process for complying with the 50% of the cost of any single service copayment limitation of 20 CSR 400-7.100 is as follows:

1. When a claim is submitted, the Company's Facets claim processing system has the capability to identify claims where the standard copayment is greater than 50% of the total cost of providing any single service.
2. When Facets identifies a claim impacted by the 50% copay rule, the claim is then manually priced and the appropriate copayment is applied to the claim.
3. An EOB is sent to the member and a RA is sent to the provider to inform both the member and the provider of the appropriate copayment.
4. Within 30 days of receipt of payment for the claim from the Company, the provider is required (pursuant to its provider contract with the Company) to refund any amount it collected in excess of the appropriate copayment.

This process prompted a recommendation in the Company's previous market conduct examination report that, "The Company should have some process in place to monitor whether or not providers that collect copayments in excess of 50% of any single service make the necessary refunds to members." In an effort to follow up on this recommendation, the examiners requested information from the Company regarding what steps it had taken since the time of the last examination. The Company explained it had taken the following steps:

2009: The Company selected a sample of 56 claims from 2008 where the standard copayment exceeded 50% for "six key provider groups represented on the Company's Practice Manager's Advisory Committee ("PMAC") and the top fifty non-PMAC provider groups" and contacted the providers to verify the status of any refunds. For five of the 56 claims (8.93%), the providers indicated that refunds were either not made prior to the call (four of the claims) or the necessary refund could not be confirmed due to archiving of records by the provider (one of the claims).

2010: The Company identified the top 50 providers by potential copayment refunds for 2009 claims and sent them a letter and summary claims report requesting that they review their patient accounts to make sure all appropriate refunds were made. Unlike the 2009 review of 2008 claims, however, the Company did not otherwise contact

providers to verify that refunds were made. In addition to the letters, the Company added information regarding copayment refunds to its "Provider Office Guide," EOBs and provider remittance advice forms in 2010.

2011: The Company expanded its letter and 2010 summary claims report communication to all providers rather than just the top 50. In addition, a survey was sent out to providers in December 2011 inquiring about their copayment refund processes.

In order to conduct a review of the Company's handling of claims where the scheduled copayment exceeded 50%, the examiners requested a listing of any and all claims from Missouri providers or Missouri enrollees that were submitted, reviewed or processed between 1/1/2009 and 12/31/2009 where the standard copayment applicable to the claim exceeded 50% of the total cost of providing any single service. The Company provided a listing that contained claim lines for 96,620 claim numbers submitted under HMO contracts issued in Missouri. From these 96,620 claim numbers, the examiners extracted a sample of 87 claim numbers and requested copies of the claim files for review.

Field Size:	96,620
Sample Size:	87
Type of Sample	Random
Number of Errors:	83
Error Ratio:	95%

The examiners noted the following errors in this review.

The examiners noted that the Company's calculation of the applicable copayment under the 50% limitation appeared to be correct for all 87 claim numbers. In reviewing the documentation in these claim files, however, the examiners noted the following:

1. The documentation in the claim files for 14 of the claim numbers showed an amount collected from the member by the provider. The claim files for 10 of these 14 claim numbers showed an amount collected by the provider that exceeded the 50% copayment limitation, but there was no documentation in the file showing that the provider had made a refund of the excess amount.
2. The claim files for the remaining 73 claim numbers in the sample did not contain any documentation of the copayment amount collected by the provider, nor did the files document a refund of any excess collected.

Section 374.205.2(2), requires insurers to maintain claim files for examination purposes. What constitutes a complete claim file for examination purposes is set forth in 20 CSR 100-8.040(3)(B). This regulation provides that:

> The claim file shall be maintained so as to show clearly the inception, handling, and disposition of each claim. The claim file(s) shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

The claim files for 83 claim numbers out of the 87 claim number sample did not appear to comply with these requirements in that:

1. Seventy-three of the claims did not have sufficient documentation to show what, if any, copayment was collected by the provider at the time of service.
2. Eighty- three of the claims did not have sufficient documentation to show the final disposition of the claim, including any refund of excess copayments collected.

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040(3)(B)

As noted above, the Company's procedures for processing claims do not require it to secure and maintain documentation in its claim files of the handling and refund of copayments by providers. In 83 of the 87 claim numbers in the sample, this failure to maintain such documentation resulted in both the examiners and the Company being unable to verify the handling and disposition of the claims contrary to the claim file documentation requirements of §374.205.2(2) and 20 CSR 100-8.040(3)(B). By establishing a process that fails to comply with the claim file documentation requirements of Missouri law, it appears to the examiners the Company's actions relative to the 83 claim numbers are the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §§375.1007(3) and 375.1007(4), RSMo.

In response to EF7, the Company disagreed with the examiners' criticism above on the basis that:

1. The Company's claim files were appropriately documented since it did not believe it had a responsibility to have a system in place to monitor provider's collection or refund of copayments.
2. Because the Company believed its claim files were appropriately documented, its processing of these 83 claims was not contrary to §375.1007(3) and (4).

V. Unfair Claims Practices – Refund Requests and Offsets

As stated in §376.384.1(3), RSMo Supp. 2013, an HMO may "not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider." To test for compliance with this claim processing requirement, the examiners extracted 554 claim numbers from the data provided by the Company where an adjustment to the claim had occurred more than 365 days after initial payment. Of the 554, the examiners selected a

random sample of 83 claim numbers and requested information from the Company as to whether the subsequent adjustment of the claims had involved a refund or offset.

Field Size:	554
Sample Size:	83
Type of Sample	Random
Number of Errors:	4
Error Ratio:	4.8%

The examiners noted the following errors in their review.

In reviewing the information provided by the Company for the 83 claim numbers, the examiners noted that the documentation for four of the claim numbers appeared to show that the Company had requested a refund or made an offset beyond the 12 month limitation in §376.384.1(3). The Company agreed in its response to EF 5 that it had requested a refund or made an offset against these four claim numbers more than 12 months after its initial payment of the claims and indicated it would reprocess and pay the claims. Although the Company made refunds with interest for these four claim numbers during the course of the examination, its processing of these four claims in a manner inconsistent with §376.384.1(3) appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §375.1007(3) and (4), RSMo, and §376.384.1(3), RSMo Supp. 2013

W. Unfair Claims Practices – Coordination of Benefit Denied

Under Missouri's "Group Coordination of Benefits" regulation, 20 CSR 400-2.030, health carriers are permitted to coordinate benefits with any other insurance coverage that meets the definition of a "plan" in 20 CSR 400-2.030(2)(F). To test for compliance with this claim processing requirement, examiners extracted 92,035 claim numbers from the data provided by the Company that were identified in the data as being either "Primary" or "Secondary" and the claim status was marked as "denied". Of the 92,035 claim numbers, the examiners selected a random sample of 86 claim numbers and requested copies to the claim files for review.

Field Size:	92,035
Sample Size:	86
Type of Sample	Random
Number of Errors:	3
Error Ratio:	3.5%

The examiners noted the following errors in their review:

In response to EF 3, the Company agreed that it had failed to pay three claims (one in which its liability was primary and two in which its liability was secondary) due to manual processing errors. The Company reprocessed and paid these three claims

with interest during the course of the examination, but its initial failure to correctly process these three claims in accordance with 20 CSR 400-2.030 prior to the examination appears to by the type of claims settlement practice prohibited by §375.1007(4), RSMo.

Reference: §375.1007(4), RSMo, and 20 CSR 400-2.030(4) and (5)

III. COMPLAINTS

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

A. Maintenance of Complaint Register

Section 375.936(3), RSMo, and 20 CSR 100-8.040(3)(D) require companies to maintain a register of all written complaints received for at least the last three years. The register must include all Missouri complaints, including those sent to the DIFP and those sent directly to the Company. HMOs are also required to maintain a register of complaints that constitute "grievances" pursuant to §§354.445 and 376.1375, RSMo, and 20 CSR 400-7.110(3).

Examiners verified the Company's complaint registry, dated January 1, 2006 through December 31, 2009. The registry contained a total of 63 complaints submitted directly to the DIFP and 1,793 Company complaints which it received directly from members or other interested parties.

The examiners found no errors regarding complaint register maintenance.

B. Handling of DIFP Complaints

Examiners requested copies of the complaint files for the 63 complaints filed directly with the DIFP and reviewed the Company's handling of these complaints. This included a review of the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint.

The examiners found no errors during their review of DIFP complaint files.

C. Handling of Direct Complaints

The examiners selected a random sample of 113 complaints/grievances from the listing of 1,793 complaints/grievances that the Company received directly and requested copies of the complaint files for review.

The examiners found the following errors in their review:

1. In reviewing complaint/grievance files in which a claim denial was overturned upon appeal, the examiners noted that some reprocessed claims appeared to contain incorrect interest payments. In some instances, the interest payments were less than required. In some, instances the interest payments were missing.

In response to EF 1, the Company agreed that interest payments had been incorrectly calculated for 10 appealed claims. The Company explained that this was due to manual processing errors by its appeals department staff. To alleviate such errors, the Company indicated that it had changed its processes in 2010 and transferred the responsibility for adjusting claims related to appeals to its operations staff whose primary duty was claims processing.

The Company reprocessed and paid interest on the 10 appealed claims during the course of the examination. Its failure to have processes in place to pay interest on these appealed claims as required by §376.383.5, RSMo Supp. 2009, however, appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §375.1007(3) and (4), RSMo, and §376.383.5, RSMo Supp. 2009

2. In one complaint/grievance file, the Company had initially denied claims filed by a surgeon and a hospital on the basis that the procedure being provided was "investigational" in nature. The surgeon appealed the denial and provided medical literature indicating the procedure was appropriate and medically necessary for the member's condition when other therapies had failed. The Company agreed with the surgeon's position and reprocessed and paid the surgeon's claim with interest. The hospital's claim, however, was not reprocessed and paid, so it continued to be denied.

   In response to EF 2, the Company agreed that the hospital's claim had been incorrectly processed. As with the complaint/grievance files noted above, the Company explained that this was due to manual processing errors by its appeals department staff, which it had addressed through a change in its processes for adjusting appealed claims. The Company's failure to have processes in place to properly adjust such denied claims upon appeal, however, appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

   Reference: §375.1007(3) and (4), RSMo.

IV. EXAMINER FINDINGS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to examiner findings. Missouri statutes and regulations require companies to respond to examiner findings and formal requests within 10 calendar days. Please note, in the event an extension of time was requested by the Company and granted by the examiners, the response was deemed timely if it was received within the time frame granted by the examiners. If the response was not received within the allotted time, the response was not considered timely.

A. Examiner Findings Time Study

Number of Calendar Days to Respond	Number of Findings	Percentage of Total
0 to 10 days	4	29%
Over 10 days with extension	10	71%
Over 10 days without extension	0	0%
Totals	14	100%

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	2	4%
Over 10 days with extension	51	94%
Over 10 days without extension	1	2%
Totals	54	100%

The Company was unable to provide complete documentation for three claim files requested in FR 46. In response to EF 13, the Company indicated this was due to technical issues with its imaging system.

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

EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Good Health HMO, Inc. d/b/a Blue Care (NAIC #95315), Examination Number 1003-06-TGT. This examination was conducted by John Korte, John Clubb, Rita Heimericks-Ash, Mike Woolbright and Kembra Springs. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated November 12, 2014. 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.

7/25/15
Date

Jim Mealer
Chief Market Conduct Examiner

Kansas City
2301 Main Street Kansas City, MO 64108 • (816) 395-2222 • BlueKC.com

February 26, 2015

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DEPT OF INSURANCE,
FINANCIAL INSTITUTIONS &
PROFESSIONAL REGISTRATION

Mr. Stewart Freilich
Senior Regulatory Affairs Counsel
Department of Insurance Financial Institutions and Professional Registration
P.O. Box 690
Jefferson City, MO 65102

RE: Missouri Market Conduct Examination #1003-06-TGT
Good Health HMO, Inc. d/b/a Blue Care (NAIC #95315)

Mr. Freilich:

Attached please find the Company's response to the items noted in the Missouri Department of Insurance, Financial Institutions and Professional Registration ("DIFP") draft Market Conduct Examination report received by the Company on November 21, 2014.

Instances in which examiners noted exceptions in the draft DIFP report have been excerpted and included in the Company's response. While the DIFP draft report generally summarized the Company's response to examiner findings, complete responses to the exceptions contained in the draft report have been provided in an effort to provide readers with additional context.

As requested in your correspondence dated November 18, 2014, you will receive an electronic copy of the Company's response via e-mail, as well as a hard copy. We look forward to working with you to resolve any outstanding questions and to conclude this exam.

Sincerely,

Brian Spicer
Director of Audit Services

Cc: Coni Fries, BCBSKC

Enclosures: *Attachment A – 20030904 DIFP Letter from Kembra Springs*
Attachment B – 20100310 Letter to Carolyn Kerr

Blue Cross and Blue Shield of Kansas City is an independent licensee of the Blue Cross and Blue Shield Association

DIFP Report: Item I.A Forms and Filings - Ambulance Benefit Provisions

In reviewing claim files related to emergency services, the examiners noted provisions in the issued certificate forms that placed maximum payment amounts on ambulance benefits. This prompted the examiners to conduct a review of the Company's certificate forms filed with the Department from 2007 through 2009. In this review, the examiners noted that the "Ambulance" provision in the "Benefit Schedule" (form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09) stated as follows:

> *[No Copayment - $500] Air Ambulance Copayment. [Ground Ambulance limited to $[150 - 10,000] Benefit maximum per use]*

Based upon the "Variable List" filed by the Company with the certificate form filings, the examiners understood this provision to mean:

1. *The words "Air Ambulance Copayment," which are not in brackets, will always be in the "Benefit Schedule" of issued certificates since the words are not indicated as a variable.*

2. *The bracketed variable "[No Copayment - $500]" that precedes the non-variable words "Air Ambulance Copayment" designates the range of air ambulance copayments that will be in the "Benefit Schedule" of issued certificates.*

3. *The entire bracketed phrase "[Ground Ambulance limited to $[150 - 10,000] Benefit maximum per use]" is a variable that can either be in or out of the "Benefit Schedule" of issued certificates, and if it is in an issued certificate, the internal bracketed numbers "[150 - 10,000]" represent the variable range for the phrase when it is included in the "Benefit Schedule" of issued certificates.*

In reviewing the issued certificates provided in response to FR 25 and FR 47, however, the examiners noted the following:

1. *Forty-seven of the certificates provided in response to FR 25 that utilized "Benefit Schedule" form numbers MO-HMO-07 or MO-HMO-09 had the following in the "Ambulance" provision:*

   > *No Copayment*
   > *Ground Ambulance limited to $500 Benefit maximum per use*

2. *One of the certificates provided in response to FR 47 that utilized "Benefit Schedule" form number MO-HMO-09 (i.e., group number 10994000) had the following in the "Ambulance" provision:*

   > *No Copayment*
   > *Ground Ambulance limited to $5,000 Benefit maximum per use*

3. *One of the certificates provided in response to FR 47 that utilized "Benefit Schedule" form number MO-HMO-09 (i.e., group number 10638000) had only the words "No Copayment" in the "Ambulance" provision.*

In each case, the provision used in the issued certificate differs from the provision filed and approved by the Department in that:

1. *None of the issued certificates contain the words "Air Ambulance Copayment," which is required to be included in each certificate since it was not designated as a bracketed variable in the form filings.*

2. *All of the issued certificates contain the words "No Copayment" without the words "Air Ambulance Copayment" even though the form filings indicate this was part of the bracketed variable for the copayment range to be utilized with the non-variable "Air Ambulance Copayment" language.*

By issuing certificates that are inconsistent with the forms filed and approved by the Department, it appears the Company is utilizing unapproved certificate forms contrary to the requirements of §354.405.4, §354.430.2 and 20 CSR 400-7.010.

Reference: §354.405.4, RSMo Supp. 2013, §354.430.2, RSMo, and 20 CSR 400-7.010.

Although the Department's Life and Healthcare Section approved form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09, this approval appears to have been mistaken since the terms applicable to the "Ambulance" benefit do not appear to comply with the requirements for HMOs in that:

1. *If the cost sharing being imposed upon members (i.e., all amounts in excess of a cap) is not considered a copayment, the certificate forms appear to be contrary to requirements in §354.410.1(2) and 20 CSR 400-7.100 that limit member cost sharing to copayments.*

2. *If the cost sharing being imposed upon members is considered a copayment, which would be consistent with the definition of "copayment" in 20 CSR 400-7.150(l)(A), the certificate forms also appear to be contrary to §354.410.1(2) and 20 CSR 400-7.100 since the member cost sharing is not expressed as either a percentage or a flat dollar amount.*

3. *In either case, the terms applicable to the "Ambulance" benefit appear to be contrary to the requirements for an evidence of coverage in §354.430.3(1).*

Reference: §§354.410.1(2) and 354.430.3(1), RSMo, and 20 CSR 400-7.100.

In response to EF 14, the Company acknowledged that it had inadvertently excluded the words "Air Ambulance" from the issued certificates, but it disagreed that differences in the certificate language referenced above constituted the use of unapproved certificate forms contrary to the requirements of §354.405.4, §354.430 and 20 CSR 400-7.010. The Company also disagreed that its certificate forms as filed were contrary to the provisions of §354.410.1(2), §354.430.3(1) and 20 CSR 400-7.100 based upon its position that ambulance benefits were not "basic health care services," so member cost sharing was not limited to copayments.

Company Response: Item I.A Forms and Filings - Ambulance Benefit Provisions

The Company continues to respectfully *disagree* with the examiner's finding that differences in the certificate language referenced represent its utilization of unapproved certificate forms contrary to the requirements of §354.405.4, §354.430 and 20 CSR 400-7.010.

The Company believes a correct accounting of this finding would indicate 34 certificates were impacted by a production error, not 49. Examiners identified 49 certificates, counting multiple certificates more than one time because this finding was based on claims which shared common certificates (i.e., same group, product, time period). The Company disagrees with the examiner finding for the following reasons:

- **No impact to claim processing:**
  While the Company acknowledges that the words "Air Ambulance" were inadvertently excluded within the Benefit Schedule section of 34 unique certificates and regrets this clerical oversight, it did not represent a change in coverage from the certificate filed with the Department. Despite the omission of "Air Ambulance" in the Benefit Schedule of the certificates identified, the subsequent detailed description of covered services related to "Ambulance Services" clearly articulates that any copayment indicated is applicable to air ambulance:

  > *You must pay an Ambulance Copayment for each usage of an air Ambulance if indicated in the Benefit Schedule.*

  Further, this clerical issue did not impact member claim payments.

- **Missouri statutes defining basic health care services do not include emergency services such as ambulance:**
  The Company also continues to respectfully *disagree* with the examiner's assertion that ambulance benefits are part of "basic health care services".

  Ambulance services are deemed to be "emergency services", as set forth in Chapter 190. RSMo. Section 354.415.1(b)(6) provides that "the powers of a health maintenance organization include, but are not limited to, the power to...offer, in addition to basic health care services...indemnity benefits covering out-of-area or emergency services". Thus, Missouri statutes specifically provide that "emergency services" are not "basic health care services", because HMO's are permitted to offer "emergency services" *in addition to* "basic health care services."

  Member liability for ambulance service is an amount that exceeds a specific maximum for benefits, and is therefore the member's responsibility. While the DIFP correctly notes, per 20 CSR 400-7.100, that "copayments shall be the only allowable charge, other than premiums" for basic health care services, Missouri law indicates that ambulance service is not included within "basic health care services", as such term is defined in RSMo. 354.100(1). Therefore, copayments and premiums are not the only allowable charge for ambulance services. As specified in the Certificate of Coverage (approved by DIFP), the "Out-of-Pocket Maximum does not include...any amount that exceeds a specific maximum for Benefits". Member liability for ambulance service is an amount that exceeds a specific maximum for benefits, and is therefore the member's responsibility (although not a deductible, copayment or coinsurance, as noted by the DIFP) and is not included as part of the member's Out-of-Pocket Maximum.

- **The Company relied on numerous DIFP approvals of the ambulance benefit:** Finally, the Company respectfully submits that the Department's Life and Health Section approved certificates containing the same ambulance benefit language on multiple occasions, approximately 10 times over the last 15 years. The Company believes it was entitled to rely upon these approved certificates. Furthermore, the Company's product premium rates were based on the approved benefit limits, and consumers received the benefits described and approved by the DIFP.

DIFP Report: Item I.B Forms and Filings – Chiropractic Services Provisions

Due to issues in the claim review for chiropractic services, the examiners also reviewed the "Chiropractic Services" provision in the "Benefit Schedule" of the Company's certificate form filings from 2007 through 2009 (form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09). The "Chiropractic Services" provision in these form filings is stated as follows:

> *[No Copayment - $80 Copayment]*
> *[26 - Unlimited Calendar Year Maximum]*

As noted above, the "Variable List" filed by the Company with the certificate form filings indicates that the presence of brackets around these two phrases means that either of the phrases could be in or out of the "Benefit Schedule" of the issued certificate, and if either of the phrases is included in the "Benefit Schedule" of the issued certificate, the phrase would be within the range shown. While the phrase "[No Copayment - $80 Copayment]" appeared clear to the examiners, since the word "Copayment" is included at both ends of the range, the phrase "[26 – Unlimited Calendar Year Maximum]" appeared less clear due to the lack of any additional language after the "26" at the lower end of the range. The examiners suspected the Company intended for the words "Calendar Year Maximum" to act as a modifier for the entire range, so they reviewed the issued certificates supplied in response to FR 25. In doing so, the examiners noted that 68 issued certificates had the following in the "Chiropractic Services" provision:

> *No Copayment*
> *26 visit Calendar Year Maximum*

These issued certificates appear to show the Company intended that the words "Calendar Year Maximum" would always appear with "26" when it issued certificates. While this could have been stated more clearly in the form filing by inserting brackets around the internal variable (i.e., "[[26 - Unlimited] Calendar Year Maximum]") the actual language used in these 68 certificates also contains the word "visit" that does not appear in the form filing. By issuing certificates that are inconsistent with the forms filed and approved by the Department, it appears the Company is utilizing unapproved certificate forms contrary to the requirements of §354.405.4, §354.430.2 and 20 CSR 400-7.010.

Reference: §354.405.4, RSMo Supp. 2013, §354.430.2, RSMo, and 20 CSR 400-7.010.

In addition, although the Department's Life and Healthcare Section approved form numbers MO-HMO-07, MO-HMO-08 and MO-HMO-09, this approval appears to have been mistaken since §376.1230 (as discussed below in the "Claims Practices" section) does not authorize health carriers to have such a blanket limitation on chiropractic benefits.

Reference: §376.1230, RSMo Supp. 2013, and §354.430.3(1), RSMo

The Company explained in its responses to FR 44 and EF 8 that it believed its certificate provisions and its administration of claims pursuant to those provisions were in compliance with §376.1230 based upon correspondence with the Department's Life and Healthcare Section and the Life and Healthcare Section's approval of the forms with the limitation. When the Company discovered in 2009 that the Department's interpretation of §376.1230 was different than what the Company had previously thought, it modified its processes going forward to allow more than 26 chiropractic visits within a calendar year.

Company Response: Item I.B Forms and Filings – Chiropractic Services Provisions

The Company acknowledges inadvertent errors in the bracketing of phrases and the omission of the word "visit" within the certificate form filings of MO-HMO-07, MO-HMO-08, and MO-HMO-09 and regrets this clerical oversight. However, the Company respectfully *disagrees* with the examiner's finding that the certificates issued were unapproved and did not comply with §376.1230.1 RSMo. for the following reasons:

- **The Company relied on DIFP guidance:**
  The Company based its chiropractic claim benefit on communications with Kembra Springs, Insurance Product Analysis II, Life & Health Section dated September 4, 2003. The communication was previously supplied to examiners, as an attachment to the Company's Formal Request 35 response and again in Examiner Finding 8–Attachment 1, and is separately attached again to this response as "**Attachment A**". The letter states in part:

  > *"...The fact that coverage of 26 visits is expressed as a minimum expectation of the law appears to distinguish what must be covered by the carrier (without imposition of any prior authorization or notification requirements) from what the carrier may chose (sic.) to provide in addition to the mandated coverage or benefits (and for which the carrier may require prior authorization or notice)."*

- **The Company relied on DIFP approvals:**
  The Company respectfully submits that the Department's Life and Health Section approved certificates it filed containing the same chiropractic benefit language on multiple occasions, approximately 10 times over the last 12 years. Despite the DIFP's own characterization of having approved the certificate forms as a "mistake" within this finding, the Company believes it was entitled to rely upon these 10 approved certificates and that any subsequent change in the Department's perspective with regard to its chiropractic benefit structure does not represent a finding for which the Company would be held responsible.

- **No issues in prior Market Conduct Exams:**
  The DIFP 2003-2005 Good Health HMO Market Conduct Examination report contained no mention of issues with respect to the Company's certificates, benefit structure, or processing of chiropractic claims.

- **Good faith by the Company:**
  During September 2009, the Company decided to update its chiropractic benefits, effective January 1, 2009, based on a change in the DIFP's interpretation of

§376.1230.1 indicated in the DIFP Market Conduct Examination report of another Missouri HMO insurer.

The Company prospectively changed its claim processing system and undertook an initiative to reprocess claims with 2009 dates of service that had been processed prior to the system change.

Missouri consumers received the benefits described in their certificates and approved by the DIFP.

DIFP Report: Item II.E Unfair Claims Practices – Chiropractic Benefits Denied

Section 376.1230 requires benefits for chiropractic services to be provided in health benefit plans. The examiners extracted 21,114 claim numbers (representing 38,664 claim lines) from the data provided by the Company that were indicated in the data as either being "denied" or "paid" at $0.00 and where the provider code was designated as "chiropractor" and the procedure or diagnostic codes were related to chiropractic care. From this, the examiners selected a random sample of 109 claim numbers (representing 363 claim lines) for review. After determining that the denial codes in the data for 43 claim numbers indicated that the claims appeared to have been properly denied, the examiners requested copies of the claim files for the remaining 66 claim numbers for review.

Field Size:	*21,114*
Sample Size:	*109*
Type of Sample	*Random*
Number of Errors:	*15*
Error Ratio:	*13.8%*

The examiners noted the following errors during their review:

1. *Section 376.1230, RSMo Supp. 2013, requires health carriers to provide their members with coverage for up to 26 chiropractic office visits per policy period without obtaining a prior authorization. For visits after the 26th, the statute allows a health carrier to require "prior authorization or notification" in order to make a determination as to medical necessity; however, the statute does not permit the limitation of benefits to 26 visits if proof of medical necessity is provided.*

   In reviewing the sample claim files, the examiners noted that 15 claims for chiropractic services had been denied because the member had exceeded the maximum number of chiropractic visits allowed. Denial of chiropractic visits in excess of 26 without allowing or considering prior authorization requests by the member for additional visits is inconsistent with §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013.

   Reference: §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013

   In response to EF 8, the Company disagreed that its processing of the 15 claims was contrary to §375.1007 and §376.1230.1. As noted above in the "Underwriting and Rating Practices" section, the Company explained that it believed its certificate provisions and its administration of claims pursuant to those provisions were in

compliance with §376.1230 based upon correspondence with the Department's Life and Healthcare Section and the Life and Healthcare Section's approval of the forms with the limitation. In September 2009, the Company noted what it termed as a "change" in the Department's interpretation of §376.1230 in the market conduct examination report of another HMO, so the Company said it made a "business decision to update its chiropractic benefits, effective January 1, 2009." This involved a change to the Company's claim processing system to allow more than 26 chiropractic visits and a Company "initiative" to "reprocess claims with 2009 dates of service that had been processed prior to the system change." The Company acknowledged that its reprocessing efforts had failed to identify 11 of the 15 claim numbers, and it reprocessed and paid these 11 claim numbers during the course of the examination. The Company declined to pay the remaining four of the 15 claim numbers, however, because their dates of service were prior to 2009.

2. *The examiners requested and received from the Company listings of (1) all the claims the Company reprocessed and paid as a result of the 2009 "initiative," and (2) all of the chiropractic claims the Company had denied due to the member exceeding the maximum number of visits in the 2006 through 2009 examination time period. Analysis of this information revealed the following:*

   - *The Company only reprocessed and paid 22 claim numbers (representing 56 claims lines) as a result of its 2009 "initiative";*
   - *Of the 5,506 denied claim numbers (representing 14.455 claim lines) in the 2006 through 2009 listing provided by the Company, 1,047 claim numbers had 2009 dates of service.*
   - *The remaining 4,459 claim numbers had dates of service in 2006 through 2008.*

   In EF 9 and EF 10, the examiners criticized the Company for (1) failing to correctly process these 5,506 claim numbers when the claims were first presented, (2) failing to reprocess and pay all 1,047 claim numbers with 2009 dates of service as part of its 2009 "initiative," and (3) failing to reprocess and pay the 4,459 claim numbers with 2006 through 2008 dates of service after learning of the Department's interpretation of §376.1230 in 2009. In response to EF 9 and EF 10, the Company disagreed with the examiners and reiterated its belief that its actions were reasonable based upon its communications with the Department. The Company reprocessed and paid, with interest, the remaining denied claims with 2009 dates of service during the course of the examination, but it declined to reprocess and pay the declined claims with dates of service from 2006 through 2008.

   The Company is required to interpret its certificate and administer claims for benefits under its certificate in a manner consistent with Missouri law as indicated in the certificate's "Conformity with State Laws" provision. When the Company learned in 2009 of its mistake in processing chiropractic claims, it should have taken steps necessary to remedy the situation. The Company's inadequate investigation and reprocessing of denied claims with 2009 dates of service and its refusal to take any action with regard to denied claims with dates of service from 2006 through 2008 appear to be the type of claims settlement practices prohibited by §375.1007(1), (3), (4) and (6), RSMo, and contrary to the requirements of §376.1230.1, RSMo Supp. 2013.

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Good Health HMO, Inc. d/b/a Blue Care (NAIC #95315)

Reference: §375.1007(1), (3), (4) and (6), RSMo, and §376.1230.1, RSMo Supp. 2013

Company Response: Item II.E Unfair Claims Practices – Chiropractic Benefits Denied

As previously stated, the Company respectfully *disagrees* with the examiner's finding that the certificates issued were unapproved and did not comply with §376.1230.1 RSMo. for the following reasons:

- **The Company relied on DIFP guidance:**
  The Company based its chiropractic claim benefit on communications with Kembra Springs, Insurance Product Analysis II, Life & Health Section dated September 4, 2003. The communication was previously supplied to examiners, as an attachment to the Company's Formal Request 35 response and again in Examiner Finding 8-Attachment 1, and is separately attached again to this response as "**Attachment A**". The letter states in part:

  "...The fact that coverage of 26 visits is expressed as a minimum expectation of the law appears to distinguish what must be covered by the carrier (without imposition of any prior authorization or notification requirements) from what the carrier may chose (sic.) to provide in addition to the mandated coverage or benefits (and for which the carrier may require prior authorization or notice)."

- **The Company relied on DIFP approvals:**
  The Company respectfully submits that the Department's Life and Health Section approved certificates it filed containing the same chiropractic benefit language on multiple occasions, approximately 10 times over the last 12 years. Despite the DIFP's own characterization of having approved the certificate forms as a "mistake" within this finding, the Company believes it was entitled to rely upon these 10 approved certificates and that any subsequent change in the Department's perspective with regard to its chiropractic benefit structure does not represent a finding for which the Company would be held responsible.

- **No issues in prior Market Conduct Exams:**
  The DIFP 2003-2005 Good Health HMO Market Conduct Examination report contained no mention of issues with respect to the Company's processing of chiropractic claims.

- **Good faith by the Company:**
  During September 2009, the Company decided to update its chiropractic benefits, effective January 1, 2009, based on a change in the DIFP's interpretation of §376.1230 indicated in the DIFP Market Conduct Examination report of another Missouri HMO insurer.

  The Company prospectively changed its claim processing system and undertook an initiative to reprocess claims with 2009 dates of service that had been processed prior to the system change. Unfortunately, the query to identify 2009 claims did not capture all information necessary for the Company to reprocess claims in accordance with the decision. As such, 11 of the 15 claims were reprocessed by the Company during 2012 in accordance with its effort to fully execute the 2009 decision.

Four claims were not part of the Company's chiropractic claim reprocessing effort because the dates of service were prior to the effective date of the revised chiropractic benefit.

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  The Company also respectfully *disagrees* with the examiner finding that the 15 claims referenced constituted an unfair claims practice under §375.1007(1), (3), and (6), RSMo.

  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo. which provides:

  "It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

  (1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

  (2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

  The Company believes its actions *do not* meet the terms of §375.1005, RSMo. based on the same facts outlined with respect to §376.1230 above, specifically:

  - The Company based its chiropractic claim benefit on communications with Kembra Springs, Insurance Product Analysis II, Life & Health Section dated September 4, 2003 (**Attachment A**).
  - The Company's chiropractic benefits were clearly stated in member certificates subsequently reviewed and approved in filings to the DIFP over multiple years; and
  - The 2003-2005 DIFP Market Conduct Examination report contained no mention of issues with respect to the Company's processing of chiropractic claims.

  As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

  Furthermore, the Company's actions were not consistent with §375.1007(1), (3), (4), and (6). With respect to the specific elements of §375.1007, RSMo identified by examiners:

  (1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

  As previously indicated, the Company *did not* misrepresent relevant facts or policy provisions relating to chiropractic benefits. Member certificates in effect during the exam period (2006-2009), which included chiropractic benefits, were filed with the DIFP and approved numerous times. These certificates clearly stated that the

member's benefits for chiropractic services were limited to 26 visits. The Company provided the DIFP approved certificates in its response to Formal Request 40.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company clearly adjudicated the claims and applied chiropractic benefits, as approved by the DIFP, consistent with the member's certificate.

The Company in fact did have reasonable standards for the prompt investigation and settlement of claims arising under its policies, as is evidenced by the timely adjudication of these claims in accordance with the member certificate and clear communication of the claim's disposition to the member and provider. Although the Company's effort to investigate and reprocess chiropractic claims with dates of service in 2009 was incomplete, deficiencies in the query criteria reflect human error in the development and execution of the decision to provide greater benefits than were stipulated in the member's certificate. They do not represent a failure to implement reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

The Company's original processing of these claims was consistent with DIFP approvals and guidance, and member certificates. The Company's 2009 decision to re-adjudicate chiropractic claims clearly demonstrates that the Company acted in "good faith" to effectuate prompt, fair and equitable settlement of claims.

As noted immediately above, deficiencies in the Company's query criteria reflect human error in the development and execution of the decision.

(6) Refusing to pay claims without conducting a reasonable investigation;

As noted immediately above, deficiencies in the Company's query criteria reflect human error in the development and execution of the decision to provide greater benefits than were stipulated in the member's certificate. They do not represent a refusal to pay claims without conducting a reasonable investigation.

DIFP Report: Item II.J Unfair Claims Practices – Emergency Room and Ambulance Benefits Denied

Emergency medical services are required as part of the "basic health care services" provided by HMOs. In addition, §376.1367, RSMo, requires health carriers to provide benefits for emergency services in managed care plans. The examiners extracted 4,558 claim numbers (representing 4,983 claim lines) from the data provided by the Company that were identified in the data as being "denied" and where the procedure and diagnostic codes were related to emergency room and ambulance services. From the 4,558 claim numbers, the examiners extracted 108 claim numbers (representing 440 claim lines) and requested copies of the claim files for the 108 claims numbers to review for errors in claim processing.

Field Size:	*4,558*
Sample Size:	*108*

Type of Sample	*Random*
Number of Errors:	*4*
Error Ratio:	*3.7%*

The examiners noted the following errors during their review.

The explanation given on the EOBs for the denial of some of the claim lines for ambulance services in four claim files was that, "The annual maximum allowed has been met." In reviewing the corresponding benefit certificates for these four claim numbers, however, the examiners noted that there was no annual maximum benefit limitation for ambulance services, only a $500.00 benefit maximum for each use of ambulance services. Accordingly, the reason for denial given conflicted with the terms of the members' benefit certificates. Providing members with inaccurate explanations for denial of claims that conflict with provisions of their benefit certificates appears to be the type of conduct prohibited by §375.1007(1) and (12), RSMo, and 20 CSR 100-1.020(1)(A).

Reference: §375.1007(1) and (12), 20 CSR 100-1.020(1)(A) and 20 CSR 100-1.010(1)(C).1

In response to EF 4, the Company agreed that the EOB language did not reflect the manner in which ambulance benefits were processed, but it noted that the benefit certificates did accurately describe the benefits and the claim system processed the claims in accordance with the described benefits. The Company indicated that 1,681 of the claim lines for ambulance services in the 2009 claims data provided to the examiners had a disposition code that would generate this inaccurate EOB message, but it stated that it would update the EOB language to accurately reflect the benefits in the certificate.

Company Response: Item II.J Unfair Claims Practices – Emergency Room and Ambulance Benefits Denied

The Company *agrees* that the Explanation of Benefit (EOB) language did not reflect the manner in which ambulance benefits were processed. However, the member certificates clearly and accurately described the benefits as required by §375.1007(1), and the Company's claim processing system was correctly configured to provide ambulance benefits as stated in the member certificate.

The Company regularly reviews explanatory language used in member EOBs; however, this particular message, associated with a single disposition code, did not convey actual benefits adjudicated with the clarity the Company intends to provide.

The Company updated the EOB language associated with the disposition code to more accurately align it with the member benefits stated in the certificates.

Missouri consumers received the benefits described in the certificates which were approved by the DIFP.

DIFP Report: Item II.K Unfair Claims Practices – Ambulance Benefits Paid, Denied, or Adjusted

Due to the observed benefit maximums being placed on ambulance services by the Company, the examiners determined that an additional review of ambulance claims should be conducted. The examiners extracted 1,159 claim numbers (representing 4,134 claim lines) from the data provided by the Company with disposition codes of TR2 ("The charge

exceeds the covered amount for the service") or TR3 ("Covered Amount greater than Service allowed amount plus related history amount") and a "Place of Service" code of 41 ("Ambulance Land"). Because the examiners noted that the extracted claim numbers all fell within one of four categories, they selected for review a sample of 103 claims (i.e., the original claim numbers and all adjustments) as follows: (1) the single claim in "Category 1 Claims Paid at more than $500"; (2) a random sample of 15 claims in "Category 2 - Claims Paid at $500,"; (3) all 26 of the claims in "Category 3 - Claims Paid at less than $500 and more than $0.00"; and (4) all 61 of the claims in "Category 4 - Claims Paid at $0.00."

Field Size:	*1159*
Sample Size:	*103*
Type of Sample	*Stratified*
Number of Errors:	*37*
Error Ratio:	*36%*

The examiners noted the following errors during their review.

1. ***Category 1 - Claims Paid at more than $500***

   According to the Company's response to FR 41, the single claim in this category was initially paid at $500 and subsequently re-adjudicated to pay billed charges. The Company's response indicated the re-adjudication was due to a "benefit exception ... granted by Company management, [but the] related documentation for this exception was not retained due to clerical error."

   As noted above in the "Underwriting and Rating Practices" section, the imposition of a cap for ambulance benefits when this claim was initially adjudicated appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. As indicated in the certificate's "Conformity with State Laws" provision, the Company is required to interpret its certificate and administer claims for benefits under its certificate in a manner consistent with Missouri law. Consequently, the Company's application of a benefit cap when this claim was first adjudicated appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4). While the Company corrected the initial adjudication when it granted a "benefit exception," it failed to maintain adequate documentation of the basis for this "exception" in its claim file as required by §374.205.2(2) and 20 CSR 100-8.040(3)(B). A failure to adopt or implement claim processing standards that appropriately document claim files as required by Missouri law appears to be the type of claim settlement practice prohibited by §375.1007(3).

   Reference: §§354.410.1(2), 374.205.2(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

   In the Company's response to EF 14, it disagreed that its initial imposition of a cap in processing this claim for ambulance benefits was contrary to §354.410.1(2), §375.1007(1), (3) and (4), and 20 CSR 400-7.100 based upon its position that ambulance benefits were not "basic health care services," so member cost sharing was not limited to copayments. The Company also disagreed that its failure to maintain documentation of the benefit exception for this claim was contrary to the requirements of §374.205.2(2), §375.1007(3), and 20 CSR 100- 8.040(3)(B) since this merely represented a single "clerical error" on the Company's part.

2. *Category 2 - Claims Paid at $500*

The Company limited the per-trip benefit to $500 when processing all 15 claims in this category. Again, the imposition of a cap for ambulance benefits when these claims were adjudicated appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100, and the adjudication of these claims in a manner inconsistent with Missouri law appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4). In addition, the amount of cost sharing being imposed upon the member in one of the claims exceeded the 50% limitation in 20 CSR 400-7.100, which also appears to be the type of claims settlement practice prohibited by §375.1007(1), (3) and (4).

Reference: §§354.410.1(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

The Company's response regarding these 15 claims in EF 14 reiterated its disagreement with the examiners' criticism for the same reasons noted above.

3. *Category 3 - Claims Paid as less than $500 and more than $0*

In reviewing the 26 claims in this category to respond to FR 41, the Company noted that manual processing errors for three of the claims had resulted in payments for the claims in an amount less than the $500 per trip cap specified in the certificate. The Company's response to FR 41 indicated these errors were "based on the inaccurate reflection of a provider discount from the claim's billed charge."

The Company stated that it would re-adjudicate and pay these three claims with interest in its response to FR41, but the re-adjudication would still impose the $500 per trip cap that appears to be inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. Consequently, both the Company's initial adjudication of these claims and its subsequent re-adjudication appear to be the type of claims settlement practices prohibited by §375.1007(1), (3) and (4).

Reference: §§354.410.1(2) and 375.1007(1), (3) and (4), RSMo, and 20 CSR 400-7.100.

The Company's response regarding these three claims in EF 14 reiterated its disagreement with the examiners' criticism for the same reasons noted above.

4. *Category 4 - Claims paid at $0*

Of the 61 claims in this category, the examiners noted errors in the processing of the following 18 claims.

A. *<u>Claims incorrectly denied as duplicates and re-adjudicated during the course of the examination:</u> In its response to FR 41, the Company indicated that it had found five claims that had been incorrectly denied as duplicates. The Company explained that these errors were due to multiple ambulance trips being provided on the same date of service for the same member to different locations. The Company stated that it would re-adjudicate and pay these five claims with interest in its response to FR41;*

however, the Company's initial denial of these claims as duplicates when they were not appears to be the type of claims settlement practice prohibited by §375.1007(1), (3), (4) and (6).

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

The Company's response to this criticism in EF 14 expressed the Company's belief that its processing of these five claims did not constitute violations of §375.1007(1), (3), (4) and (6).

B. *<u>Claims incorrectly denied as duplicates and re-adjudicated prior to the examination:</u> Information provided by the Company in response to FR 41 indicated that five claims had been initially denied as duplicates, but the Company subsequently re-adjudicated and paid all five claims prior to the examination. In re-adjudicating and paying these claims, however, a $500 per trip cap was applied to the claims resulting in member cost sharing for all but one of the claims that was inconsistent with the requirements of §354.410.1(2) and 20 CSR 400-7.100. Additionally, the member cost sharing for two of the claims exceeded the 50% limitation in 20 CSR 400-7.100. The Company's actions in processing these five claims appeared to the examiners to be the kind of claims settlement practices prohibited by §375.1007(1), (3), (4) and (6).*

Reference: §§354.410.1(2) and 375.1007(1), (3), (4) and (6), RSMo, and 20 CSR 400-7.100.

As with the five claims noted above, the Company's response to this criticism in EF 14 again expressed the Company's belief that its processing of these five claims did not constitute violations of §375.1007(1), (3), (4) and (6).

C. *<u>Claims for which the Company received refunds from providers due to payment by automobile insurance:</u> In the Company's written response to FR 41, the reasons given for no payment on eight claims were either "Unsolicited refund received -- Automobile insurance primary" or "Provider request - Automobile insurance primary." Two potential sources of automobile insurance payments that could pay for the medical expenses of the Company's members are:*

1. *Medical payments coverage ("Med-Pay Coverage") of the policy covering the automobile in which the member was the driver or passenger: Under Missouri's "Group Coordination of Benefits" regulation, 20 CSR 400-2.030, health carriers are not permitted to coordinate benefits with MedPay Coverage for Missouri residents covered under group health plans due to the exclusion of Med-Pay Coverage provided under "traditional automobile fault contracts" written on an individual basis from the definition of "plan" in 20 CSR 400-2.030(2)(F)3.F.*

2. *Bodily injury liability coverage of the policy covering the automobile of a driver other than the member who was at-fault in the accident: Payments for medical expenses under the bodily injury liability coverage of the at-fault driver represent compensatory damages that the at-fault driver would be required to pay in response to a tort claim by the Company's member. In addition to this type of insurance coverage not being listed in the definition of "plan" in the "Group Coordination of Benefits" regulation, the regulation also makes it clear that a*

health carrier may not reduce its benefits by amounts received under bodily injury liability insurance coverage in the prohibition against subrogation contained in 20 CSR 400-2.030(6)(D)3.

In reviewing the claim files for three of the eight claims, the examiners noted documentation indicating that the source of the funds received by the ambulance provider that prompted it to refund money to the Company was Med-Pay Coverage. As such, these funds should have been sent to the Company's member, who was the one entitled to the benefits under the MedPay Coverage. By receiving and retaining money attributable to Med-Pay Coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have effectively coordinated its benefits with Med-Pay Coverage in a manner inconsistent with the provisions of 20 CSR 400-2.030(2)(F)3.F. As a result, the Company's actions in processing these three claims appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

In reviewing the claim file for one of the eight claims, examiners noted an EOB from an automobile insurance carrier indicating that payment was made to the ambulance provider under coverage identified as "ABI Auto Bodily Injury." As such, these funds should have been sent to the Company's member, who was the one entitled to the amounts paid under the bodily injury liability coverage provided by the at-fault driver's automobile insurance. By receiving and retaining money attributable to bodily injury liability coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have effectively coordinated its benefits with and subrogated its claim to compensatory damages for a tort claim paid by bodily injury liability coverage in a manner inconsistent with the provisions of 20 CSR 400-2.030(2)(F) and 20 CSR 400-2.030(6)(D)3. As a result, the Company's actions in processing this claim appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

The examiners review of the claim files for four of the eight claims indicated that the source of the funds paid to the ambulance providers that prompted their refund to the Company was automobile insurance, but none of the four files contained any documentation indicating whether this was Med-Pay Coverage or bodily injury liability coverage. Regardless, these funds should have been sent to the Company's member, who was the one entitled to the amounts paid under either Med-Pay Coverage or the bodily injury liability coverage provided by the at-fault driver's automobile insurance. By receiving and retaining money attributable to either Med-Pay Coverage or bodily injury liability coverage, using these amounts to offset its claim liability, and issuing EOBs indicating that it was coordinating benefits on the claim, the Company appears to have processed these four claims in a manner inconsistent with the provisions of 20 CSR 400-2.030. As a result, the Company's actions in processing these four claims appear to be the type of conduct prohibited by §375.1007(1), (3) and (4).

Reference: §375.1007(1), (3) and (4), RSMo, and 20 CSR 400-2.030.

In response to the above criticisms in EF 14, the Company disagreed with the examiners' findings stating that:

- *The Company processed the claim, and paid the full extent of ambulance benefits per the certificate to the ambulance provider as is required by §190.205.1, RSMo.*

- *The Company did not seek to coordinate benefits with another carrier, nor did it engage in any subrogation activity as was referenced by examiners in relation to 20 CSR 400- 2.030(6)(D)3. Unsolicited by the Company, the provider refunded or requested the Company recoup amounts it had previously paid. This provider request was based on what would appear to be the receipt of payments in excess of billed charges resulting from its simultaneous billing of the Company and an auto carrier.*

Company Response: Item II.K Unfair Claims Practices – Ambulance Benefits Paid, Denied, or Adjusted

The Company respectfully *disagrees* with the examiner's assertion that ambulance benefits are part of "basic health care services", as was previously noted in Item I.A.

- **Missouri statutes defining basic health care services do not include emergency services such as ambulance:**
  Ambulance services are deemed to be "emergency services", as set forth in Chapter 190. RSMo. Section 354.415.1(b)(6) provides that "the powers of a health maintenance organization include, but are not limited to, the power to...offer, in addition to basic health care services...indemnity benefits covering out-of-area or emergency services". Thus, Missouri statutes specifically provide that "emergency services" are not "basic health care services", because HMO's are permitted to offer "emergency services" *in addition to* "basic health care services."

- **Ambulance services are not subject to basic health care services regulations:**
  Member liability for ambulance service is an amount that exceeds a specific maximum for benefits, and is therefore the member's responsibility. While the DIFP correctly notes, per 20 CSR 400-7.100, that "copayments shall be the only allowable charge, other than premiums" for basic health care services, Missouri law indicates that ambulance service is not included within "basic health care services", as such term is defined in RSMo. 354.100(1). Therefore, copayments and premiums are not the only allowable charge for ambulance services. As specified in the Certificate of Coverage (approved by DIFP), the "Out-of-Pocket Maximum does not include...any amount that exceeds a specific maximum for Benefits". Member liability for ambulance service is an amount that exceeds a specific maximum for benefits, and is therefore the member's responsibility (although not a deductible, copayment or coinsurance, as noted by the DIFP) and is not included as part of the member's Out-of-Pocket Maximum.

- **The Company relied on numerous DIFP approvals of the ambulance benefit:**
  Finally, the Company respectfully submits that the Department's Life and Health Section approved certificates containing the same ambulance benefit language on multiple occasions, approximately 10 times over the last 15 years. The Company believes it was entitled to rely upon these approved certificates. Furthermore, the Company's product premium rates were based on the approved benefit limits, and consumers received the benefits described and approved by the DIFP.

Category 1 – Claims Paid at more than $500
The Company respectfully *disagrees* with the examiner's finding for this one claim as described below.

§354.410.1(2), RSMo, and 20 CSR 400-7.100
The requirements of §354.410.1(2), RSMo, and 20 CSR 400-7.100, are predicated on the examiner's assertion that ambulance benefits are included within the context of "basic health care services".

- **The exception noted represented a clerical error and not a refusal to submit to examination or comply with a reasonable request:**
  374.205.2(2)
  The requirements of 374.205.2(2) are as follows:

  > *(2) Every company or person from whom information is sought, its officers, directors and agents shall provide to the examiners appointed pursuant to subdivision (1) of this subsection timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The company or person being examined shall provide within ten calendar days any record requested by an examiner during a market conduct examination, unless such company or person demonstrates to the satisfaction of the director that the requested record cannot be provided within ten calendar days of the request. All policy records for each policy issued shall be maintained for the duration of the current policy term plus two calendar years and all claim files shall be maintained for the calendar year in which the claim is closed plus three calendar years. The officers, directors, employees and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of, any license or authority held by the company to engage in an insurance or other business subject to the director's jurisdiction. Any such proceeding for suspension, revocation or refusal of any license or authority shall be conducted pursuant to section 374.046.*

  The Company's inability to locate benefit exception documentation for a single claim represented a clerical error in document retention, and was not the result of a refusal to submit to examination or comply with a reasonable request of the examiners.

- **The exception noted does not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(1), (3) and (4)
  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  > *"It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:*
  >
  > *(1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or*

(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

The Company believes the inability to produce benefit exception documentation for a single claim *does not* meet the terms of §375.1005, RSMo.

As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

Furthermore, the Company's actions were not consistent with §375.1007(1), (3), and (4).

With respect to the specific elements of §375.1007, RSMo identified by examiners:

(1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

The Company's inability to locate benefit exception documentation for one claim did not involve a misrepresentation to claimants and insureds relevant facts or policy provisions relating to coverages at issue.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company's inability to locate benefit exception documentation for one claim was the result of a clerical error, and did not represent a failure to adopt reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

The Company's inability to locate benefit exception documentation for a single claim had no bearing on the good faith settlement of this claim in a prompt, fair, and equitable manner. Further, the Company's reliance upon certificates approved by the Department's Life and Health Section demonstrates its good faith effort with respect to the settlement of this claim.

Category 2 – Claims Paid at $500
The Company respectfully *disagrees* with the examiner's finding for these 15 claims as described below.

§354.410.1(2), RSMo, and 20 CSR 400-7.100
The requirements of §354.410.1(2), RSMo, and 20 CSR 400-7.100, are predicated on the examiner's assertion that ambulance benefits are included within the context of "basic health care services".

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(1), (3) and (4)

In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

"It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

(1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

The Company's adjudication of these 15 claims, in accordance with benefits approved numerous times by the Department's Life and Health Section and detailed in the applicable group certificates, *does not* meet the terms of §375.1005, RSMo.

The Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

Furthermore, the Company's actions were not consistent with §375.1007(1), (3), and (4).

With respect to the specific elements of §375.1007, RSMo identified by examiners:

(1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

The Company's certificates, which were approved by the Department on numerous occasions, clearly described the ambulance benefit structure and were administered in accordance therewith. Thus, there was not a misrepresentation to claimants and insureds of relevant facts or policy provisions relating to coverages at issue.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company has reasonable standards in place, and settled the 15 claims indicated above in a timely manner in accordance with the group certificate. Thus, there was no failure to adopt reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

There was a good faith attempt to effectuate prompt, fair, and equitable settlement of the 15 claims indicated through the Company's reliance upon certificates approved by the Department's Life and Health Section with respect to the settlement of these claims.

Category 3 – Claims Paid as less than $500 and more than $0
The Company respectfully *disagrees* with the examiner's finding for these three claims as described below.

§354.410.1(2), RSMo, and 20 CSR 400-7.100
The requirements of §354.410.1(2), RSMo, and 20 CSR 400-7.100, are predicated on the examiner's assertion that ambulance benefits are included within the context of "basic health care services".

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(1), (3) and (4)
  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  "It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

  (1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

  (2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

  The Company believes its initial adjudication, and re-adjudication of these three claims, in accordance with benefits approved numerous times by the Department's Life and Health Section and detailed in the applicable group certificates, *does not* meet the terms of §375.1005, RSMo.

  The Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

  Furthermore, the Company's actions were not consistent with §375.1007(1), (3), and (4).

  With respect to the specific elements of §375.1007, RSMo identified by examiners:

  (1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

  The Company's certificates, which were approved by the Department on numerous occasions, clearly described the ambulance benefit structure. Thus, there was not a misrepresentation to claimants and insureds of relevant facts or policy provisions relating to coverages at issue.

  (3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

  The Company has reasonable standards in place; unfortunately processing errors were made during the initial adjudication of these three claims. The Company took action to re-adjudicate the claims based on the processing errors identified. Thus, there was no failure to adopt reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

The errors which occurred during the initial adjudication of these three claims were the result of manual processing issues. The initial adjudication represented the Company's good faith effectuation of their prompt, fair, and equitable settlement in accordance with the group's certificate. The Company has re-adjudicated these three claims. Thus, there was a good faith attempt to effectuate prompt, fair, and equitable settlement of the claims indicated. Further, the Company's reliance upon certificates approved by the Department's Life and Health Section demonstrates its good faith effort with respect to the settlement of these claims.

Category 4 – Claims Paid at $0

The Company respectfully *disagrees* with the examiner's finding for these 18 claims as described below.

1. *Claims incorrectly denied as duplicates and re-adjudicated during the course of the examination:*

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(1), (3), (4) and (6)
  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  "It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

  (1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

  (2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

  The Company believes its initial adjudication, and re-adjudication of these five claims, in accordance with benefits approved by the Department's Life and Health Section and detailed in the applicable group certificates, *does not* meet the terms of §375.1005, RSMo.

  The Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

  Furthermore, the Company's actions were not consistent with §375.1007(1), (3), (4), and (6).

  With respect to the specific elements of §375.1007, RSMo identified by examiners:

  (1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

The Company's certificates, which were approved by the Department on numerous occasions, clearly described the ambulance benefit structure. Thus, there was not a misrepresentation to claimants and insureds of relevant facts or policy provisions relating to coverages at issue.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company has reasonable standards in place, unfortunately these five claims were inaccurately denied as a duplicate when multiple ambulance trips were provided on the same date of service for the same member to different locations (e.g., scene of accident to hospital and subsequent hospital to hospital transfer). The Company took action to re-adjudicate the claims based on the processing errors identified. Thus, there was no failure to adopt reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

Processing errors which occurred during the initial adjudication of these five claims were the result of minor differences in claims for multiple ambulance trips provided on the same date of service for the same member to different locations. The initial adjudication represented the Company's good faith effectuation of their prompt, fair, and equitable settlement in accordance with the group's certificate. The Company has re-adjudicated these five claims. Thus, there was a good faith attempt to effectuate prompt, fair, and equitable settlement of the claims indicated. Further, the Company's reliance upon certificates approved by the Department's Life and Health Section demonstrates its good faith effort with respect to the settlement of these claims.

(6) Refusing to pay claims without conducting a reasonable investigation;

Processing errors which occurred during the initial adjudication of these five claims were the result of minor differences in claims for multiple ambulance trips provided on the same date of service for the same member to different locations. Their initial adjudication was a manual processing error, but did not represent a refusal to pay claims without conducting a reasonable investigation.

2. *Claims incorrectly denied as duplicates and re-adjudicated prior to the examination:*

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(1), (3), (4) and (6)
  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  "It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

  (1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

The Company believes its actions: (1) initial adjudication; (2) self-identification of processing errors through the Company's own processes; and (3) resulting re-adjudication, in accordance with benefits approved by the Department's Life and Health Section and detailed in the applicable group certificates, for these five claims well in advance of the examination *do not* meet the terms of §375.1005, RSMo.

As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

Furthermore, the Company's actions were not consistent with §375.1007(1), (3), (4), and (6).

With respect to the specific elements of §375.1007, RSMo identified by examiners:

(1) Misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

The Company's certificates, which were approved by the Department on numerous occasions, clearly described the ambulance benefit structure. Thus, there was not a misrepresentation to claimants and insureds of relevant facts or policy provisions relating to coverages at issue.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company has reasonable standards in place, as demonstrated in each of these instances where the Company's own processes identified the initial adjudication errors. The claims referenced were re-adjudicated as a result of the processing errors identified well in advance of the Market Conduct Examination. Thus, there was no failure to adopt reasonable standards for the prompt investigation and settlement of claims.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

The re-adjudication of these five claims clearly indicates the Company's good faith effectuation of prompt, fair, and equitable settlement in accordance with the group's benefits. Further, the Company's reliance upon certificates approved by the Department's Life and Health Section demonstrates its good faith effort with respect to the settlement of these claims.

(6) Refusing to pay claims without conducting a reasonable investigation;

In each of these instances the Company's own processes identified initial adjudication issues, and resulted in re-adjudication of the claims. The re-adjudication of these five claims clearly demonstrates the Company's good faith effectuation of their prompt, fair, and equitable settlement in accordance with the

group's benefits, and did not represent a refusal to pay claims without conducting a reasonable investigation.

3. *Claims for which the Company received refunds from providers due to payment by automobile insurance:*

   - The Company processed these eight claims, and paid the full extent of ambulance benefits per the certificate to the ambulance provider as is required by §190.205.1, RSMo.

   - The Company did not seek to coordinate benefits with another carrier, nor did it engage in any subrogation activity as was referenced by examiners in relation to 20 CSR 400-2.030(6)(D)3. Unsolicited by the Company, the provider refunded or requested the Company recoup amounts it had previously paid. This provider request was based on what would appear to be the receipt of payments in excess of billed charges resulting from its simultaneous billing of the Company and an auto carrier.

DIFP Report: Item II.U Unfair Claims Practices – Copayments

Regulation 20 CSR 400-7.100 prohibits HMOs from "impos[ing] copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees." The Company's process for complying with the 50% of the cost of any single service copayment limitation of 20 CSR 400-7.100 is as follows:

1. *When a claim is submitted, the Company's Facets claim processing system has the capability to identify claims where the standard copayment is greater than 50% of the total cost of providing any single service.*

2. *When Facets identifies a claim impacted by the 50% copay rule, the claim is then manually priced and the appropriate copayment is applied to the claim.*

3. *An EOB is sent to the member and a RA is sent to the provider to inform both the member and the provider of the appropriate copayment.*

4. *Within 30 days of receipt of payment for the claim from the Company, the provider is required (pursuant to its provider contract with the Company) to refund any amount it collected in excess of the appropriate copayment.*

This process prompted a recommendation in the Company's previous Market conduct Examination report that, "The Company should have some process in place to monitor whether or not providers that collect copayments in excess of 50% of any single service make the necessary refunds to members." In an effort to follow up on this recommendation, the examiners requested information from the Company regarding what steps it had taken since the time of the last examination. The Company explained it had taken the following steps:

2009: The Company selected a sample of 56 claims from 2008 where the standard copayment exceeded 50% for "six key provider groups represented on the Company's Practice Manager's Advisory Committee ("PMAC") and the top fifty non-PMAC provider groups" and contacted the providers to verify the status of any refunds. For five of the 56

claims (8.93%), the providers indicated that refunds were either not made prior to the call (four of the claims) or the necessary refund could not be confirmed due to archiving of records by the provider (one of the claims).

2010: The Company identified the top 50 providers by potential copayment refunds for 2009 claims and sent them a letter and summary claims report requesting that they review their patient accounts to make sure all appropriate refunds were made. Unlike the 2009 review of 2008 claims, however, the Company did not otherwise contact providers to verify that refunds were made. In addition to the letters, the Company added information regarding copayment refunds to its "Provider Office Guide," EOBs and provider remittance advice forms in 2010.

2011: The Company expanded its letter and 2010 summary claims report communication to all providers rather than just the top 50. In addition, a survey was sent out to providers in December 2011 inquiring about their copayment refund processes.

In order to conduct a review of the Company's handling of claims where the scheduled copayment exceeded 50%, the examiners requested a listing of any and all claims from Missouri providers or Missouri enrollees that were submitted, reviewed or processed between 1/1/2009 and 12/31/2009 where the standard copayment applicable to the claim exceeded 50% of the total cost of providing any single service. The Company provided a listing that contained claim lines for 96,620 claim numbers submitted under HMO contracts issued in Missouri. From these 96,620 claim numbers, the examiners extracted a sample of 87 claim numbers and requested copies of the claim files for review.

Field Size:	*96.620*
Sample Size:	*87*
Type of Sample	*Random*
Number of Errors:	*83*
Error Ratio:	*95%*

The examiners noted the following errors in this review.

The examiners noted that the Company's calculation of the applicable copayment under the 50% limitation appeared to be correct for all 87 claim numbers. In reviewing the documentation in these claim files, however, the examiners noted the following:

1. *The documentation in the claim files for 14 of the claim numbers showed an amount collected from the member by the provider. The claim files for 10 of these 14 claim numbers showed an amount collected by the provider that exceeded the 50% copayment limitation, but there was no documentation in the file showing that the provider had made a refund of the excess amount.*

2. *The claim files for the remaining 73 claim numbers in the sample did not contain any documentation of the copayment amount collected by the provider, nor did the files document a refund of any excess collected.*

Section 374.205.2(2), requires insurers to maintain claim files for examination purposes. What constitutes a complete claim file for examination purposes is set forth in 20 CSR 100-8.040(3)(B). This regulation provides that:

> *The claim file shall be maintained so as to show clearly the inception, handling, and disposition of each claim. The claim file(s) shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.*

The claim files for 83 claim numbers out of the 87 claim number sample did not appear to comply with these requirements in that:

1. *Seventy-three of the claims did not have sufficient documentation to show what, if any, copayment was collected by the provider at the time of service.*

2. *Eighty-three of the claims did not have sufficient documentation to show the final disposition of the claim, including any refund of excess copayments collected.*

Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040(3)(B)

As noted above, the Company's procedures for processing claims do not require it to secure and maintain documentation in its claim files of the handling and refund of copayments by providers. In 83 of the 87 claim numbers in the sample, this failure to maintain such documentation resulted in both the examiners and the Company being unable to verify the handling and disposition of the claims contrary to the claim file documentation requirements of §374.205.2(2) and 20 CSR 100-8.040(3)(B). By establishing a process that fails to comply with the claim file documentation requirements of Missouri law, it appears to the examiners the Company's actions relative to the 83 claim numbers are the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §§375.1007(3) and 375.1007(4), RSMo.

In response to EF7, the Company disagreed with the examiners' criticism above on the basis that:

1. *The Company's claim files were appropriately documented since it did not believe it had a responsibility to have a system in place to monitor provider's collection or refund of copayments.*

2. *Because the Company believed its claim files were appropriately documented, its processing of these 83 claims was not contrary to §375.1007(3) and (4).*

Company Response: Item II.U Unfair Claims Practices – Copayments

The Company respectfully *disagrees* with the examiner finding that the claim files referenced did not comply with §374.205.2(2), RSMo, and 20 CSR 100-8.040(3)(B).

- **The Company's adjudication of claims complies with the copay regulation:** All copayments are calculated in accordance with the regulation and communicated to providers and members. The examiner finding appears to suggest the Company has an additional responsibility to monitor and record copayment transactions between the member and provider. The relevant portion of the Department's regulation related to copayment limitations, 20 CSR 400-7.100 ("50% Rule") provides that:

  > *"A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty*

percent (20%) of the total cost of providing all basic health services." (emphasis added)

- **The company did not impose copayment charges exceeding 50%:**
The Company does not have a responsibility to audit a provider's collection or refund of copayments. The Company's position regarding the monitoring of provider refund activity was previously explained in a letter dated March 10, 2010, to Carolyn Kerr, Senior Counsel, Market Conduct Section, related to the Blue Care, Inc. and Blue Advantage, Inc. Market Conduct Exams (#0612-57-TGT and 0612-48-TGT). A copy of this letter was provided during the examination and is separately attached again to this response as "**Attachment B**".

  As the letter states, with regard to 20 CSR 400-7.100, the Company has a responsibility to not *impose* copayment charges that exceed 50% of the total cost of providing any single service to its enrollees. The Company clearly complied with this requirement, as evidenced by the EOBs and remittance advices within claim files provided to DIFP examiners.

  As noted by examiners, the relevant portion of 20 CSR 100-8.040(3)(B) provides that:

  > *"The claim file shall be maintained so as to show clearly the inception, handling, and disposition of each claim. The claim file(s) shall be sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed."*

  The Company has complied with the regulation. The "handling and disposition" of claims, as described therein, does not include collecting data on any financial transactions that may take place between the member and provider (e.g., collection of copayment charges in excess of those calculated by the Company), whether in advance of or subsequent to the Company's adjudication (i.e., "handling and disposition") of the claim. Thus, it is not the Company's responsibility to capture in its claim files information related to any such transactions between providers and their patients. Through its compliance with 20 CSR 100-8.040(3)(B), the Company meets requirements to maintain claim files outlined in the statute it supports, 374.205.2(2), RSMo, which provides in relevant part:

  > *"All policy records for each policy issued shall be maintained for the duration of the current policy term plus two calendar years and all claim files shall be maintained for the calendar year in which the claim is closed plus three calendar years."*

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
The Company also respectfully *disagrees* with the examiner finding that the claim files referenced constituted an unfair claims practice under §375.1007(3) and 375.1007(4), RSMo. The examiner finding with regard to these statutes appears to again be predicated upon the belief that the Company has a responsibility to record details of financial transactions between the member and provider. The Company's disagreement with this matter is discussed in response to the first part of this finding above.

  §375.1007(3), RSMo
  §375.1007(3), RSMo, required insurers *"to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."*

The Company did employ reasonable standards to promptly investigate and settle the claims in question. Specifically, the Company believes that:

- Benefits described in the member's policies were correctly applied when the claims were adjudicated.
- Limitations on copayments (i.e., 50% Rule) were accurately calculated and reflected in the Company's payment to providers and explanations of benefits sent to members. Those payments were both timely and accurate.
- The copayment requirements for each claim were communicated to members and providers through EOBs and remittance advices, respectively.

§375.1007(4), RSMo
§375.1007(4), RSMo, required that insurers attempt *"in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear."*

As previously discussed, the Company's timely and accurate adjudication of these claims met the "good faith" standards set forth in this statue regarding claim settlement.

DIFP Report: Item II.V Unfair Claims Practices – Refund Requests and Offsets

As stated in §376.384.1(3), RSMo Supp. 2013, an HMO may "not request a refund or offset against a claim more than twelve months after a health carrier has paid a claim except in cases of fraud or misrepresentation by the health care provider." To test for compliance with this claim processing requirement, the examiners extracted 554 claim numbers from the data provided by the Company where an adjustment to the claim had occurred more than 365 days after initial payment. Of the 554, the examiners selected a random sample of 83 claim numbers and requested information from the Company as to whether the subsequent adjustment of the claims had involved a refund or offset.

Field Size:	*554*
Sample Size:	*83*
Type of Sample	*Random*
Number of Errors:	*4*
Error Ratio:	*4.8%*

The examiners noted the following errors in their review.

In reviewing the information provided by the Company for the 83 claim numbers, the examiners noted that the documentation for four of the claim numbers appeared to show that the Company had requested a refund or made an offset beyond the 12 month limitation in §376.384.1(3). The Company agreed in its response to EF 5 that it had requested a refund or made an offset against these four claim numbers more than 12 months after its initial payment of the claims and indicated it would reprocess and pay the claims. Although the Company made refunds with interest for these four claim numbers during the course of the examination, its processing of these four claims in a manner inconsistent with §376.384.1(3) appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §375.1007(3) and (4), RSMo, and §376.384.1(3), RSMo Supp. 2013

Company Response: Item II.V Unfair Claims Practices – Refund Requests and Offsets

The Company *agrees* that a refund or offset was made more than 12 months after the Company paid four claims noted by DIFP examiners. However, the Company respectfully points out that the calculated error ratio of 4.8% is less than the 5% compliance tolerance stipulated in §376.384.3, which states.

> *"Compliance shall be defined as properly processing and paying ninety-five percent of all claims received in a given calendar year in accordance with the provisions of this section and section 376.383."*

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(3) and (4)
  The Company respectfully *disagrees* with the examiner finding that the claim files referenced constituted an unfair claims practice under §375.1007(3) and 375.1007(4), RSMo.

  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  > *"It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:*
  >
  > *(1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or*
  >
  > *(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."*

  The Company believes the re-adjudication of these four claims, and the resulting refund or offset request beyond the allowed 12 month period, represented isolated processing errors which *do not* meet the terms of §375.1005, RSMo.

  As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice, as is evidenced by the results of examiner testing.

  Furthermore, the Company's actions were not consistent with §375.1007(3) and (4).

  With respect to the specific elements of §375.1007, RSMo identified by examiners:

  > *(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;*
  >
  > As is evidenced by the low number of exceptions in the sample selection, four of 83 claims tested, the instances in question represented outliers in the Company's processes. As such, the Company has adopted and implemented reasonable standards to promptly investigate and settle the claims in question.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

The Company's initial primary payment on each of the four claims in question clearly indicates its actions to "in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear", as it had not received an indication of secondary insurance at the time these claims were processed. While the Company's requests for a refund of its primary payment, based on the subsequent identification of its liability as secondary, fell outside the regulatory requirement in four of 83 instances, they represent isolated mistakes and do not indicate an effort to request refunds or offsets in a manner contrary to §375.1007(4).

DIFP Report: Item II.W Unfair Claims Practices – Coordination of Benefit Denied

Under Missouri's "Group Coordination of Benefits" regulation, 20 CSR 400-2.030, health carriers are permitted to coordinate benefits with any other insurance coverage that meets the definition of a "plan" in 20 CSR 400-2.030(2)(F). To test for compliance with this claim processing requirement, examiners extracted 92,035 claim numbers from the data provided by the Company that were identified in the data as being either "Primary" or "Secondary" and the claim status was marked as "denied". Of the 92,035 claim numbers, the examiners selected a random sample of 86 claim numbers and requested copies to the claim files for review.

Field Size:	*92,035*
Sample Size:	*86*
Type of Sample	*Random*
Number of Errors:	*3*
Error Ratio:	*3.5%*

The examiners noted the following errors in their review:

In response to EF 3, the Company agreed that it had failed to pay three claims (one in which its liability was primary and two in which its liability was secondary) due to manual processing errors. The Company reprocessed and paid these three claims with interest during the course of the examination, but its initial failure to correctly process these three claims in accordance with 20 CSR 400-2.030 prior to the examination appears to by the type of claims settlement practice prohibited by §375.1007(4), RSMo.

Reference: §375.1007(4), RSMo, and 20 CSR 400-2.030(4) and (5)

Company Response: Item II.W Unfair Claims Practices – Coordination of Benefit Denied

The Company agrees that another carrier was initially identified as the primary insurer, per the order of benefit rules described within the subscriber's certificate. At that time, the Company suspended further processing of these claims, pending receipt of the primary insurer's explanation of benefits, to accurately determine potential secondary liability. During the examination the Company determined that manual processing errors were made during the initial adjudication and additional provider payment was due for three claims. The Company had secondary liability for two of the claims and, based upon information the

Company received subsequent to when the original claim was processed, primary liability for one claim. The Company re-adjudicated these claims, including interest.

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  375.1007(4)
  The Company respectfully *disagrees* with the examiner finding that the three claims referenced constituted an unfair claims practice under § 375.1007(4), RSMo.

  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  "It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

  (1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

  (2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

  The Company believes its failure to complete adjudication of these three claims represented isolated processing errors associated with processing claims with coordination of benefits which *does not* meet the terms of §375.1005, RSMo.

  As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice.

  Furthermore, the Company's actions were not consistent with §375.1007(3) and (4).

  With respect to the specific element of §375.1007, RSMo identified by examiners:

  (4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

  As described in the response immediately above, the Company clearly acted "in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear". The exceptions noted in three of 86 claims sampled represent isolated mistakes and do not indicate an effort to process the claims in a manner contrary to §375.1007(4).

DIFP Report: Item III.C Handling of Direct Complaints
The examiners selected a random sample of 113 complaints/grievances from the listing of 1,793 complaints/grievances that the Company received directly and requested copies of the complaint files for review.

The examiners found the following errors in their review:

1. *In reviewing complaint/grievance files in which a claim denial was overturned upon appeal, the examiners noted that some reprocessed claims appeared to contain incorrect interest payments. In some instances, the interest payments were less than required. In some, instances the interest payments were missing.*

In response to EF 1, the Company agreed that interest payments had been incorrectly calculated for 16 appealed claims. The Company explained that this was due to manual processing errors by its appeals department staff. To alleviate such errors, the Company indicated that it had changed its processes in 2010 and transferred the responsibility for adjusting claims related to appeals to its operations staff whose primary duty was claims processing.

The Company reprocessed and paid interest on the 16 appealed claims during the course of the examination. Its failure to have processes in place to pay interest on these appealed claims as required by §376.383.5, RSMo Supp. 2009, however, appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

Reference: §375.1007(3) and (4), RSMo, and §376.383.5, RSMo Supp. 2009

2. *In one complaint/grievance file, the Company had initially denied claims filed by a surgeon and a hospital on the basis that the procedure being provided was "investigational" in nature. The surgeon appealed the denial and provided medical literature indicating the procedure was appropriate and medically necessary for the member's condition when other therapies had failed. The Company agreed with the surgeon's position and reprocessed and paid the surgeon's claim with interest. The hospital's claim, however, was not reprocessed and paid, so it continued to be denied.*

   In response to EF 2, the Company agreed that the hospital's claim had been incorrectly processed. As with the complaint/grievance files noted above, the Company explained that this was due to manual processing errors by its appeals department staff, which it had addressed through a change in its processes for adjusting appealed claims. The Company's failure to have processes in place to properly adjust such denied claims upon appeal, however, appears to be the type of claim settlement practice prohibited by §375.1007(3) and (4).

   Reference: §375.1007(3) and (4), RSMo.

Company Response: Item III.C Handling of Direct Complaints

The Company respectfully *disagrees* that interest should have been paid on the claims in question and that the Company's actions constitute an unfair claims practice under RSMo. 375.1007.

- **ERISA preempts the application of interest and the appeals were properly denied based on the information available at that time:**
  The Company acknowledges its response to EF1, indicating that it agreed with the DIFP's position that interest should have been paid on the claims in question. However, subsequent research has confirmed that this is not the case. ERISA preempts the application of interest under RSMo. 376.383 and 384 for six of the 16 claims in question, meaning that interest was not required to be paid on such claims. Further, even if ERISA did not preempt the application of interest under RSMo. 376.383 and 384 to these six claims, they were properly denied upon initial adjudication. The 10 other

claims in question were also properly denied upon initial adjudication. In each instance, the Company denied the claim based upon information available at the time and consistent with the terms of its contracts. Upon appeal, subsequent information was presented to the Company, resulting in the Company's decision to pay the claims. As such, interest under RSMo. 376.383 and 384 was not required for these claims.

- **The exceptions noted do not meet the unfair claim practice standards defined by Missouri statute:**
  Because the Company was not required to pay interest on these claims, its actions do not constitute a violation under RSMo. 376.1007. However, even if interest was required to be paid under RSMo. 376.383 and 384, which it was not, as set forth above, the Company *disagrees* with the examiner finding that the Company's actions constituted an unfair claims practice under §375.1007(3) and 375.1007(4), RSMo.

  In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005 RSMo, which provides:

  > *"It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:*
  >
  > *(1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or*
  >
  > *(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."*

  As noted, the Company changed its processes in 2010 and transferred the responsibility for adjusting claims related to appeals to its operations staff. This reflects that the Company's actions were not in "conscious disregard" for RSMo. 375.1000 to 1018 or any regulations promulgated thereunder. Further, the Company's actions with respect to the claims in question represented isolated issues associated with processing claims, and were therefore not committed with such frequency to indicate a general business practice.

  Furthermore, the Company's actions were not consistent with §375.1007(3) and (4).

  With respect to the specific elements of §375.1007, RSMo identified by examiners:

  (3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

  The Company timely processed the claims in question and did so per the terms of the applicable contract based on information available at the time. Upon appeal, the Company received additional information and decided to overturn the initial denial. None of these actions represents a failure to adopt and implement reasonable standards for prompt investigation and settlement of claims.

  (4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

  As described in the response immediately above, the Company clearly acted "in good faith to effectuate prompt, fair and equitable settlement of claims". In fact, all of the

claims in question were adjudicated within the timeframe specified in RSMo. 376.383 and 384. And, as mentioned above, the Company processed the claims in question per the terms of the applicable contract based on information available at the time. The Company's actions do not indicate an effort to process the claims in a manner contrary to §375.1007(4).

2. The Company acknowledges that a manual processing error resulted in incorrect processing of one claim associated with the complaint / grievance file, but respectfully *disagrees* with the examiner finding that this single instance constituted an unfair claims practice under §375.1007(3) and 375.1007(4), RSMo.

- **The exception noted does not meet the unfair claim practice standards defined by Missouri statute:**
In order to be considered in violation of §375.1007, RSMo, the insurer's actions must meet the terms of §375.1005, RSMo, which provides:

"It is an improper claims practice for any domestic, foreign or alien insurer transacting business in this state to commit any of the acts defined in section 375.1007 if:

(1) It is committed in conscious disregard of sections 375.1000 to 375.1018 or any rules promulgated under sections 375.1000 to 375.1018; or

(2) It has been committed with such frequency to indicate a general business practice to engage in that type of conduct."

The Company believes its failure to re-adjudicate one claim associated with this complaint / grievance file represented an isolated processing error which *does not* meet the terms of §375.1005, RSMo.

As such, the Company did not exhibit a conscious disregard for the applicable requirements of statutes 375.1000 to 375.1018, nor did it engage in improper conduct with a frequency which could be construed as a general business practice. In fact, the Company changed procedures to prevent similar errors.

Furthermore, the Company's actions were not consistent with §375.1007(3) and (4).

With respect to the specific elements of §375.1007, RSMo identified by examiners:

(3) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

The Company did employ reasonable standards to promptly investigate and settle the claim in question. The single exception noted represented an isolated mistake.

(4) Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

As described in the response immediately above, the Company clearly acted "in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear". The single exception noted

represented an isolated mistake and does not indicate an effort to process the claim in a manner contrary to §375.1007(4).

State of Missouri

Bob Holden, Governor

Department of Insurance
P.O. Box 690
Jefferson City, Missouri 65102-0690

Scott B. Lakin
Director

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LEGAL DEPT.

September 4, 2003

Rena Brown
Sr. Contract & Compliance Analyst
Blue Cross Blue Shield of Kansas City
D/b/a Blue-Advantage
2301 Main Street
Kansas City, MO 64108

RE: MDI File #: 03H034942
Form(s): BA-403-03-M Chiropractic Amendment

Dear Ms. Brown:

This letter is to replace the letter concerning the above listed Amendment previously sent to you and dated September 2, 2003. This letter concerns the revised Chiropractic Amendment hand delivered to this office by Ms. Coni Fries on September 3, 2003.

Section C., Covered Services, includes the bracketed statement "Diagnostic services…and tests required to diagnosis the illness or injury *or* other Covered Services **must be Approved in Advance by Us.**" RSMo 376.1230.1, which mandates chiropractic coverage for group health plans, particularly HMO's, clearly indicates covered person have access to network chiropractor services without a prior authorization from their primary care physician. The law states that an enrollee may be required to provide the carrier with notice prior to any *additional visit* as a condition of coverage. Only those services considered to be "follow-up diagnostic tests" or treatment in addition to the first 26 treatments in a benefit period may by conditioned upon prior authorization by the plan. The fact that coverage of 26 visits is expressed as a minimum expectation of the law appears to distinguish what must be covered by the carrier (without imposition of any prior authorization or notification requirements) from what the carrier may chose to provide in addition to the mandated coverage or benefits (and for which the carrier may require prior authorization or notice). This Amendment cannot be approved with the implication that prior authorization is required for the first 26 visits within a policy period. Referrals from the Primary Care Physician or other health care provider are allowed when referrals are required for other medically necessary services provided to the enrollee with health care providers within the HMO's network. Please modify this amendment.

Although section 376.1230, RSMo clearly provides that health plans shall cover 26 visits for clinically appropriate and medically necessary chiropractic care, these provisions do not attempt to address or limit the provision contained in a carrier's contract with network providers that may assure access to chiropractic care, these provisions do not attempt to address or limit the provisions contained in a carrier's contract with network providers that may obligate the provider to participate in a utilization review progress. The purpose of the law, to assure access to chiropractic care appears to be fulfilled if the member is held harmless if the provider fails to follow the terms of their agreement with the insurer or HMO.

If you will submit the above listed form in final print, incorporating these requirements, I will be pleased to reconsider your submission. It will be very helpful if you would in some way highlight or indicate the changes. This will greatly speed up the review of your submission. On resubmission, please use the MDI file number found above.

Should you have any additional questions or comments, please do not hesitate to contact me at (573) 526-1371 or via e-mail at KSprings@sdcnotes.state.mo.us.

Respectfully,

Kembra Springs

Kembra Springs
Insurance Product Analysis II
Life & Health Section
Missouri Department of Insurance

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March 10, 2010

VIA FACSIMILE AND U.S. MAIL

Carolyn Kerr
Senior Counsel, Market Conduct Section
Missouri Department of Insurance
P.O. Box 690
Jefferson City, MO 65102

Re: Market Conduct Exams #0612-57-TGT and 0612-48-TGT (Blue-Care, Inc. and Blue-Advantage, Inc.)

Dear Carolyn:

As you know, the Market Conduct Section finalized the above Exams in January of 2010. Both Exams contained a finding concerning co-payments. Specifically, the Department stated as follows in the executive summary of each Exam:

> *The Company does not have any process in place to monitor whether or not providers make refunds of copayments that exceed 50% of a single service in compliance with 20 CSR 400-7.100.*

The Companies responded to this finding by pointing out that their copayment requirements do not exceed 50% of a single service. To the extent an enrollee makes a copayment in excess of 50% of a single service to a provider, an explanation of benefit form is generated advising both the enrollee and the provider of the overpayment. The providers are instructed to refund any excess copayment. Enrollees are instructed to contact the Companies should they require assistance concerning the copayment. These processes exceed the Companies' obligations under the applicable regulation and we are aware of no formal complaints about the process.

As part of informal conversations between the Companies and the Department, Department personnel advised the Companies that this issue will be reviewed in the next round of Market Conduct Exams. Department personnel indicated that the Department intends to audit whether enrollees have made copayments in excess of 50% of a single service as well as whether providers have

refunded those copayments. Department personnel also indicated that the next Market Conduct Exam findings may require the Companies to refund any copayments in excess of 50% of a single service.

The Companies believe that the Department's interpretation and implementation of the regulation is not consistent with the plain language of the regulation. Regulations must be interpreted using principles of statutory construction. The primary rule of construction is to determine intent by examining the plain and ordinary meaning of the words used. ***Daly v. State Tax Commission*, 120 S.W.3d 262, 267 (Mo.App. 2003).**

The relevant portion of the Department's regulation, 4 CSR 400-7.100 reads as follows:

> "A health maintenance organization (HMO) may require copayments of its enrollees as a condition of the receipt of specific health care services. An HMO may not impose copayment charges that exceed fifty percent (50%) of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty percent (20%) of the total cost of providing all basic health services."

The regulation does not require the company to "have in place a system to monitor whether or not providers make refunds of copayments that exceed 50% of a single service." The regulation is limited solely to whether the "HMO" has "imposed" copayments in excess of 50%. On its face, the regulation only applies to the actions of the HMO, not the actions of providers, and it only regulates whether the HMO may "impose" excessive copayments. Webster's Dictionary defines "impose" as "to establish or apply by authority." The regulation only applies to the established amount of copayments, and does not extend to require an HMO to have a system in place to police the way providers collect or refund copayments.

The regulation's intent is also reflected in the Department's own purpose statement, contained in the regulation itself. The Department indicates that the substantive authority for the regulation is found in §354.430 RSMo. That statute applies to provisions contained in the "evidence of coverage" and does not address the manner in which HMOs operate. "An administrative agency enjoys no more authority than that granted by statute." ***Gee v. Dep't of Soc. Servs., Family Support Div.*, 207 S.W.3d 715, 719 (Mo. App. 2006)** "Regulations may be promulgated only to the extent of and within the delegated authority of the statute involved." ***Id.*** The very statute the Department cites as authority for the regulation only applies to the copayment established by the HMO. It does not cover the collection of copayments by providers, nor does it impose an obligation on the companies to oversee that process.

I can find no statute or regulation that requires the companies to regulate the way providers go about making refunds when the providers have collected a higher copayment than the companies have imposed.[1] Without such a statute or properly promulgated regulation, the Department has no authority to enforce the policy articulated in the executive summaries. ***State ex rel. Barnett v. State Lottery Commission*, 196 S.W.3d 72, 77 (Mo.App. 2006).** Simply put, even if the Department's statements in the just completed examinations were true, they would not constitute a violation of the insurance laws of this state. Extending a future Market Conduct Exam into this area, and charging the company for the expenses of such examination, would be improper and would likely exceed the Department's authority.

Please let me know in advance if the Department still intends to extend the scope of the companies' next Exams to include the review discussed herein. I'm hopeful that we can resolve any outstanding issues and avoid further controversy about this issue.

Sincerely,

Charles W. Hatfield

CWH:as

[1] I do not intend to comment on whether the Department would have the authority to promulgate such a regulation, but one would certainly be required if the Department wishes to enforce a policy of general applicability concerning collection of copayments.