STATE OF MISSOURI

DEPARTMENT OF COMMERCE & INSURANCE

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

***In Re*:**	)	
	)	
GOOD HEALTH HMO, INC.	)	**Market Conduct Investigation No. 374687**
(NAIC # 537-95315)	)	

ORDER OF THE DIRECTOR

NOW, on this 10th day of December, 2024, Director Chlora Lindley-Myers, after consideration and review of the market conduct examination report of Good Health HMO, Inc. (hereinafter "Good Health"), examination report number #374687, prepared and submitted by the Division of Insurance Market Regulation (hereinafter "Division") pursuant to §374.205.3(3)(a)[1], does hereby adopt such report as filed. After consideration and review of the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation"), relating to the market conduct examination #374687, the examination 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). The Director does hereby issue the following orders:

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

IT IS THEREFORE ORDERED that the Director does hereby approve the Stipulation as agreed to by Good Health and the Division.

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[1] All references, unless otherwise noted, are to Revised Statutes of Missouri 2016.

IT IS FURTHER ORDERED that Good Health shall not engage in any of the violations of statutes and regulations set forth in the Stipulation, shall implement procedures to place it in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri, shall maintain those corrective actions at all times, and shall fully comply with all terms of the Stipulation.

IT IS FURTHER ORDERED that Good Health shall pay, and the Department of Commerce and Insurance, State of Missouri, shall accept, the Voluntary Forfeiture of $4,500.00, 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 10th day of December, 2024.

Chlora Lindley-Myers
Director

IN THE DEPARTMENT OF COMMERCE AND INSURANCE
STATE OF MISSOURI

***In Re*:**	)	
	)	
Good Health HMO, Inc.	)	
(NAIC # 537-95315)	)	**Market Conduct Examination No. 374687**
	)	

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. (hereinafter "Good Health"), as follows:

WHEREAS, the Division is a unit of the Missouri Department of Commerce and Insurance (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 of 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, examination no. 374687; and

WHEREAS, based on the market conduct examination of Good Health, the Division alleges that:

1. Good Health was required to submit three iterations of its complaint log during the course of the examination due to data inaccuracies present in the first two submissions, in violation of § 375.936(3), § 375.934(2), RSMo[1] and 20 CSR 100-8.040(3)(D).

2. Good Health did not maintain its complaint register in a manner in which it could be provided to the Department so that complaint handling could be readily ascertained, in violation

[1] All statutory references, unless otherwise noted, are to the 2016 Revised Statutes of Missouri.

of § 374.205.2(2) and 20 CSR 100-8.040(2).

3. Good Health reported inaccurate grievance counts to the Department in 2018, 2019, and 2020 in conjunction with its submission of its Annual Reporting of Utilization Review Activities, implicating the provisions of § 374.210.1(2).

4. In nine second-level grievances initiated after August 28, 2019, Good Health inappropriately notified members that clinical peers were included on the grievance advisory panel, in violation of § 375.936(4) and § 375.934(2).

5. In seven second-level grievances initiated after August 28, 2019, clinical peers did not act independently when making a determination regarding the grievance outcome, in violation of § 376.1385.2, RSMo 2019.

6. In 20 second-level grievances, Certificate BC-CERT-17-M contains an inaccurate description of Good Health's grievance procedures as it relates to second-level grievances, in violation of § 376.1378.

7. Certificates issued after August 28, 2019, did not contain a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints, in violation of § 354.430.3(2)(e).

8. For ten first-level grievances, Good Health did not send an acknowledgement response, in violation of § 376.1382.2(1).

9. For four second-level grievances, the examiners found that Good Health did not send acknowledgment correspondence, in violation of § 376.1385.3, RSMo 2019 and § 376.1382.2(1).

10. For two second-level grievances, Good Health did not provide a timely acknowledgment response within ten working days, in violation of § 376.1385.3, RSMo 2019.

11. Good Health omitted Utilization Review Agents on its annual Utilization Review Activities Reports for 2018, 2019, and 2020, in violation of § 376.1359.2 and 20 CSR 400-

10.020(1)(B).

12. For eight ambulance claims, Good Health issued Explanations of Benefits (EOBs) which incorrectly advised insureds "[m]aximum benefits payable under the member's coverage has been provided," in violation of § 375.1007(1) and § 375.1005.

13. In 37 instances, Good Health did not implement reasonable standards to allow for the payment of billed charges for ambulance claims, in violation of § 375.1007(3) and § 375.1005.

14. In 39 claims associated with the cost of basic healthcare services for ambulance charges, member liability was applied in a form other than that of a deductible, co-insurance, or copayment, in violation of § 354.410.1(2).

WHEREAS, the Division and Good Health have agreed to resolve the issues raised in the market conduct examination as follows:

A. **Scope of Agreement.** This Stipulation of Settlement and Voluntary Forfeiture (hereinafter "Stipulation") 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. Such remedial actions shall include the following:

1. Good Health agrees to maintain its complaint logs in a manner that is compliant with § 375.936(3), § 375.205.2(2), 20 CSR 100-8.040(3)(D), and 20 CSR 100-8.040(2).

2. Good Health agrees to revise its second-level grievance correspondence to accurately reflect the participants of grievance advisory panels.

3. Good Health agrees to immediately direct any third-party Independent Review

Organization(s) acting on its behalf to immediately cease the practice of appointing and utilizing a lead clinical peer reviewer for all pending and future second-level reviews. Good Health further agrees to develop and implement policies and procedures applicable to the Company and any third-party Independent Review Organizations utilized by the Company that:

a. prohibit the appointment of a lead reviewer for all pending and future second-level reviews; and

b. forbid the two assigned independent clinical peers from sharing their own opinions or conclusions about the case during any consultation with physicians or at any time prior to the issuance of findings in the case.

4. Good Health agrees to review all marketed and in-force coverage forms to ensure that they accurately reflect Good Health's second-level grievance procedures. Good Health shall file an amendment for those forms which do not reflect the correct process and issue the amendment to all in-force policy and certificate holders.

5. Good Health agrees to amend its evidence of coverage to include a clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

6. Good Health agrees to acknowledge all first and second-level grievances in accordance with § 376.1382 and § 376.1385.

7. Good Health agrees to audit and resubmit revised annual Utilization Review Activities reports for the years 2021, 2022, and 2023 that were filed in the years 2022, 2023, and 2024, respectively.

8. Good Health shall ensure Explanations of Benefits accurately represent relevant facts, payments, and member liability amounts related to claims at issue.

9. Good Health shall correct the programming error that caused Good Health to not allow

for the payment of billed charges for ambulance claims.

10. Good Health agrees to pay restitution to members for 39 ambulance claims for any amount underpaid, incorrectly processed, or charged in excess of applicable co-payments, coinsurance, or deductibles together with interest in an amount determined pursuant to § 374.191. Any payment of restitution issued shall be accompanied by a letter including pertinent information in a manner approved by the Division, and stating that, as a result of a Missouri Market Conduct Examination, it was determined that a payment was owed. Good Health shall provide proof of payment of these claims in a manner acceptable to the Division.

11. Good Health agrees to conduct a review of all ambulance claims for the years 2021, 2022, and 2023 to identify whether the claims were underpaid; whether the claims were incorrectly processed, and whether members were held responsible for payments in excess of applicable co-payments, coinsurance, or deductibles. Good Health shall provide payment of restitution to members for any claims identified during the review, for any amount underpaid, incorrectly processed, or charged in excess of applicable co-payments, coinsurance, or deductibles, together with interest in an amount determined pursuant to § 374.191. Any payment of restitution issued shall be accompanied by a letter including pertinent information in a manner approved by the Division, and stating that, as a result of a Missouri Market Conduct Examination, it was determined that a payment was owed. Good Health shall provide proof of these remedial actions in a manner acceptable to the Division.

C. **Compliance.** Good Health agrees to file documentation pursuant to § 374.190 with the Division, in a format acceptable to the Division, within 30 days of the entry of an Order approving this Stipulation (hereinafter "Order"), of any remedial action taken to implement compliance with the terms of this Stipulation.

D. **Voluntary Forfeiture.** Good Health agrees, voluntarily and knowingly, to

surrender and forfeit the sum of $4,500.00, payable to the Missouri State School Fund, in accordance with §§ 374.049.11 and 374.280.2, within fifteen (15) days of the date the Director of the Department (hereinafter "Director") signs an Order approving this Stipulation.

E. **Non-Admission.** Nothing in this Stipulation shall be construed as an admission by Good Health, this Stipulation being part of a compromise settlement to resolve disputed factual and legal allegations arising out of the above referenced market conduct examination.

F. **Waivers.** Good Health, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights to 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 market conduct examination no. 374687.

G. **Amendments.** No amendments to this Stipulation shall be effective unless made in writing and agreed to by authorized representatives of the Division and Good Health.

H. **Governing Law.** This Stipulation 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, on behalf of the Division and Good Health, respectively.

J. **Counterparts.** This Stipulation may be executed in multiple counterparts, each of which shall be deemed an original and all of which taken together shall constitute a single document. Execution by facsimile or by electronically transmitted signature shall be fully and legally effective and binding.

K. **Effect of Stipulation.** This Stipulation shall not become effective until entry of an Order by the Director approving this Stipulation.

L. **Request for an Order.** The signatories below request that the Director issue an Order approving this Stipulation and ordering the relief agreed to in the Stipulation, and consent

to the issuance of such Order.

DATED: November 26, 2024

Teresa Kroll
Chief Market Conduct Examiner
Division of Insurance Market Regulation

DATED: 11.6.24

Phil Bowling
SVP, Chief Financial Officer
Good Health HMO, Inc.

MARKET CONDUCT EXAMINATION REPORT
Health Business of

Good Health HMO, Inc. dba Blue Care
NAIC # 95315

MISSOURI SBS EXAMINATION # 374687

NAIC MATS #MO-HICKSSS1-154

August 21, 2023

Home Office
2301 Main Street
Kansas City, Missouri 64108

STATE OF MISSOURI
DEPARTMENT OF COMMERCE & INSURANCE

JEFFERSON CITY, MISSOURI

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August 21, 2023

Honorable Chlora Lindley-Myers, Director
Missouri Department of Commerce and Insurance
301 West High Street, Room 530
Jefferson City, Missouri 65101

Director Lindley-Myers:

In accordance with your market conduct examination warrant, a targeted market conduct examination has been conducted of the specified lines of business and business practices of

Good Health HMO, Inc. dba Blue-Care Insurance Company (NAIC #95315)

hereinafter referred to as Good Health or as the Company. This examination was conducted as a desk examination at the offices of the Missouri Department of Commerce and Insurance (DCI).

FOREWORD

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 DCI.

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

When used in this report:

- "Company" refers to the Good Health HMO, Inc. dba Blue-Care Insurance Company
- "CSR" refers to the Missouri Code of State Regulations
- "DCI" refers to the Missouri Department of Commerce and Insurance
- "Director" refers to the Director of the Missouri Department of Commerce and Insurance
- "NAIC" refers to the National Association of Insurance Commissioners
- "RSMo" refers to the 2016 Revised Statutes of Missouri, unless otherwise noted

SCOPE OF EXAMINATION

The DCI 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, conducted in accordance with §374.205, RSMo.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DCI regulations. The primary period covered by this review is January 1, 2018 through December 31, 2020, unless otherwise noted. Errors found outside of this time period may also be included in the report.

The examination was a targeted examination involving the following business functions: Health Insurance - Complaint Handling, Grievance Procedures, Claims, and Utilization Review.

The examination was conducted in accordance with the standards in the NAIC's *2021 Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *2021 Market Regulation Handbook* when conducting reviews that are subject to a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices it is ten percent (10%). Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized for reviews not applying the general business practice standard.

In performing this examination, the examiners reviewed only a sample of the Company's practices, procedures, products and files. Therefore, some noncompliant practices, procedures, products and files may not have been found. As such, this report may not fully reflect all of the practices and procedures of the Company.

COMPANY PROFILE

Good Health HMO, Inc., a wholly owned subsidiary of Blue Cross and Blue Shield of Kansas City. Good Health HMO, Inc. was incorporated as a "General Business Corporation" on October 12, 1988, and was subsequently granted a certificate of authority to operate as a Health Maintenance Organization (HMO) under the provisions of Chapter 354, RSMo. The Company provides comprehensive health care services to its members on a prepaid basis. The Company does business under the fictitious name of "Blue-Care," and the records of the Missouri Secretary of State indicate the Company's fictitious name registration is effective until February 28, 2025.

The Company is licensed as a 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.

EXECUTIVE SUMMARY

The DCI conducted a targeted market conduct examination of the Company. The examiners found the following areas of concern:

COMPLAINT HANDLING

- During the course of the examination, the Company had to submit three iterations of its complaint log due to data inaccuracies present in the first two submissions. Reference: §375.936(3); §375.934(2), RSMo, and 20 CSR 100-8.040(3)(D).
- The Company did not maintain its complaint register in a manner in which the Company could provide it to the DCI so that complaint handling practices could be readily ascertained. Reference: §374.205.2(2), RSMo, and 20 CSR 100-8.040(2).

GRIEVANCE PROCEDURES

- The Company reported an inaccurate count of grievances for its 2018, 2019, and 2020 Annual Reporting of Utilization Review Activities. Reference: §§376.1359.2, 374.210.1(2), RSMo, and 20 CSR 400-10.020(1)(A)-(B).
- In nine of 20 second level grievances initiated after August 28, 2019, the Company inappropriately notified members that clinical peers were included on the grievance advisory panel. Reference: §375.1007(1), RSMo.
- In seven of 20 second level grievances initiated after August 28, 2019 clinical peers did not act independently when making a determination regarding the grievance outcome. These reviewers discussed the cases on the telephone and agreed to the outcome prior to submitting their documented findings. Reference: §376.1385.2, RSMo, 2019.
- Certificates of Coverage did not contain an accurate description of the Company's grievance procedures. Reference: §§376.1378, RSMo.
- Certificates of Coverage issued after August 28, 2019 did not accurately represent the terms and advantages of the policy with respect to second level grievances. Reference: §354.430.3(2)(e), RSMo.
- The Company did not provide an acknowledgment letter for 10 first level grievances. Reference: §376.1382.2(1), RSMo.
- The Company did not provide an acknowledgment response on four second level grievances. Reference: §§376.1382.2(1), 376.1385.3, RSMo.
- The Company did not provide a timely acknowledgment response to two members regarding their second level grievance. Reference: §§376.1382.2(1), 376.1385.3, RSMo.

UTILIZATION REVIEW

- The Company omitted three Utilization Review Agents from its Annual Report of Utilization Review Activities reports during the exam period. Reference: §376.1359 RSMo, and 20 CSR 400-10.020(1)(B)

CLAIMS

- The Company issued Explanations of Benefits (EOBs) for eight ambulance claims, which incorrectly advised insureds "Maximum benefits payable under the member's coverage has been provided." Reference: §375.1007(1), RSMo.
- The Company did not pay billed charges for 37 ambulance claims. Reference: §375.1007(3), RSMo.
- Member liability was applied for basic health care services in a form other than co-insurance, deductibles, or copayments. Reference: §§354.410.1(2), 354.400(1), and 354.470.1(3), RSMo.

EXAMINATION FINDINGS

II. COMPLAINT HANDLING

The complaint handling portion of the examination provides a review of the Company's complaint handling practices. The examiners reviewed how the Company handled complaints to ensure it was performing according to its own guidelines and Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 20 – Complaint Handling Standard 1: All complaints are recorded in the required format on the regulated entity's complaint register.

To test for this standard, the examiners requested and reviewed a copy of the Company's complaint register, complaints the DCI received, and noted any complaints received through the review of files to assess whether the Company included all complaints on the complaint register.

Finding 1: During the course of the examination, the Company had to submit three iterations of its complaint log due to data inaccuracies present in the first two submissions. These data inaccuracies ranged from the omission of relevant, responsive complaints to the inclusion of complaints outside of the scope of the exam. Company records, including the Company's complaint log are expected to be maintained in a manner such that the complete and accurate record can be produced during an examination within 10 calendar.

Reference: §375.936(3), §375.934(2), RSMo, and 20 CSR 100-8.040(3)(D).

Finding 2: The Company did not maintain its complaint register in a manner in which it could be provided to the DCI so that complaint handling could be readily ascertained. Three requests for a complete complaint log had to be submitted during the examination.

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

B. NAIC Market Regulation Handbook Chapter 20 – Complaint Handling Standard 2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders.

To test for this standard, the examiners requested and reviewed a copy of the Company's complaint handling procedures manual.

The examiners found no errors in this review.

C. NAIC Market Regulation Handbook Chapter 20 – Complaint Handling Standard 3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

To test for this standard, the examiners reviewed a census of 20 complaints submitted to the DCI. The examiners then reviewed the files to determine if the Company took adequate steps to finalize and dispose of the complaints.

The examiners found no errors in this review.

D. NAIC Market Regulation Handbook Chapter 20 – Complaint Handling Standard 4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations.

To test for this standard, the examiners reviewed a census of 20 complaints submitted to the DCI. The examiners then reviewed the files to determine if the Company responded to complaints in a timely manner.

The examiners found no errors in this review.

II. GRIEVANCE PROCEDURES

The grievance procedures portion of the examination is designed to evaluate how well the Company handles grievances. The Missouri definition of a "grievance" is set forth in §376.1350(17), RSMo.

A. NAIC Market Regulation Handbook Chapter 24 – Grievance Procedures Standard 1: The health carrier treats a grievance as any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination; 2) claims payment, handling or reimbursement for health care services; or 3) the contractual relationship between a covered person and the health carrier.

To test for this standard, the examiners reviewed a sample of 76 first level grievances from a population of 817 first level grievances. The examiners also reviewed a census of 24 second level grievances as well as a census of nine expedited grievances. From these populations, the examiners assessed whether the Company was correctly identifying and treating grievances that meet the definition in §376.1350(17), RSMo, as complaints.

The examiners found no errors in this review.

B. NAIC Market Regulation Handbook Chapter 24 – Grievance Procedures Standard 2: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners requested the Company provide its grievance log in conjunction with the complaint log requested in Complaint Handling Standard 1 above. Since the Company maintains a consolidated log (i.e., all complaints, including complaints that constitute grievances, are maintained in the same log), the examiners reviewed the complaint log to assess whether it meets the standards in §§376.1375, 376.1378, 354.445, RSMo, and 20 CSR 400-7.110.

Finding 1: The Company reported inaccurate grievance counts to the DCI in 2018, 2019, and 2020 in conjunction with its submission of its Annual Reporting of Utilization Review Activities.

Reference: §§376.1359.2, 374.210.1(2), RSMo, and 20 CSR 400-10.020(1)(A)-(B).

C. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 3: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

To test for this standard, the examiners requested and reviewed the Company's procedures specific to grievances in conjunction with the request for complaint handling procedures in Complaint Handling Standard 2 above. In addition, the examiners verified whether the Company filed its grievance procedures with the DCI and that the Company informs enrollees of those procedures. The examiners also reviewed the member Certificate of Coverage documents to determine if the provisions communicate clear procedures on how to file a grievance.

In 2019, Senate Bill 514 revised subsection 376.1385.2 RSMo, related to second level grievance procedures. The revised statute became effective August 28, 2019. Under this standard, the examiners reviewed a census of 20 second level grievances, which were initiated after August 28, 2019 to determine compliance with the updated provisions of the law.

Citations	Sample Size	Sample Type	No. of Errors	Error Ratio
§376.1385.2	20	Census	9	45%
§376.1378	20	Census	20	100%
§375.936(6)(a)	20	Census	20	100%

*Policies with more than one error were only counted once per statute subsection.

Finding 1: In nine of 20 second level grievances initiated after August 28, 2019, the Company inappropriately notified members that clinical peers were included on the grievance advisory panel.

Reference: §375.1007(1), RSMo.

Finding 2: In seven of 20 second level grievances initiated after August 28, 2019, clinical peer reviewers did not act independently when making a determination regarding the grievance outcome. Although the Company contracted with a peer review entity to conduct these reviews, files show the peer reviewers discussed the case over the telephone prior to submitting their clinical opinion to the Company.

Reference: §376.1385.2, RSMo, 2019.

Finding 3: Certificate BC-CERT-17-M, found in all 20 second level grievances, does not contain an accurate description of the Company's grievance procedures as it relates to second level grievances.

Reference: §376.1378, RSMo.

Finding 4: Certificates issued after August 28, 2019 did not accurately represent the terms and advantages of the policies. The Company modified its second level grievance procedures in August of 2019 to align with §376.1385.2 RSMo, but did not disclose such modifications through the contract to its insureds.

Reference: §354.430.3(2)(e), RSMo.

D. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 4: The health carrier has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners requested and reviewed the Company's procedures specific to grievances in conjunction with the request for complaint handling procedures in Complaint Handling Standard 2 above. The examiners assessed whether any complaints dealing with a first level grievance review involving an adverse determination are being handled in accordance with the requirements of §376.1382, RSMo and the Company's written procedures. Examiners also selected and reviewed 131 first level grievance files from a population of 817 to evaluate whether the Company correctly processed grievances in accordance with Missouri laws.

Citations	Sample Size	Sample Type	No. of Errors
§376.1382.2(1)	131	Random Stratified	10

Finding 1: The Company did not provide an acknowledgment letter for ten first level grievances.

Reference: §376.1382.2(1), RSMo.

E. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 6: The health carrier has procedures for voluntary reviews of grievances and conducts voluntary reviews of grievances in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners requested and reviewed the Company's procedures specific to second level grievances in conjunction with the request for complaint handling procedures in Complaint Handling Standard 2 above. The examiners also reviewed the member Certificate of Coverage documents to determine if the provisions communicate clear procedures on how to file a grievance.

Citations	Field Size	Sample Type	No. of Errors
376.1385.3 RSMo 2019	55	Census	6

Finding 1: The Company did not provide an acknowledgment response for four second level grievances.

Reference: §§376.1385.3, 376.1382.2(1), RSMo, 2019.

Finding 2: The Company did not provide a timely acknowledgment response to two members regarding their second level grievance.

Reference: §376.1385.3, RSMo, 2019.

F. NAIC Market Regulation Handbook Chapter 24 - Grievance Procedures Standard 7: The health carrier has procedures for and conducts expedited reviews of urgent care requests of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners reviewed a census of expedited grievances from the Company provided grievance log requested in Complaint Handling Standard 1 above. The examiners requested and reviewed the Company's procedures specific to expedited grievances in conjunction with the request for complaint handling procedures in Complaint Handling Standard 2 above. The examiners also reviewed the member Certificate of Coverage documents to determine if the provisions communicate clear procedures on how to file a grievance.

The examiners found no errors in this review.

III. UTILIZATION REVIEW

The Utilization Review portion of the examination provides a review of the Company's compliance with Missouri statutes and regulations regarding utilization review practices such agent and administrator licensing, oversight, adherence to contract provisions, and compliance with Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 24 - Utilization Review Standard 1: The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

To test for this standard, the examiners compared information obtained through formal requests during the examination to the Company's filed Annual Utilization Review Activities reports.

Finding 1: The Company omitted three Utilization Review Agents from its annual Utilization Review Activities reports during the exam period.

Reference: §376.1359, RSMo, and 20 CSR 400-10.020(1)(B).

IV. CLAIMS

The claims portion of the examination provides a review of the Company's compliance with Missouri statutes and regulations regarding claims handling practices such as the timeliness of

handling, accuracy of payment, adherence to contract provisions, and compliance with Missouri statutes and regulations.

A. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 6: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations.

From claims data supplied by the Company, the examiners extracted a set of claims for ambulance services. The examiners selected a random sample of 108 ambulance claims. Examiners reviewed claim files for compliance with Missouri laws and rules. The examiners also requested and reviewed claim manuals. The results of this review are summarized below.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
375.1007(1)	108	Random Stratified	8	7.4%
375.1007(3)	108	Random Stratified	37	34.3%
375.1007(4)	108	Random Stratified	39	36.1%
375.445.1(2)	108	Random Stratified	39	36.1%
354.410.1(2)	108	Random Stratified	39	36.1%

Finding 1: The Company issued Explanations Of Benefits (EOBs) for eight ambulance claims, which incorrectly advised insureds "Maximum benefits payable under the member's coverage has been provided."

Reference: §375.1007(1), RSMo.

Finding 2: The Company did not implement reasonable standards to allow for the payment of billed charges for ambulance claims in 37 instances.

Reference: §375.1007(3), RSMo.

Finding 3: For 39 claims, member liability was applied in a form other than that of a deductible, co-insurance, or copayment. Members held responsible for charges associated with this basic health care service provided by non-HMO ambulance providers.

Reference: §§354.410.1(2), 354.400(1), and 354.470.1(3), RSMo.

B. NAIC Market Regulation Handbook Chapter 20 - Claims Standard 9: Denied and closed without payment claims are handled in accordance with policy provisions and state law.

Claims data for a specific laboratory provider was supplied by the Company. From data supplied, the examiners extracted a random sample of 43 claims from the population of 103 claims. Examiners reviewed claim files for compliance with Missouri laws. The results of this review are summarized below.

Citations	Field Size	Sample Type	No. of Errors	Error Ratio
375.1007(1)	43	Random Stratified	26	60.4%

Finding 1: In 26 instances, explanations of benefits misrepresented to insureds that they were financially responsible for charges incurred from this non-network, participating laboratory when, in fact, member liability written off was due to a contract between the Company and the non-network but participating laboratory provider.

Reference: §375.1007(1), RSMo.

VIII. CRITICISMS AND FORMAL REQUESTS TIME STUDY

This study is based upon the time required by the Company to provide the examiners with the requested material or to respond to criticisms. Missouri statutes and regulations require companies to respond to criticisms and formal requests within 10 calendar days. 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 subsequent time frame. If the response was not received within the allotted time, the response was not considered timely.

A. Criticism Time Study

Number of Calendar Days to Respond	Number of Criticisms	Percentage of Total
0 to 10 days	14	100%
Over 10 days with extension	0	0%
Over 10 days without extension or after extension due date	0	0%
Totals	14	100%

The examiners found no errors in this review.

B. Formal Request Time Study

Number of Calendar Days to Respond	Number of Requests	Percentage of Total
0 to 10 days	39	88.63%
Over 10 days with extension	5	11.36%
Over 10 days without extension or after extension due date	0	0%
Totals	44	100%

The examiners found no errors in this review.

FINAL EXAMINATION REPORT SUBMISSION AND ACKNOWLEDGEMENT

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Good Health HMO, Inc. (NAIC #537-95315), Missouri Examination Number 374687. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated August 21, 2023. 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.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the Examination are hereby acknowledged.

December 9, 2024
Date

Teresa Kroll
Chief Examiner, Market Conduct

This examination was conducted by and the draft report was produced by the following team members:

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