

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

In Re:)	
)	
TIME INSURANCE COMPANY (NAIC #69477))	Market Conduction Examination
UNION SECURITY INSURANCE)	Numbers 0706-08-TGT
COMPANY (NAIC #70408))	0706-09-TGT
JOHN ALDEN LIFE INSURANCE)	0706-10-TGT
COMPANY (NAIC #65080))	

ORDER OF THE DIRECTOR

NOW, on this 15 day of July, 2013, Director John M. Huff, after consideration and review of the market conduct examination reports of Time Insurance Company (NAIC #69477) (hereafter referred to as "Time") and Union Security Insurance Company (NAIC #70408) (hereafter referred to as Union Security) report numbers 0706-08-TGT and 0706-09-TGT, prepared and submitted by the Division of Insurance Market Regulation (hereafter "Division") pursuant to §374.205.3(3) (a)¹ and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") entered into by the Division, Time, Union Security and John Alden Life Insurance Company (NAIC #65080) (hereafter "John Alden") does hereby adopt such reports as filed. After consideration and review of the Stipulation, reports, relevant work papers, and any written submissions or rebuttals, the findings and conclusions of such reports 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. 2012), is in the public interest.

IT IS THEREFORE ORDERED that Time, Union Security, John Alden 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 Time, Union, Security and John Alden shall not engage

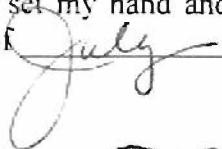
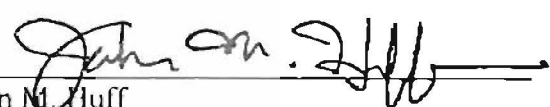
¹ All references, unless otherwise noted, are to Missouri Revised Statutes 2000 as amended.

in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures, and take all other actions required, to place the Companies 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 Time, Union Security and John Alden shall collectively pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$500,000 payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 5th day of July, 2013.



John M. Huff
Director



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

In Re:)	
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TIME INSURANCE COMPANY (NAIC #69477))	Market Conduction Examination
UNION SECURITY INSURANCE)	Numbers 0706-08-TGT
COMPANY (NAIC #70408))	0706-09-TGT
JOHN ALDEN LIFE INSURANCE)	0706-10-TGT
COMPANY (NAIC #65080))	

STIPULATION OF SETTLEMENT
AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by the Division of Insurance Market Regulation (hereinafter "the Division") and Time Insurance Company (NAIC #69477) (hereinafter referred to as "Time"), Union Security Insurance Company (NAIC #70408) (hereinafter referred to as "Union Security"), and John Alden Life Insurance Company (NAIC # 65080) (hereinafter referred to as "John Alden"), 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; and

WHEREAS, Time, Union Security and John Alden have been granted certificates of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Division conducted a Market Conduct Examination of Time and prepared report number 0706-08-TGT; and

WHEREAS, the Division conducted a Market Conduct Examination of Union Security and prepared report number 0706-09-TGT; and

WHEREAS, the Division conducted a Market Conduct Examination of John Alden, exam number 0706-10-TGT, but preparation of a market conduct examination report was suspended pending the negotiation of this settlement; and

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

1. In 115 instances, errors were identified in Time's application and enrollment forms in violation of §375.936 (11) (f)¹ and 20 CSR 300-2.200;

2. In 33 instances, errors were identified in Time's handling of cancer screening claims denied in 2004 in violation of §§375.1007 (1), (3), (4), (6), 376.1250.1 (3) and 376.383.5;

3. In 23 instances, errors were identified in Time's handling of cancer screening claims denied in 2005 in violation of §§375.1007 (1), (3), (4), (6), 376.1250, and 20 CSR 300-2.200;

4. In 12 instances, errors were identified in Time's handling of cancer screening claims denied in 2006 in violation of §§375.1007 (1), (3), (4), (6), 376.1250, and 20 CSR 100-1.050 (1) (A);

5. In 27 instances, errors were identified in Time's handling of childhood immunization claims denied in 2004 in violation of §§376.1215, 375.1007 (1), (3), (4), and 376.383.5;

6. In 194 instances, errors were identified in Time's handling of childhood immunization claims denied in 2005 in violation of §§376.1215, 375.1007 (3), (4), and 376.383.5;

7. In 6 instances, errors were identified in Time's handling of childhood immunization claims denied in 2006 in violation of §§376.1215, 375.1007 (1), (3), (4), and 376.383.5;

8. In 3 instances, errors were identified in Time's handling of childhood immunization claims paid in 2004 in violation of §§376.1215, 375.1007 (1), (3), and (4);

9. In 17 instances, errors were identified in Time's handling of childhood immunization claims paid in 2005 in violation of §§376.1215, 375.1007 (1), (3), (4), and 376.383.5;

10. In 5 instances, errors were identified in Time's handling of childhood immunization claims paid in 2006 in violation of §§376.1215, 375.1007 (1), (3), (4), 376.383.5, and 19 CSR 20-28.060.

11. In 22 instances, errors were identified in Time's handling of emergency room and ambulance claims denied in 2004 in violation of §375.1007 (1), (3), (4), and 20 CSR 300-2.200;

12. In 31 instances, errors were identified in Time's handling of emergency room and ambulance claims denied in 2005 in violation of §§375.1007 (1), (3), (4), 375.995.4 (6), and 376.383.5;

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

13. In 11 instances, errors were identified in Time's handling of emergency room and ambulance claims denied in 2006 in violation of §§375.1007 (1), (3), (4), 376.1367, and 376.383.5;

14. In 14 instances, errors were identified in Time's handling of mammogram claims denied in 2004 in violation of §§375.1007 (4), (6), and 376.782.2 (1), (2);

15. In 7 instances, errors were identified in Time's handling of mammogram claims denied in 2005 in violation of §§375.1007 (1), (3), (4), (6), and 376.782.2 (1), (2);

16. In 7 instances, errors were identified in Time's handling of mammogram claims denied in 2006 in violation of §§375.1007 (1), (3), (4), (6), and 376.782.2 (1), (2);

17. In 264 instances, errors were identified in Time's handling of pap smear claims denied in 2004 in violation of §§375.1007 (1), (3), (4), (6), 376.1250.1 (1), and 20 CSR 300-2.200;

18. In 237 instances, errors were identified in Time's handling of pap smear claims denied in 2005 in violation of §§375.1007 (1), (3), (4), (6), 376.1250.1 (1), and 376.383.5;

19. In 211 instances, errors were identified in Time's handling of pap smear claims denied in 2006 in violation of §§375.1007 (1), (3), (4), (6), 376.1250.1 (1), 376.383.5, and 20 CSR 100-1.050;

20. In 28 instances, errors were identified in Time's handling of PSA claims denied in 2004 in violation of §§375.1007 (1), (3), (4), 376.1250.1 (2), and 376.383.5;

21. In 37 instances, errors were identified in Time's handling of PSA claims denied in 2005 in violation of §§375.1007 (1), (3), (4), 376.1250.1 (2), 376.383.5, 374.205.2 (2), and 20 CSR 300-2.200;

22. In 20 instances, errors were identified in Time's handling of PSA claims denied in 2006 in violation of §§375.1007 (1), (3), (4), (6), 376.1250.1 (2), 376.383.5, and 20 CSR 300-2.200;

23. In 9 instances, errors were identified in Time's handling of pre-existing condition claims denied in 2004 in violation of §§375.1007 (1), (3), (4), (6), and 20 CSR 300-2.200;

24. In 2 instances, errors were identified in Time's handling of pre-existing condition claims denied in 2006 in violation of §§375.1007 (1), (3), (6), and 20 CSR 300-2.200;

25. In 1285 instances, Time failed to pay or underpaid interest on claims in violation of

§376.383.5²:

26. In 86 instances, errors were identified in Time's handling of consumer complaints sent directly to the Company in violation of §§375.1007 (1), (3), (4), (6), 375.995.4 (6), 376.441, 376.1350 (12), and 376.1367;

27. In 14 instances, errors were identified in Time's handling of consumer complaints received from the Department in violation of §§375.1007 (1), (3), (4), (6), 376.1350 (12), and 376.1367;

WHEREAS, the market conduct examination report of Union Security revealed substantially similar errors to the ones noted above for Time.

WHEREAS, no market conduct report has been prepared for John Alden, but the market conduct examination of John Alden revealed substantially similar errors to the ones noted above for Time.

WHEREAS, Time, Union Security and John Alden in the interest of resolving these Market Conduct Examinations have agreed to resolve the issues raised in the Market Conduct Examinations 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.** Time, Union Security and John Alden agree to take remedial action bringing each into compliance with the statutes and regulations of Missouri and agree to maintain those remedial actions at all times, to reasonably assure that the errors noted in the Time and Union Security examination reports do not recur. Such remedial actions shall include, but not be limited to, the following:

1. Time, Union Security, and John Alden agree to provide immunization benefits for children without copayments, coinsurance, deductibles or waiting periods in compliance with §376.1215 in all policies and certificates providing health insurance coverage to residents of

² Some of these errors were also noted in paragraphs 1-24 above.

Missouri, including certificates issued to Missouri residents providing coverage under a group policy issued in another state, and to process claims for immunization benefits made by Missouri residents in compliance with these same requirements for coverage in §376.1215.

2. Time. Union Security and John Alden agree, to the extent they have not already done so, to review all denied cancer screening claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims pursuant to §408.020. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

3. Time. Union Security and John Alden agree, to the extent they have not already done so, to review all denied childhood immunization claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims pursuant to §408.020. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

4. Time. Union Security and John Alden agree, to the extent they have not already done so, to review all childhood immunization paid claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to determine if the correct amount was paid. If an additional payment is owed on the claim, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims

pursuant to §408.020. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

5. Time, Union Security and John Alden agree, to the extent they have not already done so, to review all denied mammogram claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims pursuant to §408.020. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

6. Time, Union Security and John Alden agree, to the extent they have not already done so, to review all denied Pap smear claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims pursuant to §408.020. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

7. Time, Union Security and John Alden agree, to the extent they have not already done so, to review all denied PSA test claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. In addition, interest at the rate of 9% per annum must be included on all paper claims pursuant to §408.020. A letter must

be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

8. **Time.** Union Security and John Alden agree, to the extent they have not already done so, to review all paid short term major medical claims submitted to each Company dated January 1, 2004 through the date of the Order finalizing these examinations to determine whether the proper amount of interest was paid on the claims. If an incorrect amount of interest was paid on a claim, the Company shall issue the remaining payments that are due to the claimants bearing in mind that an additional payment of 1% interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt pursuant to §376.383. A letter must be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim.

C. **Compliance.** Time, Union Security and John Alden agree to file documentation with the Division within 120 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 payment of restitution required by this stipulation.

D. **Voluntary Forfeiture.** Time, Union Security and John Alden agree, voluntarily and knowingly, to collectively surrender and forfeit the sum of \$500,000, such sum payable to the Missouri State School Fund, in accordance with §374.280. Payment of \$500,000 shall be due within 10 days of the entry of a final order by the Director closing these examinations.

E. **Charitable Contribution.** Time, Union Security and John Alden (themselves or through Assurant, Inc.) agree, voluntarily and knowingly, to collectively contribute the sum of \$500,000 to a Missouri charitable or non-profit organization selected by Time, Union Security and John Alden and subject to the approval of the Department. Such contribution shall be made within 60 days of the entry of a final order closing these exams.

E. **Other Penalties.** The Division agrees that it will not seek penalties against Time, Union Security and John Alden, other than those agreed to in this Stipulation, for the conduct found in Market Conduct Examinations 0706-08-TGT, 0706-09-TGT or 0706-10-TGT.

F. **Waivers.** Time, Union Security and John Alden, 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. The parties agree that any future Market Conduct Examination of Time, Union Security, or John Alden by the Division relating to any issues actually addressed in Market Conduct Examinations 0706-08-TGT, 0706-09-TGT, and 0706-10-TGT shall have a review period beginning after the entry of the Final Order by the Director of the Department. This shall not preclude the Division from initiating an examination of Time, Union Security, or John Alden for a review period beginning prior to entry of the Final Order by the Director of the Department, pursuant to the laws of the State of Missouri, with respect to issues that were not actually addressed in Market Conduct Examinations 0706-08-TGT, -0706-09-TGT, and 0706-10-TGT.

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:

7/9/13


Stewart Freilich
Legal Counsel
Division of Insurance Market Regulation

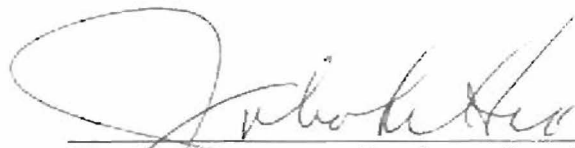
DATED:

6/13/13


Vice President Assurant Regulatory Compliance
& Assurant Health Compliance Officer
Time Insurance Company
(Assurant Health)


DATED:

6/13/13

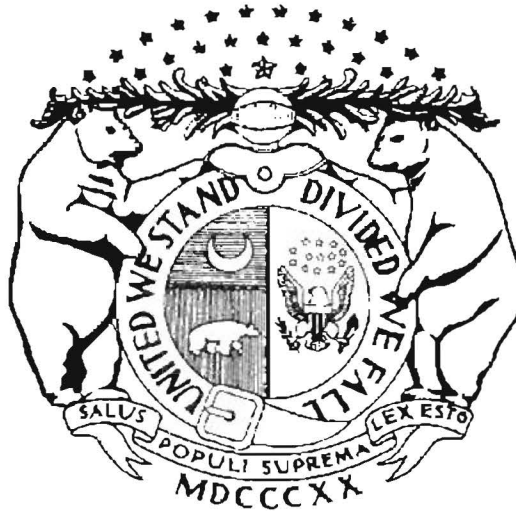

Vice President Assurant Regulatory Compliance
& Assurant Health Compliance Officer
Union Security Insurance Company
(Assurant Health)

DATED:

6/13/13


Vice President Assurant Regulatory Compliance
& Assurant Health Compliance Officer
John Alden Life Insurance Company
(Assurant Health)

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



FINAL MARKET CONDUCT EXAMINATION REPORT
Of the Life and Health Business of

TIME INSURANCE COMPANY
NAIC #69477

MISSOURI EXAMINATION #0706-08-TGT

July 8, 2013

Home Office
501 West Michigan Street
Milwaukee, WI 52302

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FOREWORD

This is a targeted market conduct examination report of the Time Insurance Company. (NAIC Code # 69477). This examination was conducted at the offices of Time Insurance Company, located at 501 West Michigan Street, Milwaukee, Wisconsin, and 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.

Wherever used in the report:

- “CPT” refers to the Current Procedural Terminology code set;
- “Company” refers to Time Insurance Company, Inc.;
- “CSR” refers to Code of State Regulations;
- “Department” or “DIFP” refers to the Department of Insurance, Financial Institutions and Professional Registration;
- “EOB” refers to Explanation of Benefits;
- “HAA” refers to Health Advocates Alliance;
- “ICD-9” refers to the International Classification of Diseases, Ninth Revision;
- “ICU” refers to Intensive Care Unit;
- “NAIC” refers to the National Association of Insurance Commissioners;
- “PPO” refers to Preferred Provider Organization; and
- “RSMo” refers to the Revised Statutes of Missouri.

SCOPE OF THE EXAMINATION

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

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2004, through December 31, 2006, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: underwriting and rating practices, claims handling practices, and the handling of complaints and grievances for major medical health insurance.

The examination was conducted in accordance with the standards in the NAIC's *Market Regulation Handbook*. As such, the examiners utilized the benchmark error rate guidelines from the *Market Regulation Handbook* when conducting reviews that applied a general business practice standard. The NAIC benchmark error rate for claims practices is seven percent (7%) and for other trade practices is ten percent (10%). Pursuant to §376.384, prompt payment reviews of health claims are subject to a five percent (5%) error rate. Error rates exceeding these benchmarks are presumed to indicate a general business practice. The benchmark error rates were not utilized, however, for reviews not applying the general business practice standard.

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

COMPANY PROFILE

The following Company profile was provided to the examiners by the Company:

The Company first organized in LaCrosse, Wisconsin in 1892 as the LaCrosse Mutual Aid Association. The Company then moved to Milwaukee in 1900 and by 1905 took the name Time Indemnity. On February 11, 1910 the Company incorporated and changed its name to Time Insurance Company. Time Insurance Company commenced business on March 6, 1910.

In April, 1969, Time Holdings, Inc., was formed to become the parent Company of Time Insurance Company. During January 1978, control of Time Holdings, Inc. was acquired by N.V. AMEV, a Dutch financial services Company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. Effective April 1, 1998, Time Insurance Company changed its name to Fortis Insurance Company. Fortis Insurance Company's direct parent is Interfinancial, Inc., which in turn, is controlled by Fortis, Inc., in New York, New York. The ultimate controlling entities are Fortis AG, located in Belgium, and Fortis AMEV. Effective January 1, 1999, Fortis AG was renamed Fortis (B) and Fortis AMEV was renamed Fortis (NL) N.V. On September 27, 2001, Fortis (B) was replaced by Fortis SA/NV, a Belgian Company and Fortis (NL) N.V. was replaced by Fortis N.V., a Netherlands Company. The U.S. operations were known as Fortis, Inc., which was renamed Assurant, Inc. when it became a publicly traded Company on the New York Stock Exchange through an Initial Public Offering (IPO) on February 5, 2004. Effective September 6, 2005, Fortis Insurance Company changed its name to Time Insurance Company.

The Company is licensed by the DIFP under Chapters 375 and 376, RSMo, to write life and health insurance as set forth in its Certificate of Authority.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Time Insurance Company. The examiners found the following principal areas of concern.

I. UNDERWRITING AND RATING PRACTICES

A. Forms and Filings

- The Company took the position that the policies it issued to an association group situated in Illinois and a multiple employer trust group situated in Alabama were not required to comply with the requirements of §376.1215, RSMo. relating to childhood immunizations, despite having been apprised by letter that the Department interprets this statute to apply to all coverage provided in Missouri. *(Pages 12 – 13.)*
- The examiners found that the Company asked insurance applicants in writing and via telephone interviews whether other insurance carriers had previously denied or restricted coverage, contrary to §375.936(11)(f), RSMo. Two new compliant enrollment forms (29300-MO and 29500-MO) were deployed for use during the course of this examination on 07/26/08. *(Pages 13 - 14)*

B. Small Employer Group Underwriting and Rating

- The examiners noted no errors concerning general underwriting guidelines and procedures in a review of 43 underwriting files from a list of 111 small group policies. *(Page 14.)*

C. Rescissions

- The Company failed to maintain sufficient documentation in a rescission file that would allow the examiners to ascertain whether or not the Company's actions were appropriate. *(Pages 14 - 15)*

II. CLAIM PRACTICES

A. Unfair Claim Practices – Denied Claims for Cancer Screenings

- The Company erred in processing 32.7% of claims in 2004; 20.9% of claims in 2005; and 20.0% of claims in 2006. *(Pages 17 – 23.)*
- The Company failed to pay or underpaid interest on many colorectal cancer screening claims paid more than 45 days after receipt, contrary to §376.383.5, RSMo. The Company declined to make additional payments during the course of the examination.
- The Company improperly denied claims for being subject to a waiting period, for preventive care exclusions, and for failure to submit claims to the PPO network intermediary under contract with the Company, contrary to §§375.1007(1), (3), (4), and (6), and 376.1250, RSMo.
- Because conflicting reasons were given for denial of a claim in many cases, the examiners could not readily ascertain the reasons for the Company's claim

processing practices, contrary to 20 CSR 300-2.200 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08].

B. Unfair Claim Practices – Denied Claims for Childhood Immunizations

- The Company erred in processing 13.4% of claims in 2004; 27.1% of claims in 2005; and 1.9% of claims in 2006. (*Pages 23 – 28.*)
- The Company failed to pay or underpaid interest on many childhood immunization claims paid more than 45 days after receipt, contrary to §376.383.5, RSMo, and declined to make additional payments during the course of the examination in some cases.
- The Company improperly denied claims for being subject to a waiting period, for preventive care exclusions, for asserting that procedures were included in other reimbursed procedures, and for failure to submit claims to the PPO network intermediary under contract with the Company, contrary to §§375.1007 (1), (3), (4), and (6), and 376.1215, RSMo.
- The Company improperly denied benefits on two claims by applying benefits to co-payments or deductibles, contrary to §376.1215, RSMo.

C. Unfair Claim Practices – Paid Claims for Childhood Immunizations – Benefits Applied to Deductibles or Co-Payments

- The Company erred in processing 1.4% of claims in 2004; 3.4% of claims in 2005; and 2.1% of claims in 2006. (*Pages 29 – 32.*)
- The Company improperly denied 19 claims for childhood immunizations by applying benefits to deductibles or copayments contrary to §§375.1007(1), (3), and (4), and 376.1215, RSMo.
- The Company improperly denied four claims for childhood immunizations by asserting that the charges were included as part of other covered charges, contrary to §375.1007(1), (3), and (4), RSMo.
- The Company failed to pay or underpaid interest on many childhood immunization claims paid more than 45 days after receipt, contrary to §376.383.5, RSMo, and declined to make additional payments during the course of the examination in some cases.
- The Company denied benefits for several claims because policies were situated in Illinois and Alabama, contrary to §§375.1007(1), (3), and (4), and 376.1215, RSMo.

D. Unfair Claim Practices – Denied Claims for Emergency Room and Ambulance Services

- The Company erred in processing 8.1% of claims in 2004; 11.8% of claims in 2005; and 4.5% of claims in 2006. (*Pages 32 – 34.*)
- The Company failed to pay or underpaid interest on many emergency claims paid more than 45 days after receipt, contrary to §376.383.5, RSMo, and

declined to make additional payments during the course of the examination in some cases.

- The Company improperly denied a claim for complications of pregnancy, contrary to §375.995.4(6), RSMo. and improperly reduced benefits for failure to pre-authorize emergency care, contrary to §376.1367(1), RSMo.

E. Unfair Claim Practices – Denied Claims for Mammograms

- The Company erred in processing 14.0% of claims in 2004; 10.3% of claims in 2005; and 17.1% of claims in 2006. *(Pages 35 – 38.)*
- The Company failed to pay or underpaid interest on two mammogram claims paid more than 45 days after receipt, contrary to §376.383.5, RSMo.
- The Company improperly denied some mammogram claims for unknown reasons, for failure to submit claims to the PPO network intermediary under contract with the Company, because insureds had exceeded benefit maximums, and without making reasonable investigations contrary to §§375.1007(1), (3), (4), and (6), and 376.782, RSMo.

F. Unfair Claim Practices – Denied Claims for Pap Smears

- The Company erred in processing 57.8% of claims in 2004; 61.9% of claims in 2005; and 83% of claims in 2006. *(Pages 38 – 42)*
- The Company failed to pay, or underpaid interest on many claims that were paid more than 45 days after receipt, contrary to §376.383.5, RSMo, and declined to make additional payments during the course of the examination in some cases.
- The Company improperly denied many claims for being subject to a waiting period, as not being covered services, and for failure to submit claims to the PPO network intermediary under contract with the Company, without making a reasonable investigation to determine amounts payable, contrary to §§375.1007 (1), (3), (4), and (6), and 376.1250.1.(1), RSMo.

G. Unfair Claim Practices – Denied Claims for PSA Tests

- The Company erred in processing 46.7% of claims in 2004; 49.3% of claims in 2005; and 42.6% of claims in 2006. *(Pages 42 – 46.)*
- The Company denied claims as involving a pre-existing condition or as subject to a Special Exception Rider, even though the service was unconnected to the excluded conditions, contrary to §§375.1007(1) and (4), 376.383.5, and 376.1250.1(2), RSMo.
- The Company improperly denied many claims for being subject to waiting periods and for failure to submit claims to the PPO network intermediary under contract with the Company without making a reasonable investigation to determine amounts payable, contrary to §§375.1007(1), (3), (4), and (6), and 376.1250.1.(2), RSMo.

- The Company was unable to locate records and documents relating to several claim denials, contrary to 20 CSR 300.2.200 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08].

H. Unfair Claim Practices – Denied Claims for Pre-Existing

- The Company erred in processing 19.1% of claims in 2004; 4.0% of claims in 2005; and 7.1% of claims in 2006. *(Pages 46 – 50.)*
- The Company improperly denied many claims as involving a pre-existing condition, even though (1) the Company did not have documentation verifying that the condition was validly subject to the pre-existing condition exclusion; (2) the 12 month pre-existing condition exclusion period had expired at the time the services were delivered; or (3) the insured had prior creditable coverage that would require the pre-existing condition exclusion to be waived, contrary to the terms of its own policies, §§375.1007(1), (3), (4), and (6), RSMo, and 20 CSR 300.2.200 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08].

I. Compliance with Interest Payment Requirements for Short-Term Major Medical Claims – 2004 through 2006

Of the 1,396 claims reviewed, the Company underpaid the amount of interest due on 382 claims and completely failed to pay any interest on 903 claims. In many cases, the Company declined to pay any additional interest during the course of the examination based upon its interpretation that the timeframes in §376.383, RSMo, are subject to a “clean claim” standard. In other cases, the Company agreed additional interest was payable but did not furnish evidence of payment during the course of the examination. *(Page 50.)*

III. COMPLAINTS AND GRIEVANCES

A. Consumer Complaints Sent Directly to the Company

The examiners noted that the Company erred in processing claims related to consumer complaints and grievances between 2004 and 2006. The errors in the complaints and grievances can be summarized as follows: *(Pages 52 – 68.)*

- In many cases, the Company improperly denied claims for complications of pregnancy on the basis of policy definitions which were more restrictive than allowed in Missouri, contrary to §375.995.4(6), RSMo. The Company argued that it was not required to comply with the requirements of §375.995.4(6), RSMo, because the master policy providing the coverage had been issued to an association group in Illinois.
- In many cases, the Company improperly denied claims for emergency room or ambulance services, contrary to §376.1367, RSMo. The Company argued that it was not required to comply with the requirements of §376.1367, RSMo, because its plans were not “managed care plans” even though they utilized a

PPO network.

- In many cases, the Company improperly denied claims for pre-existing conditions without documentation that the conditions involved were validly subject to the policy's pre-existing condition exclusion.
- In some cases, the Company improperly denied claims for mandated benefits, contrary to §376.1250.1(1) and (3), RSMo.
- In these and other cases, the Company improperly denied claims by misrepresenting relevant facts or policy provisions; failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims; not attempting in good faith to effect prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear; and refused to pay claims without making a reasonable investigation, contrary to §375.1007(1), (3), (4), and (6), RSMo.
- The Company failed to pay or underpaid interest on many claims that were paid more than 45 days after receipt, contrary to §376.383.5, RSMo, and declined to make additional payments during the course of the examination.
- In some cases, the Company failed to obtain and/or retain documentation essential to its claim and complaint files to allow the examiners to readily ascertain the Company's practices and procedures, contrary to 20 CSR 300-2.200 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08]

B. DIFP Consumer Complaints

The examiners noted that the Company erred in processing claims related to three consumer complaints between 2004 and 2006. The errors can be summarized as follows: (*Pages 68 – 69.*)

- In two cases, the Company improperly denied claims for pre-existing conditions without documentation that the conditions involved were validly subject to the policy's pre-existing condition exclusion. In one of these cases, the Company acknowledged that interest was owed on the claim pursuant to §376.383.5, RSMo.
- In one case, the Company improperly reduced benefits for emergency room care because it did not have a pre-authorization, contrary to §376.1367, RSMo.
- In the above cases, the Company improperly denied claims by misrepresenting relevant facts or policy provisions; failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims; not attempting in good faith to effect prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear; and refused to pay claims without making a reasonable investigation, contrary to §375.1007(1), (3), (4), and (6), RSMo.

Examiners requested that the Company make refunds concerning claim underpayments and unpaid or underpaid interest found for amounts greater than \$5.00 during the examination.

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

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report details the examiners' review of the Company's underwriting and rating practices. Such practices may include the filing and use of policy forms, adherence to underwriting guidelines, assessment of premiums for coverage, and procedures used to decline, non-renew, or terminate coverage. The examiners' review of the Company's underwriting and rating practices sought to determine whether the Company complied with Missouri's laws and regulations as these relate to coverage afforded by the policy. To minimize the duration of the examination, while still achieving an accurate evaluation of underwriting and rating practices, the examiners reviewed a statistical sample of the policy files. The DIFP defines a policy file, in the context of a sampling unit, as a contract between the Company and the insured. A policy file includes all of the parties' obligations to the contract. The percentage of files found to be in error is the most appropriate statistic to measure compliance with Missouri law regarding rating, underwriting, rescissions, or terminations.

The DIFP defines an underwriting or rating error according to NAIC guidelines, which define an error as any of the following:

- A miscalculation of premium;
- An improper acceptance of an application;
- An improper rejection of an application;
- An improper termination of coverage;
- A misapplication of the Company's underwriting guidelines; or
- Any other underwriting or rating action that violates Missouri laws.

A. Forms and Filings

As a part of the review of the Company's claims practices, the examiners conducted a limited review of certain certificate and application forms to determine the Company's compliance with Missouri laws and regulations that refer to filing, approval, and content. In this review, the examiners noted the following exceptions:

1. Out of State Group Policies Providing Coverage in Missouri

The examiners reviewed forms for an Illinois situated association group providing individual market coverage to association members in Missouri and an Alabama situated multiple employer trust providing coverage to small employers in Missouri.

With regard to the 225 Series certificate form, the Company initially filed the policy forms with the State of Illinois, as these forms are specifically intended to afford coverage for members of the Illinois domiciled association group, Health Advocates Alliance (HAA). The Company subsequently filed the certificate forms for informational purposes with the Department. The Company sells this product to

individual applicants that join the HAA. Section 376.421.1(5). RSMo. allows a Company to individually underwrite applicants under such individual market group coverage. The letter sent to the Company in response to the filing was the standard letter utilized by the Department for out-of-state group form filings (the OS2 letter). This letter advised the Company of its responsibility to comply with Missouri law in its provision of benefits, including the childhood immunization requirements of §376.1215, RSMo. Despite this statement, the Company took the position in several of its responses to examiner criticisms regarding claims that §376.1215, RSMo. is inapplicable to the benefits provided under this policy in Missouri.

Reference: §376.1215, RSMo

The Examiners also reviewed the C99 Series certificate form, plan code CC2K. This certificate affords coverage for employees and dependents of participating small employer groups (2 to 50 employees) in many states, including Missouri. The master policy is issued to the Praesidium Trust situated in the State of Alabama. The Company filed the group of forms comprising the C99 certificate for approval with the Alabama Insurance Department in 1999. In the transmittal letter to the filing, the Company indicated that the forms "will not be issued to employees of groups located in Alabama." The Alabama Insurance Department approved the certificate forms upon that basis.

In Formal Request #088, the examiners requested that the Company provide documentation of the filing and approval of the certificate forms in Alabama and Missouri. The Company provided a copy of the Alabama filing and explained that the certificate forms had not been filed in Missouri due to a statement in the OS2 letter that the Company had received from the Department in response to the filing of the P97 policy and the C98 certificate forms, i.e., "Based upon the information you have provided, the above-referenced form filing is not required by Missouri law to be filed with and approved by the Missouri Department of Insurance." As noted above, however, this letter also advised the Company of its responsibility to comply with Missouri law in its provision of benefits, including the childhood immunization requirements of §376.1215, RSMo. Despite this statement, a mandated benefit chart supplied with the Company's response to Formal Request #88 states that §376.1215, RSMo. is inapplicable to the benefits provided under this policy in Missouri.

Reference: §376.1215, RSMo

2. Application/Enrollment Forms

According to Criticism # 002, 003, 005, 009, and 175, the Company accepted 97 applications which asked whether the applicant or any person to be insured had ever been cancelled, non-renewed, declined, excluded, or rescinded. The applications included forms 24275(Re. 10/93), 26587, 26635, 27285, 27849, 27940, 29300-MO, and Short-Term Medical Application 517/518. The examiners were unable to

identify whether there were additional form numbers in the files reviewed since many of the forms in the electronic files provided by the Company had illegible form numbers or had been scanned in such a manner that no form number was visible.

Records for 18 policies in the files reviewed also included an audio file with phone interviews wherein the Company verified that the applicant was a resident of Missouri and verbally asked the same question.

This type of question on applications is a violation of the Unfair Trade Practices Act. The Act's application to coverage issued in Missouri is extra-territorial. No insurance company or its agent or representative shall require any applicant or policyholder to divulge in a written application or otherwise whether any insurer has cancelled or refused to renew or issue to the applicant or policyholder a policy of insurance.

The Company stated in response to Criticism #175 that it had reviewed all enrollment practices for coverage issued in Missouri and has amended its practices to eliminate questions that would conflict with §375.936(11)(f), RSMo. New enrollment forms were deployed for use during the course of this examination on July 26, 2008. The Company provided copies of forms 29300-MO and 29500-MO to document its change in procedures.

Reference: §375.936(11)(f), RSMo, and 20 CSR 300-2.200 (as replaced by 20 CSR 100-8.040, eff. 7/30/08)

B. Small Employer Group Underwriting and Rating

The examiners reviewed general underwriting guidelines and procedures to determine whether the Company adhered to prescribed and acceptable underwriting criteria. The review sampled 43 underwriting files from a list of 111 small group policies. No errors were noted in this review.

C. Rescissions

During the course of reviewing the Company's claims practices, the examiners also reviewed its handling of rescissions for calendar years 2004 through 2006. No errors were found related to rescissions handled in 2005 or 2006, but the results of the review for 2004 are as follows:

Field Size:	993
Type of Sample:	Random
Sample Size:	49
Number of Errors:	1
Error Ratio:	2%
Within DIFP Guidelines?	Yes

The examiners noted the following error in this review:

According to Criticism #167, the Company rescinded coverage in one case, but copies of the medical records essential to this decision were not available in the file. Because the examiners could not readily ascertain the correctness of the action taken to rescind this insured's coverage, the Company failed to maintain its books, records, documents and other business records in a manner so that the claims handling and payment and underwriting practices of the insurer could be readily ascertained during a market conduct examination.

Reference: 20 CSR 300-2.200(2) [as replaced by, 20 CSR 100-8.040 eff. 7/30/08]

II. CLAIM PRACTICES

The examiners reviewed the Company's claim practices in order to determine its efficiency of handling, accuracy of payment, adherence to contract provisions and compliance with Missouri law and regulations. Because this was a targeted examination, the examiners' review was limited to the following areas:

- Mandated Benefits: This included a review of paid and denied claims for childhood immunizations, denied claims for emergency services, and denied claims for mammography, colon, Pap smear and PSA cancer screening services.
- Pre-Existing Condition Exclusions: Claims denied due to pre-existing conditions were reviewed to determine if the Company acted appropriately.
- Short-Term Major Medical: Claims were reviewed to determine compliance with Missouri's prompt payment laws, §§376.383 and 376.384, RSMo.

To accomplish this review, claims meeting the above-referenced criteria were extracted from data provided by the Company, which consisted of claims closed on an annual basis between January 1, 2004, and December 31, 2006. In those instances where the number of extracted claims in a particular area was deemed too large for a census review, a statistical sampling was extracted and reviewed.

A claim file is determined in accordance with 20 CSR 100-8.040 and the NAIC *Market Regulation Handbook*. Error rates are established when testing for compliance with laws that apply a general business practice standard (e.g., §§375.1000 to 375.1018 and 375.445, RSMo) and compared with the NAIC benchmark error rate of seven percent (7%). When testing health claims for compliance with the prompt payment laws (§§376.383 – 375.384) an error rate of five percent (5%) is applied. Error rates in excess of the NAIC benchmark error rate are presumed to indicate a general business practice contrary to the law. Examples of an error include, but are not limited to: (1) any unreasonable delay in the acknowledgment, investigation, or payment/denial of a claim; (2) the failure of the Company to calculate claim benefits or interest payments accurately; or (3) the failure of the Company to comply with Missouri law regarding claim settlement practices.

During the course of the examination, the examiners noted many claims where interest was not paid or underpaid under the standard imposed by §376.383.5, RSMo, which states that interest begins to accrue at the rate of one percent per month if a claim has not been paid within 45 days of receipt. In its responses to Criticism #010, the Company expressed its belief that subsections 2, 3, and 4 of §376.383 allow it 15 days from the date any requested additional information is received in which to pay the claim before any interest begins to accrue (i.e., applying a "clean claim" standard). This difference in interpretation prompted a conference call between representatives of the Company, the examiners, and the Market Conduct Section's Senior Counsel to discuss the issue, followed by a letter to the Company from the Senior Counsel clarifying the Department's position that interest begins to accrue on all unpaid claims beginning on the 46th day after receipt of the claim, regardless of any Company request for additional information.

Also discussed during the conference call was the issue of the appropriate payee in those instances where the examiners had requested that the Company pay a denied claim. The examiners expressed their concern that some providers may have billed the insured and already received payment due to the passage of time since the claims were denied. The Company subsequently sent a letter to the Senior Counsel proposing that the Company pay the provider in those instances where an assignment of claim had been given to the provider by the insured. The Company would then depend upon the provider to refund to the insured any prior payment it may have received. The Senior Counsel responded via letter that this proposal was unacceptable; the Company would need to check with the provider and the insured to see if the bill had already been paid and then pay the claim with interest to the appropriate party.

The Company declined to follow the instructions given in either of these letters and considers the standard for calculating interest and the appropriate payee to be open issues. Consequently, in many instances noted in this report, the Company has declined to pay a claim plus interest or has declined to pay additional interest pending a final determination of these issues at the conclusion of the examination.

A. Unfair Claim Practices – Denied Claims for Cancer Screenings

The examiners reviewed the Company's adherence to claim handling requirements for denied colon cancer screening claims under §376.1250.1(3), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Cancer Screening

Field Size:	101
Type of Sample:	Census
Number of Errors:	33
Error Ratio:	32.7%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #010, the Company received two claims for the same cancer screening service on 09/18/04. The Company denied one as a duplicate and paid the other claim on 04/12/05 after receiving additional information, but the Company underpaid interest based upon its belief that interest does not begin to accrue until 15 days after the date it receives any requested additional information. The Company declined to pay any additional interest during the course of the examination.

The Company did not effectuate prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

Reference: §§375.1007(4) and 376.383.5, RSMo

- b) According to Criticisms #034 and 043, the Company denied 10 claims for cancer screening on the basis that the policy did not provide for coverage for certain preventive services and that the procedures in question were not among the covered services in the policy. In response to the criticisms from the examiners, the Company readjudicated and paid four claims with correct interest and applied the amounts on the remaining seven claims to the deductible. On one of the paid claims, however, the Company did not furnish the proof requested in Criticism #43 verifying that the insured had not already paid the bill prior to the Company paying the provider.

The Company misrepresented relevant facts or policy provisions relating to coverage available to the insured, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and did not effectuate prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), and 376.1250.1(3), RSMo

- c) According to Criticism #188, the Company received a claim for cancer screening on 03/18/04. The claim was incurred on 03/11/04. The Company improperly denied payment of benefits on 03/31/04. During the course of this examination, the Company reconsidered the claim and issued a benefit payment for the allowed amount of \$737.32. The Company also made a correct interest payment of \$340.34, calculated from the 46th day after the date of receipt through the date of payment on 03/06/08 (1,404 days).

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not effect prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), and 376.1250, RSMo

- d) According to Criticism #193, the Company denied four cancer screening claims because the provider failed to submit them to the PPO network intermediary for repricing. The examiners criticized the Company for failing to investigate by securing the repricing information directly from the PPO network intermediary with which the Company was contracted. The Company maintained that it was under no obligation to do so since the network provider was contractually obligated to send claims to the PPO network intermediary under its provider contract. In one instance, however, the claim had been resubmitted with repricing information, and the Company had inappropriately denied the claim as being subject to a waiting period. The Company acknowledged its error, readjudicated the claim, and applied the resulting \$15 allowed amount to the insured's deductible. The other three claims remain unpaid.

The Company failed to adopt and implement reasonable standards for the prompt investigation and payment of claims, misrepresented to claimants and insureds relevant facts or policy provisions relating to coverage at issue, and failed to effect prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), and 376.1250, RSMo

- e) According to Criticism #194, the Company improperly denied a claim for cancer screening and misrepresented certain facts relative to coverage for mandated cancer screening benefits by indicating that the policy did not provide coverage for the procedure.

The Company failed to adequately investigate the claim, or effectuate prompt, fair, and equitable settlement of a claim in which liability had become reasonably clear. The Company paid this claim during the course of the examination with appropriate interest.

Reference: §§375.1007(1), (3), (4), and (6), and 376.1250, RSMo

- l) According to Criticism #196, the Company improperly denied 16 cancer screening claims as being subject to a waiting period. The Company readjudicated all of the claims as a result of the examiners' inquiry. For 12 of these claims, the amount allowed was applied to the deductible. The remaining four claims were paid with interest.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not effect prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

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

2. Denied Claims – 2005 Cancer Screenings

Field Size:	110
Type of Sample	Census
Number of Errors:	23
Error Ratio:	20.9%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #044, the Company initially denied a claim for cancer screening received on 7/5/05 because it did not have repricing information. A claim with the repricing information was subsequently received on 09/21/05 and paid on 10/07/05. Although this was more than 45 days from the date the claim

was first received (07/05/05), the Company took the position that it was not obligated to do anything with the claim until it received the repricing information on 09/21/05. Since the payment was within 45 days of the second receipt date, the Company claimed that it owed no interest and declined to pay interest as requested by the examiners.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

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

- b) According to Criticism #111, the Company received a claim for cancer screening on 11/11/04 and requested additional information in the form of a pathology report. A second claim was received on 12/21/04, but the Company then went back and denied the 11/11/04 claim as a duplicate rather than the 12/21/04 submission. The Company paid the claim on 01/12/05, prior to the receipt of the requested pathology report, but indicated that it had done so incorrectly since the second submission did not have repricing information. A third submission of this claim was received on 01/28/05, and the pathology report was received on 02/01/05; however, the Company denied this third submission because it did not contain repricing information. Although payment was made more than 45 days after the claim was first received, the Company took the position that it is in compliance with the prompt payment law because it took action within 45 days of each submission. Therefore, the Company declined to pay any interest.

The Company misrepresented relevant facts or policy provisions relating to coverage, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), and 376.383.5., RSMo

- c) According to Criticism #197, the Company improperly denied 18 cancer screening claims by applying a waiting period. The Company readjudicated all 18 claims during the course of the examination. Six of the claims were paid with appropriate interest. The Company applied the allowed amount for the remaining 12 to the insured's deductible.

The Company misrepresented relevant facts or policy provisions relating to coverage and failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Reference: §§375.1007(1) and (3), and 376.1250. RSMo

- d) According to Criticism #198, the Company received a claim for cancer screening on 09/28/05. It improperly denied the claim for conflicting reasons on 10/17/05. The examiners could not readily ascertain the reason(s) for the Company's claims handling. The Company reconsidered and paid the claim with appropriate interest during the course of this examination.

The Company misrepresented relevant facts or policy provisions relating to coverage, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to make prompt, fair, and equitable settlement of a claim for which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), and 376.1250.1(3), RSMo, and 20 CSR 300-2.200(2), (6)(A) [as replaced by, 20 CSR 100-8.040 eff. 7/30/08]

- e) According to Criticism #221 and Formal Request #048, the Company denied a claim for cancer screening and requested that the provider submit the claim to the PPO network intermediary for repricing. The file contains no documentation of a subsequent request for this information, nor any evidence that the Company requested repricing information from the PPO network intermediary. The Company response stated that it saw no need to make a second request for information concerning repricing, since this was the provider's contractual obligation. As such, it declined to pay interest as requested. The claim remains payable, with an interest amount to be determined.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and denied this claim without conducting a reasonable investigation.

Reference: §§375.1007(3), (4), and (6), and 376.383.5., RSMo

- f) According to Criticism #222, the Company denied a claim for cancer screening on the basis that the insured had already maximized the benefits available under the policy's preventive care limits, which is inconsistent with the requirements of §376.1250, RSMo. The Company reprocessed and paid the claim during the course of the examination.

The Company misrepresented relevant facts or policy provisions relating to coverage and failed to make prompt, fair, and equitable settlement of a claim for which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), and 376.1250, RSMo

3. Denied Claims – 2006 Cancer Screenings

Field Size:	60
Type of Sample:	Census
Number of Errors:	12
Error Ratio:	20%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #045, the Company received a claim for cancer screening on 04/07/06 and denied payment on 04/22/06 with the reason code 0005: "Benefits are not available for the expenses submitted." The explanation did not adequately explain the reason for the denial, nor did it give the specific policy provision on which the Company based its denial. The Company reconsidered and paid this claim during the course of the examination on 12/22/08. It paid appropriate interest on the claim on 01/05/09.

The Company misrepresented relevant facts or policy provisions relative to coverage available to the insured, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to make prompt, fair, and equitable settlement of a claim for which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), and 376.1250, RSMo, and 20 CSR 100-1.050(1)(A)

- b) According to Criticism #046, the Company denied benefits for a both a colon cancer screening test and a Pap test, coverage for which is mandated in Missouri. The Company's response, which only addressed the Pap test, defended its actions, based on the diagnosis code used by the provider as indicating that the patient was not "nonsymptomatic." Since the file contained no documentation that this diagnosis was made prior to the date of the test rather than as a result of the test, the examiners determined the file to be incomplete.

Because the Company did not investigate and document when a diagnosis was made, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Reference: §§375.1007(1), (3), and (4), and 376.1250.1(1), RSMo, and 20 CSR 300-2.200(2) [as replaced by, 20 CSR 100-8.040 eff. 7/30/08]

- c) According to Criticism #047, the insured received services for cancer screening on 12/05/06. A claim was received by the Company on 12/18/06. The Company denied this claim twice because the provider failed to submit it to the PPO network intermediary for repricing. The Company finally paid the claim on the third submission because it had been repriced. Although this payment was made

on 07/16/07 (210 days after the first date of receipt), the Company did not pay interest on the claim and declined to pay any interest when requested by the examiners.

Reference: §§375.1007(3), (4), and (6), and 376.383.5, RSMo

- d) According to Criticism #200, the Company denied nine claims for mandated benefits for cancer screening tests, citing policy limitations for wellness benefits. Seven of these claims were reprocessed during the course of this examination, and benefits were applied to the deductible. Two claims were reprocessed during the course of the examination and paid with appropriate interest.

Reference: §§375.1007(1) and (3), and 376.1250, RSMo

B. Unfair Claim Practices – Denied Claims for Childhood Immunizations

The examiners reviewed the Company's adherence to claim handling requirements for denied childhood immunization claims under §376.1215, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Childhood Immunizations

Field Size:	202
Type of Sample:	Census
Number of Errors:	27
Error Ratio:	13.4%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticisms #035 and 036, the Company paid two claims for childhood immunizations more than 45 days after receipt of the claims, but failed to pay interest on the claims. The Company responded that it need not pay interest because the claims were not initially submitted to its PPO network intermediary for repricing. The Company denied these claims upon first receipt rather than asking its PPO network intermediary for the repricing information. This represents a passive approach to the Company's obligation to investigate claims, including directing the insured to contact the provider rather than the Company if the provider were to bill the insured for the expenses incurred.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and refused to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(3), (4) and (6), 376.383.5., and 376.1215, RSMo

- b) According to Criticism #224, the Company initially denied benefits for 21 childhood immunization claims on the basis that the services were subject to a waiting period. The Company agreed that these claims were payable and paid the claims during the course of this examination with appropriate interest.

Reference: §§375.1007(1), (3), and (4), and 376.1215, RSMo

- c) According to Criticism #225, the Company denied four claims for childhood immunizations because the providers did not submit the claims to the PPO network intermediary for repricing. The Company defended its actions by stating that it was the providers' contractual obligation to send the claims to the PPO network intermediary for repricing. As indicated above, the examiners do not believe this passive approach to the Company's obligation to investigate complies with Missouri law.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.1215, RSMo, and 20 CSR 100-1.050

2. Denied Claims – 2005 Childhood Immunizations

Field Size:	715
Type of Sample:	Census
Number of Errors:	194
Error Ratio:	27.1%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #016, the Company initially received this claim on 04/06/05 and denied it with the reason code 1064, which states, "These services are subject to the waiting period according to the provisions of your policy." The claim was subsequently resubmitted and paid on 07/26/05, which was more than 45 days after the date of first receipt, but no interest was paid. The Company paid the interest during the course of the examination.

Reference: §§375.1007(4) and 376.383.5, RSMo

- b) According to Criticisms #019, 041, 078, 108, and 109, the Company adjudicated and paid six claims more than 45 days after receipt, but failed to pay interest. The Company initially denied these claims rather than asking its PPO network intermediary for repricing information. It also directed the insured to contact the provider if the provider billed the insured for the expenses incurred. The Company paid interest on the two claims in Criticism #019 during the course of the examination.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), 376.383.5, and 376.1215, RSMo

- c) According to Criticisms #069, 073, and 080, the Company denied 10 claims for childhood immunizations.

With regard to Criticism #069, the Company denied two childhood immunization administration fees submitted on 06/08/05, but paid the charges for the actual immunizations submitted separately on 06/10/05. Although the Company defended its processing of the 06/08/05 submission as correct, the examiners believe the Company failed to conduct a reasonable investigation to relate administration charges billed to the vaccine charges for which benefits were paid. The Company agreed that additional benefits were payable, but did not believe interest was payable because it had correctly denied the original claim within 45 days of receipt.

With regard to Criticism #073 the Company improperly denied one claim, indicating that it was subject to a waiting period. The Company acknowledged its error and paid the claim with appropriate interest during the course of the examination. In its response to the criticism, however, the Company qualified its actions by stating that it was not statutorily required to provide the benefit since the master policy was issued in Illinois.

With regard to Criticism #080, the Company denied seven claims as being subject to a waiting period. All seven claims were reconsidered during the examination, and five were paid with appropriate interest on 03/05/08. Two of the claims, which were mistakenly denied upon first reconsideration, were subsequently paid on 03/10/08 with appropriate interest. Although the Company paid the claims with appropriate interest, the Company's position was that: (1) Missouri law does not apply because the master policy was issued in Illinois; (2) the original processing of the claims was appropriate and no reconsideration was warranted; and (3) no interest was owed, since the adjudication of the claims was timely.

The Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and failed to attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215, RSMo

- d) According to Criticism #070, the Company denied two claims for administration of childhood immunizations received on 12/01/05 and paid two claims for the actual immunizations received separately on 12/06/05. As with Criticism #069 above, the Company defended its actions, while the examiners felt a reasonable investigation could have connected the charges to each other. The Company again agreed additional benefits were payable, but did not believe interest was payable, since it had correctly denied the original claim within 45 days of receipt.

Reference: §§375.1007(3) and (4), 376.383.5, and 376.1215, RSMo

- e) According to Criticism #110, the Company denied a claim for a childhood immunization because of a waiting period. The Company declined to pay the claim plus interest as requested by the examiners.

Because the Company denied this claim for a mandated benefit without making an investigation, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and failed to attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), 376.383.5, and 376.1215, RSMo

- f) According to Formal Request #017, the Company agreed that it had erroneously denied 174 childhood immunization claim lines in 2005. The Company paid these claims, including the correct amount of interest, in March 2008 during the course of the examination. The total amount recovered was \$6,076.65, plus interest payments of \$1,923.63, for a total of \$8,041.08.

Because these claims for mandated benefits were improperly denied, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and failed to attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), and 376.1215, RSMo

3. Denied Claims – 2006 Childhood Immunizations

Field Size:	303
Type of Sample:	Census
Number of Errors:	6
Error Ratio:	1.9%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

- a) According to Criticism #089, the Company denied payment for a mandated childhood immunization on the basis that the billed charges were included in another procedure. After being notified by the provider that it had used the wrong CPT code in its initial claim submission, the Company reprocessed the claim, but it incorrectly determined that nothing further was payable due to a network discount. After reviewing the claim again in response to Criticism #089, the Company stated that its reprocessing was in error, so it would obtain a correct repricing sheet from the PPO network intermediary and pay the claim. The Company paid this claim on 09/17/09 during the course of the examination, but the amount of interest paid (\$17.95) was less than what the examiners determined should have been paid when calculated from the original claim submission date (\$27.96).

In processing this claim, Time incorrectly denied benefits, misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215, RSMo

- b) According to Criticism #091, the Company failed to pay benefits for two childhood immunization claims along with the associated physician charges due to an incorrect network discount. The Company denied a second submission of the claims with corrected discount amounts on 12/22/06, stating that the claims were duplicates of a previously submitted claim. In its response to Criticism #091, the Company acknowledged its error, indicating that it was due to the claim system not recognizing the difference from the originally submitted discount amounts, and paid the claim, with interest, during the course of the examination.

Reference: §§375.1007(1), (3), and (4), and 376.1215, RSMo

- c) According to Criticism #092, the Company inappropriately denied four claim lines as subject to a waiting period and applied the allowed amount for the fifth claim line (\$10.20) to the insured's copayment. The Company paid the four denied claim lines with appropriate interest during the course of the examination. When requested to pay the \$10.20 plus interest for the fifth claim line, however, the Company declined to do so, stating that it was not required to comply with Missouri law because the master policy had been issued in Illinois, and that it had paid the four claim lines plus interest in error.

Because the Company incorrectly applied benefits to a copayment and denied mandated benefit claims as subject to a waiting period, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards

for the prompt investigation and settlement of claims arising under its policies and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), 376.383.5., and 376.1215, RSMo

- d) According to Criticism #094, the Company inappropriately processed childhood immunization claims for two dates of service: 01/20/06 and 02/23/06.

Regarding the 01/20/06 date of service, the Company initially received a claim on 2/10/06 and denied it because it did not contain network repricing. The claim was submitted again on 03/10/06 and 05/16/06, and denied each time for the same reason. Finally, the Company realized that the provider's network had merged with another network, requiring manual processing of any claims for the original network. They readjudicated the claim on 07/13/06, but a portion of the claim was allocated to the deductible, and the interest paid was incorrectly calculated from the 05/16/06 date. The Company readjudicated and paid the unpaid portion of the claim, plus appropriate interest, as a result of the examiners' inquiries.

With regard to the 02/23/06 date of service, the Company incorrectly processed the claim by allocating a portion of the allowed amount to the deductible when it was first received on 03/10/06. It then denied it as a duplicate when it was resubmitted on 03/23/06. The Company agreed that the unpaid portion plus interest was payable, and paid the claim with the appropriate amount of interest during the course of the examination.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215, RSMo

- e) According to Criticism #106, the Company initially denied this claim for "late filing" rather than pending it, and later reconsidered the claim after the provider submitted additional documentation that the claim had previously been filed. The Company provided no explanation as to why it was not aware of the prior filing. Since the claim was paid more than 45 days after it was first received, the examiners requested that the Company pay interest. The Company declined to pay interest, stating that its initial denial had been within 45 days of the date the claim was first received.

Reference §§376.383.5 and 376.1215, RSMo

C. Unfair Claim Practices – Paid Claims for Childhood Immunizations – Benefits Applied to Deductibles or Co-Payments

The examiners reviewed the Company's adherence to claim handling requirements for paid childhood immunization claims under §376.1215.2., RSMo, for calendar years 2004 through 2006. In the following cases, claims were paid with benefits being applied to deductibles or co-payments, contrary to Missouri law.

1. Paid Claims – 2004 Childhood Immunizations – Deductible / Co-Payments

Field Size:	217
Type of Sample:	Census
Number of Errors:	3
Error Ratio:	1.4%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

According to Criticism #037, the Company received a claim on 12/11/03 for three childhood immunization services dated 09/23/03. The Company paid the claims on 12/31/03, but improperly applied the allowed amount of \$32.60 for CPT Code 90648 to the insured's deductible, contrary to the provisions of Missouri's childhood immunization statute. The Company reconsidered and paid this claim in the amount of \$32.60, plus appropriate interest of \$17.36, during the course of the examination.

Reference: §§375.1007(1), (3), and (4), and 376.1215.2, RSMo

2. Paid Claims – 2005 Childhood Immunizations – Deductible / Co-Payments

Field Size:	504
Type of Sample:	Census
Number of Errors:	17
Error Ratio:	3.4%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

- a) According to Criticism #013, the insured incurred expenses associated with four childhood immunizations on 04/21/05. The Company initially denied this claim because the provider did not submit it to the PPO network intermediary for repricing. The claim was subsequently resubmitted on 06/23/05 with the repricing information, but the Company inappropriately applied the allowed amount of \$35.13 to the deductible.

The Company readjudicated and paid the claim with interest during the course of the examination, but incorrectly calculated the interest from 06/23/05. The

Company declined to pay any additional interest since it did not feel it was required to pay any interest prior to receiving the repricing information.

Reference: §§375.1007(3) and (4), 376.383.5, and 376.1215.2, RSMo

- b) According to Criticism #015, the Company received three claims for mandated childhood immunization services. The Company applied a portion of the claims to the insured's deductible. The Company reconsidered and paid these claims, plus appropriate interest during the course of the examination.

Reference: §§ 375.1007(1), (3), and (4), and 376.1215.2, RSMo

- c) According to Criticism #018, the Company improperly applied \$320.61 to the insured's deductible when it processed a claim for mandated childhood immunizations on 07/25/06. The claim was originally received on 07/11/05. The Company reconsidered and paid this claim plus appropriate interest during the course of the examination.

Reference: §§375.1007(1), (3), and (4), and 376.1215.2, RSMo

- d) According to Criticism #072, the Company improperly applied \$17.00 to the insured's deductible on 12/22/05 on a claim for childhood immunization services incurred on 08/08/05. Although, the Company reconsidered and paid the claim plus appropriate interest during the course of the examination, it maintained its position that it was not required to comply with Missouri's childhood immunization law because the master policy under which the coverage was provided was issued in Illinois.

Reference: §§375.1007(1), (3), and (4), 376.421.2, and 376.1215.2, RSMo

- e) According to Criticism #074, the Company received a claim on 02/08/05 for six childhood immunization services incurred on 01/26/05. The Company denied all six as being subject to a waiting period. The claims were re-processed on 05/09/08 during the course of the examination, but the allowed amount was inappropriately applied to the insured's deductible. When the examiners requested that these claims plus interest be paid, the Company declined on the basis that the master policy had been issued in Illinois and was not subject to Missouri law.

The Company consequently misrepresented relevant facts or policy provisions relating to coverage at issue, failed to adopt and implement reasonable standards for the prompt payment of claims arising under its policies and failed to pay interest as a consequence of applying the allowed amount to the insured's deductible.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215.2, RSMo

- f) According to Criticism #077, the Company received claims on 08/30/05 and 09/01/05 for childhood immunization services incurred on 08/22/05. Two of the claim lines for administration services were denied as being included within the other billed items, and the remainder of the claim lines were applied towards the deductible. Eventually, the Company reconsidered and paid all of the claim lines, but the Company did not pay any interest. The Company disagreed that any interest was due, since the claims had originally been processed within 45 days of receipt.

The Company misrepresented relevant facts or policy provisions relative to the claims at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, did not attempt to effectuate prompt, fair, and equitable settlement of claims in which liability was reasonably clear.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215.2, RSMo

3. Paid Claims – 2006 Childhood Immunizations – Deductible / Co-Payments

Field Size:	239
Type of Sample:	Census
Number of Errors:	5
Error Ratio:	2.1%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

- a) According to Criticism #085, the Company received a claim on 11/14/06 for incurred medical expenses associated with two immunizations incurred on 11/06/06. The Company paid for one of the immunizations on 11/22/06, but incorrectly applied the allowed amount for the second immunization to the insured's copayment. When the examiners requested the Company pay the claim plus interest, the Company acknowledged it was payable under the terms of the certificate but declined to do so, responding that it would defer payment until after it had resolved differences with the Department concerning the payment of interest. The Company subsequently paid the claim during the course of the examination with the appropriate amount of interest.

Reference: §§375.1007(1), (3), and (4), and 376.1215.2, RSMo

- b) According to Criticism #098, the insured incurred expenses relative to two immunizations on 03/23/06, including CPT code 90657 for influenza. The Company received a claim for the expenses on 03/29/06. The Company paid for one immunization, but applied the allowed amount for the influenza vaccine to the insured's co-payment. The Company argued in its response to the criticism

that the influenza vaccine was not required; however, a review of the Advisory Committee on Immunization Practices vaccine schedule for 2006 required by 19 CSR 20-28.060, indicates that influenza vaccines were recommended for children with certain risk factors.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215.2. RSMo. and 19 CSR 20-28.060

c) According to Criticisms #104, 105 and 107, the Company inappropriately applied the allowed amount on claims for influenza immunizations to the deductible or copayment for three insureds. In one instance, the Company also denied the administration expense as being subject to a waiting period. When the examiners requested that the Company pay the claims plus interest, the Company declined to do so for the following reasons:

- In all three instances, the Company stated that they did not have to comply with the Missouri law because the master policies were issued in either Alabama or Illinois. The Company did acknowledge, however, that the policies contained the benefit anyway.
- In two instances, the Company argued that influenza vaccines are "not among the immunizations specified in Department DIFP Bulletin 96-6." This DIFP Bulletin, however, does not list specific immunizations. It merely references the Department of Health's regulation 19 CSR 20-28.060, which references the "Recommended Childhood Immunization Schedule—United States, approved by the Advisory Committee on Immunization Practices (ACIP)" as the source for required immunizations. The 2005 and 2006 ACIP schedules list influenza as required for children with certain risk factors.
- In one instance, the Company argued that the certificate provided immunization coverage based upon the published recommendations of the U.S. Preventative Services Task Force (USPSTF). A check of the "Immunizations for Children" webpage for the USPSTF, however, indicates that the USPSTF ceased updating its recommendations in 1996 and referred readers to the ACIP webpage for current recommendations (see <http://www.ahrq.gov/clinic/uspstf/uspschil.htm>).

Reference: §§375.1007(1), (3), and (4), and 376.1215.2. RSMo, 19 CSR 20-28.060

D. Unfair Claim Practices – Denied Emergency Room and Ambulance Services Claims

The examiners reviewed the Company's adherence to claim handling requirements for denied emergency room and ambulance claims under §§376.1350, and 376.1367, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Emergency Room / Ambulance

Field Size:	270
Type of Sample:	Census
Number of Errors:	22
Error Ratio:	8.1%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

According to Criticisms #055, 056, 057, 058, 059, 060, 061, 063, 064, 065, 066, 169, 172, 227, and 228, the Company denied 22 claims for emergency room care or ambulance services. The errors noted by the examiners in the processing of these claims were as follows:

- For six of the claims (Criticisms #055, 056, 059, 061, 064, and 065) the Company readjudicated and paid the claims prior to the examination, but the Company did not pay interest even though payment had occurred more than 45 days after initial receipt of the claim. The Company paid interest on these claims during the course of the examination.
- For five of the claims, the Company readjudicated and paid the claims prior to the examination, but the Company either did not pay interest (Criticisms #058, 060, 063, and 066) or underpaid interest (Criticism #057) based upon its belief that interest was only due if it failed to pay these claims within 15 days of receiving additional information. The Company declined to pay anything further on these claims in response to the criticisms.
- For three of the claims (Criticisms #169 and 172) the Company inappropriately denied the claims on the basis that they had not been submitted through the network intermediary even though the providers were not network providers. The Company agreed it had denied the claims in error, and it paid the claims, with interest, during the course of the examination.
- For one claim (Criticism #227) the Company inappropriately denied the claim as being an excluded maternity benefit even though the examiners felt it should be covered as a complication of pregnancy. The Company declined to pay anything on this claim in response to the criticism.
- For seven claims (Criticism #228) the Company inappropriately denied the claims because the providers had not submitted them through the network intermediary. The Company declined to pay anything on these claims in response to the criticism.

Reference: §§375.995.4(6), 375.1007(1), (3), and (4), 376.383.5, 376.1350(8), (12), (13), (18), (22), (24), and (25), and 376.1367(1), RSMo

2. Denied Claims – 2005 Emergency Room / Ambulance

Field Size:	263
Type of Sample:	Census
Number of Errors:	31
Error Ratio:	11.8%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

According to Criticisms #113, 114, 116, 117, 118, 119, 120, 121, 125, 127, 128, 168, and 173, the Company improperly denied 31 claims for ambulance and emergency services without making a reasonable investigation. Of these, 13 claims were readjudicated prior to the examination. Twelve of the readjudicated claims were paid (Criticisms #113, 114, 116, 117, 118, 120, 121, 125, 127, 128 – one claim, 168, and 173) and one claim had the allowed amount applied to the deductible (Criticism #128 – one claim). For the 12 claims that were paid, however, interest was either unpaid (Criticisms #114, 118, 125, 127, 128 – one claim, and 168) or underpaid (Criticisms #113, 116, 117, 120, 121, and 173). Included within the readjudicated claims was a claim (Criticism #116) involving an improper denial of complications of pregnancy in violation of §375.995.4(6), RSMo, and a claim (Criticism #168) involving improper application of a preauthorization penalty for emergency room care. The Company declined to pay any additional interest on the 12 paid claims and declined to pay the claim plus interest on the 18 denied claims.

Reference: §§375.995.4(6), 375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(8), (12), (13), (18), (22), (24), and (25), and 376.1367, RSMo

3. Denied Claims – 2006 Emergency Room / Ambulance

Field Size:	176
Type of Sample:	Census
Number of Errors:	8
Error Ratio:	4.5%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

According to Criticisms #129, 133, 162, 201 and 202, the Company denied eight claims for ambulance and emergency services. The Company readjudicated and paid six of these claims prior to the examination, but failed to pay appropriate interest. The remaining two claims remain unpaid.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(8), (12), (13), (18), (22), (24), and (25), and 376.1367, RSMo

E. Unfair Claim Practices – Denied Claims for Mammograms

The examiners reviewed the Company's adherence to claim handling requirements for denied mammogram claims under §376.782, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Mammograms

Field Size:	467
Type of Sample:	Random
Sample Size	100
Number of Errors:	14
Error Ratio:	14.0%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #122, the Company received a mammogram claim on 03/27/03 and denied it because it did not contain repricing information from the PPO network intermediary. The claim was resubmitted on 03/02/04 and denied for the same reason. The claim was resubmitted again on 07/22/04 and denied because it had not been submitted within 15 months of the date of service (03/12/03). The Company eventually recognized its mistake and paid the claim on 11/23/04, but it failed to pay the appropriate interest along with the claim. The Company paid interest on this claim during the course of the examination, but the amount was insufficient since it was based upon the 07/22/04 resubmission date rather than the 03/27/03 original date of receipt.

Reference: §§375.1007(4) and 376.383.5, RSMo

- b) According to Criticisms #123 and 126, the Company denied two mammogram claims for reasons described by the Company documents as "unknown." The Company paid the claims during the course of the exam with appropriate amounts of interest.

The Company failed to provide benefits for mandated mammogram screenings and failed to effectuate prompt, fair, and equitable settlement of claims in which liability was reasonably clear by originally denying these claims for "unknown" reasons.

Reference: §§375.1007(4) and 376.782.2(1) and (2), RSMo

- c) According to Criticism #130, 132, 155, and 156, the Company failed to provide benefits for mammogram screenings for 10 claims. The Company denied six claims because the provider failed to first submit the charges to the PPO network intermediary for repricing. Three claims were reprocessed later, and benefits

were applied to deductibles. One claim was paid more than 45 days after receipt, but appropriate interest was not paid.

The Company failed to effectuate prompt, fair, and equitable settlement of these claims by denying the claims without conducting a reasonable investigation.

Reference: §§375.1007(4) and (6), 376.383.5, and 376.782.2(1) and (2), RSMo

- d) According to Criticism #157, the Company received a claim for a mammogram on 04/24/04 and denied the claim on 04/28/04 for a "code review" without asking for supporting medical documentation from the provider. On 08/26/04, the Company paid the allowed amount of \$68.39, and applied the benefit to the deductible. In making this payment, the Company combined CPT codes 76092 and 76090 and processed the charges under CPT code 76090. This led to the provider's appeal and submission of additional documentation. The Company failed to request additional documentation from the provider before denying benefits, rebundling CPT codes, and delaying the claim settlement.

The Company failed to effectuate prompt, fair, and equitable settlement of the claim by denying the claim without conducting a reasonable investigation.

Reference: §375.1007(4) and (6), RSMo

2. Denied Claims – 2005 Mammograms

Field Size:	267
Type of Sample:	Random
Sample Size	68
Number of Errors:	7
Error Ratio:	10.3%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticisms #134, 137, 138, 142, and 163, the Company denied five mammogram claims for reasons described by the Company as "unknown." The claims were subsequently paid during the course of the exam with appropriate amounts of interest where applicable.

The Company failed to effectuate prompt, fair, and equitable settlement of claims in which liability had become reasonably clear by originally denying the claims for "unknown" reasons. The Company also failed to correctly represent to claimants relevant facts or policy provisions regarding coverage for mandated mammogram screenings.

Reference: §§375.1007(1) and (4), and 376.782.2(1) and (2), RSMo

- b) According to Criticisms #139 and 140, the Company denied two claims for benefits for mandated mammogram screenings. In its response to the criticisms, the Company stated that the denials were due to the provider failing to first submit the charges to the PPO network intermediary for repricing in accordance with the provider's network contract. The Company eventually paid the claims when the repricing information was received and applied the allowed amounts to deductibles.

Because the Company originally denied these claims based on repricing issues, rather than first conducting a reasonable investigation to resolve the repricing issue, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§ 375.1007(3), (4), and (6), and 376.782.2(1) and (2), RSMo

3. Denied Claims – 2006 Mammograms

Field Size:	129
Type of Sample:	Random
Sample Size:	41
Number of Errors:	7
Error Ratio:	17.1%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticisms #146, 147, and 153, the Company failed to provide benefits for mandated mammogram screenings for three claims. As above, the Company responded to the criticisms by stating that the denials were due to the provider failing to first submit the charges to the PPO network intermediary for repricing in accordance with the provider's network contract. The Company eventually paid the claims when the repricing information was received, and the allowed amounts were applied to the various deductibles.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and refused to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(3), (4), and (6), and 376.782.2(1) and (2), RSMo

- b) According to Criticisms #149, 150, 152, and 154, the Company denied four claims for mammograms by erroneously stating that the claimants exceeded their

maximum benefits. The Company reconsidered and paid these claims during the course of the examination with appropriate amounts of interest.

The Company did not attempt in good faith to effectuate prompt, fair, and equitable settlement of four mammogram claims where liability was reasonably clear.

Reference §§375.1007(1) and (4) and 376.782.2, RSMo

F. Unfair Claim Practices – Denied Claims for Pap Smears

The examiners reviewed the Company's adherence to claim handling requirements for denied Pap smear claims under §376.1250.1(1), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Pap Smears

Field Size:	457
Type of Sample:	Census
Number of Errors:	264
Error Ratio:	57.8%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticisms #124 and 223, the Company denied 112 claims because the provider did not submit the claims to the PPO network intermediary for repricing. Of these claims:
 - Six were readjudicated and paid without appropriate interest prior to the examination;
 - Two were readjudicated, and the allowed amount was applied to the insureds' deductibles prior to the examination;
 - One was readjudicated and paid with inadequate interest during the course of the examination; and
 - 103 were never paid.

For one of the unpaid claims, the Company was unable to locate the claim file documentation for the examiners to review. The Company declined to pay the unpaid claims with appropriate interest, declined to pay any interest on the six claims paid prior to the examination, and declined to pay additional interest on the one claim paid during the course of the examination.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not

attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1), (3), and (4), 376.1250.1(1), and 376.383.5, RSMo, and 20 CSR 300-2.200(2) [as replaced by, 20 CSR 100-8.040 eff. 7/30/08]

- b) According to Criticism #217, the Company failed to conduct reasonable investigations and failed to process 81 claims within a reasonable time period. When the examiners questioned why these claims were denied in Formal Request #025, the Company readjudicated the claims and applied the allowed amounts to the insured's deductible during the course of the examination.

Because the Company denied these claims and applied benefits to the insureds' deductibles only after receiving Formal Request #025, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims, and failed to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(3) and (6), and 376.1250.1(1), RSMo

- c) According to Criticism #218, 219 and 223, the Company inappropriately denied 54 claims for Pap smear tests. The Company processed and paid the 54 claims with appropriate interest during the course of the examination.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Reference: §375.1007(3), RSMo.

- d) According to Criticism #220, the Company denied 17 claims with the explanation that they were either subject to a waiting period or not covered services. Five of the claims were paid with appropriate interest, and 12 of the claims were approved and applied to the insureds' deductibles during the course of the examination.

Because these claims were initially denied for incorrect reasons and not paid until errors were identified during the course of the examination, the Company misrepresented relevant facts or policy provisions relating to coverages at issue, failed to pay claims without conducting reasonable investigations and failed to adopt and implement reasonable standards for prompt investigation and settlement of claims

Reference: §§375.1007(1), (3), and (6), and 376.1250.1(1), RSMo

2. Denied Claims – 2005 Pap Smears

Field Size:	383
Type of Sample:	Census
Number of Errors:	237
Error Ratio:	61.9%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #205, the Company improperly denied 141 claims for mandated Pap smear expenses because the provider failed to submit the claims to the PPO network intermediary for repricing. Two claims were reprocessed and paid during the course of the exam, but the remaining 139 claims plus interest remain unpaid.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5., and 376.1250.1(1), RSMo

- b) According to Criticism #206, the Company denied 25 claims for mandated Pap tests. The Company subsequently paid these claims during the course of the examination with appropriate interest.

Because the Company failed to pay these claims when first submitted, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), and 376.1250.1(1), RSMo

- c) According to Criticism #207, the Company denied six claims because the provider failed to submit them to the PPO network intermediary for repricing. Four of the claims were readjudicated and paid without appropriate interest when they were resubmitted with repricing information. The Company declined to pay any interest on these four claims when requested to do so by the examiners. The remaining two claims were resubmitted with repricing information, but the Company incorrectly denied them as being subject to a waiting period. When the examiners brought this to the Company's attention during the course of the examination, it readjudicated and paid one of the claims with interest and applied the allowed amount to the deductible on the second claim.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1250.1(1), RSMo

- d) According to Criticism #208, the Company improperly denied 65 claims. The Company readjudicated all of these claims during the course of the examination and applied the allowed amounts to the insureds' deductibles. These actions resulted in processing times ranging from a low of 92 days to a high of 1,161

days. As such, the Company failed to conduct reasonable investigations and failed to pay claims within a reasonable time period.

Reference: §375.1007(3) and (6), RSMo

3. Denied Claims – 2006 Pap Smears

Field Size:	254
Type of Sample:	Census
Number of Errors:	211
Error Ratio:	83%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #136, the Company initially denied two claim lines for mandated Pap tests because the Company related the claims to a policy that had been previously terminated, rather than the policy that was in force at the time the claims were incurred. The Company received the claims on 02/24/06 and 03/29/06 with sufficient information to identify the insured. The Company subsequently reprocessed the claims and applied benefits to the deductible during the course of the examination.

Because the Company erred in identifying coverage in force from information readily available in its own records, the Company misrepresented relevant facts related to coverages at issue, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), and 376.1250.1(1), RSMo

- b) According to Criticism #209, the Company denied 42 claims because the provider failed to submit the claim to the PPO network intermediary for repricing. One claim was paid during the course of the examination, but the interest that was paid was inadequate. Four claims were readjudicated and the allowed amounts were applied to the insureds' deductibles. The remaining claims have not been paid.

References: §§375.1007(1), (3), and (4), 376.383.5, and 376.1250.1(1), RSMo and 20 CSR 100-1.050

- c) According to Criticism #210, the Company agreed that it improperly denied 31 claims for Pap smears and paid the claims during the course of the examination with appropriate interest. Because these claims were not paid until after the examiners brought the errors to the Company's attention, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies

Reference: §§375.1007(3) and 376.1250.1(1), RSMo

- d) According to Criticism #211, the Company improperly denied 11 claims. When these errors were brought to the Company's attention by the examiners, it readjudicated and paid 10 claims without interest and applied the allowed amount to the insured's deductible for one claim during the course of the examination. When the examiners requested that interest be paid on the 10 paid claims, the Company subsequently did so for five of them, but failed to include additional interest for the period of time the interest had remained unpaid after the claims were paid. The Company declined to pay any interest on the remaining five claims because the provider was located in Pennsylvania.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not make prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

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

- e) According to Criticism #212, the Company processed 120 previously denied claims during this examination and applied benefits due to the plan deductible. Because these claims were not appropriately processed until after the examination began, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Reference: §375.1007(3), RSMo

- f) According to Criticism # 213, the Company improperly denied five claims filed for expenses related to mandated benefits for Pap tests. The Company subsequently paid two of the claims with appropriate interest during the course of the examination. Benefits on the other claims were applied to deductibles. Because these claims were not appropriately processed until after the examination began, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Reference: §§375.1007(1), (3), and (6), and 376.1250.1(1), RSMo

G. Unfair Claim Practices – Denied Claims for PSA Tests

The examiners reviewed the Company's adherence to claim handling requirements for denied PSA test claims under §376.1250.1(2), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 PSA Claims

Field Size:	64
Type of Sample:	Census
Number of Errors:	28
Error Ratio:	46.7%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #143, the Company denied 17 claim numbers (representing 20 claim lines) because the provider did not submit the claims to the PPO network intermediary for repricing. Three claim lines were paid without appropriate interest when resubmitted with repricing information prior to the examination. As a result of examiner inquiries, two claim lines were readjudicated with the allowed amounts being applied to the insureds' deductibles during the course of the examination. The Company declined to pay the remaining claims plus appropriate interest.

Reference: §§375.1007(1) and (4), 376.383.5, and 376.1250.1(2). RSMo

- b) According to Criticism #164, and Formal Requests #127 and 128, the Company denied five claims for expenses for PSA tests because they involved pre-existing conditions or were subject to a Special Exception Rider. The Company readjudicated four of the claims during the course of the examination by applying allowed amounts to the deductible for three claims and paying the fourth with appropriate interest. The Company maintains that its denial of the fifth claim was proper because the insured was not "nonsymptomatic" within the meaning of §376.1250.1(2), RSMo; however, the examiners felt the PSA test was unconnected to the diagnoses submitted for the other services included with the claim and should be paid.

By denying these claims, the Company misrepresented to claimants and insured relevant facts or policy provisions relating to coverages at issue and did not make prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), 376.383.5, and 376.1250.1(2). RSMo

- c) According to Criticism #216, the Company denied six claims for expenses related to PSA tests. Three claims were denied as not being covered, and three were denied as being subject to a waiting period. All six were readjudicated by the Company during the course of the examination. Three were paid with appropriate interest, and the allowed amount for the other three was applied to the insureds' deductibles.

Because these claims were not appropriately processed until after the examination began, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not attempt to make prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(3) and (4), and 376.1250.1(2), RSMo

2, Denied Claims – 2005 PSA Claims

Field Size:	75
Type of Sample:	Census
Number of Errors:	37
Error Ratio:	49.3%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #141, the Company denied 25 claims because the provider did not submit the claims to the PPO network intermediary for repricing. In its response to the criticism, the Company stated that two of the claims had been resubmitted with repricing information and readjudicated. The Company acknowledged that interest was due for one of these readjudicated claims, but it declined to pay appropriate interest on the claim during the course of the examination. The Company maintained that its action in denying the remaining 23 unpaid claims was appropriate.

The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and did not attempt to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4); and 376.383.5, and 376.1250.1(2), RSMo

- b) The Company improperly denied two claims for expenses for PSA tests, as shown in Criticism #165. In response to the criticism, the Company acknowledged that benefits were payable and reprocessed them, applying the benefits to the insureds' deductibles during the course of the examination.

Reference: §§375.1007(1) and (4), and 376.1250.1(2), RSMo

- c) According to Criticism #166, the Company improperly denied payment of a claim for expenses for a PSA test. As above, the Company acknowledged that benefits were due in its response to the criticism, but it initially declined to pay the claim, plus appropriate interest. The Company subsequently paid the claim during the course of the examination, but underpaid the amount of interest due.

Reference: §§375.1007(1) and (4), 376.383.5, and 376.1250.1(2), RSMo

- d) According to Criticism #214, the Company denied eight claims for PSA tests because the claims were subject to a waiting period. The Company responded that the claims should have been paid and reprocessed the claims during the course of the examination. One claim was paid with appropriate interest, and the allowed amounts for the remainder were applied to the insureds' deductibles.

Reference: §§375.1007(3) and (4), and 376.1250.1(2), RSMo

- e) According to Criticism #214, the Company improperly denied a claim as being subject to a waiting period. In response to the criticism, the Company stated that it was unable to locate the claim records for this claim.

Because the Company was unable to locate these records, the Company failed to maintain its books, records, documents and other business records in a manner so that the examiners may readily ascertain its claim handling and payment practices, complaint handling, termination, rating, underwriting and marketing practices.

Reference: §§374.205.2(2), 375.1007(3) and (4), and 376.1250.1(2), RSMo, and 20 CSR 300-2.200(2), (3)(B), and (6) [as replaced by, 20 CSR 100-8.040 eff. 7/30/08]

3. Denied Claims – 2006 PSA Claims

Field Size:	47
Type of Sample:	Census
Number of Errors:	20
Error Ratio:	42.6%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #131, the Company denied 14 claims for expenses for PSA tests because the provider had not submitted the claim to the PPO network intermediary for repricing. In its response to the criticism, the Company defended its actions as appropriate and explained that:

- Five of the claims had been resubmitted with repricing information. Of these, the Company readjudicated one of the claims and applied the allowed amount to the insured's deductible. The Company argued that it was not required by §376.1250.1(2), RSMo, to pay the other four claims because the insured was not "nonsymptomatic" as provided by the statute. However, the Company agreed that two of the four claims had been

inappropriately denied as duplicates and were payable based upon the provisions of the insurance contract. The Company readjudicated and paid these two claims plus interest during the course of the examination, but the interest was underpaid.

- Nine of the claims had never been resubmitted with repricing information. In addition, the Company argued that it was not required by §376.1250.1(2), RSMo, to pay four of the nine claims because the insured was not "nonsymptomatic" as provided by the statute.

Reference: §§375.1007(4), 376.383.5, and 376.1250.1(2). RSMo

- b) According to Criticism #215, the Company improperly denied six claims for expenses for PSA tests. The Company readjudicated these claims and applied the allowed amounts to the insureds' deductibles during the course of the examination.

Reference: §§375.1007(1), (3), (4), and (6), and 376.1250.1(2). RSMo

H. Denied Claims for Pre-Existing Conditions

The examiners reviewed the Company's adherence to claim handling requirements for claims denied for pre-existing conditions under §375.1007. RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Pre-Existing

Field Size:	1,894
Type of Sample:	Random
Sample Size:	47
Number of Errors:	9
Error Ratio:	19.1%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #177, the Company denied a claim as involving a pre-existing condition even though the date services were incurred was more than 12 months after the effective date of the insured's coverage. This denial was inconsistent with the pre-existing condition exclusion provision of the Company's major medical certificate form 225. The Company reconsidered and paid this claim prior to the examination.

Because the Company initially denied this claim incurred more than 12 months after the effective date of the insured's coverage, the Company misrepresented to claimants relevant facts or policy provisions regarding pre-existing conditions

contract language, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and failed to pay the claim without first conducting a reasonable investigation.

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

- b) As shown in Criticism #178, the Company denied two claims as involving a pre-existing condition without having documentation to support its decision. Upon further review of the file in response to the criticism, the Company stated that it had determined that adequate documentation no longer existed to maintain its original decision. Therefore, the Company paid these claims plus appropriate interest during the course of this examination.

The lack of adequate documentation in the Company's claim file indicates that it has not maintained its books, records, documents and other business records in a manner so that its claim handling and payment practices may be readily ascertained during market conduct examinations. The Company also misrepresented to claimants relevant facts or policy provisions regarding pre-existing conditions contract language, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, failed to pay the claim without first conducting a reasonable investigation, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §375.1007(1), (3), (4), and (6), RSMo and 20 CSR 300-2.200(2) [as replaced by, 20 CSR 100-8.040, eff. 7/30/08]

- c) According to Criticisms #189, the Company denied two claim lines as involving a pre-existing condition without having documentation to support that decision. The insured in this file sought treatment for a strep throat soon after coverage became effective. A review of the medical records by the examiners did not reveal any indication that this condition existed prior to the effective date of coverage. The Company admitted that it had inappropriately denied these claims, readjudicated them, and applied the allowed amounts to the insured's deductible during the course of the examination.

Reference: §375.1007(1) and (4), RSMo

- d) According to Criticisms #190 and 195, the Company improperly denied two claims as involving pre-existing conditions without having documentation that the conditions were in existence prior to the effective date of coverage.

(1) In Criticism #190, the Company denied a claim because of references in the medical records as to an "impression" of irritable bowel syndrome. The claim

was appealed prior to the examination, and the Company overturned its decision, applying the allowed amount to the insured's deductible. The examiners believe the Company should have conducted a more thorough investigation by requesting medical records prior to the effective date of coverage instead of just denying the claim based upon the limited information it originally possessed.

- (2) In Criticism #195, the Company denied a claim for services related to lower back pain because the records of a doctor who treated the insured six months after the coverage effective date indicated that the insured had experienced a two year history of lower back pain. The examiners felt that a reasonable investigation would have verified the accuracy of this statement by requesting medical records prior to the effective date from the doctor noted on the insured's application.

In its actions, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refused to pay these claims without conducting a reasonable investigation.

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

- e) According to Criticism #199, the Company improperly denied a claim as pre-existing although the claim was incurred more than 12 months after the effective date. By denying this claim, the Company failed to follow its own policy language regarding preexisting conditions. The Company readjudicated this claim and applied the allowed amount to the insured's deductible during the course of the examination.

By its actions, the Company misrepresented to claimants and insureds relevant facts and policy provisions related to coverages at issue, and failed to effectuate prompt, fair, and equitable settlement of a claim submitted in which liability had become reasonably clear.

Reference: §375.1007(1) and (4), RSMo

- f) According to Criticism #203, the Company denied a claim without documentation that the condition was pre-existing. Following an appeal occurring prior to the examination, the Company reversed its denial and either paid benefits or applied allowed amounts to the insured's deductible for the various charges involved. According to information supplied by the Company, its reversal of the denial was based upon additional medical records. The examiners believe an adequate investigation by the Company would have uncovered these clarifying medical records and allowed it to pay the claim when initially submitted.

In its actions, the Company misrepresented to claimants and insureds relevant facts or policy provisions regarding pre-existing conditions, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, failed to effectuate prompt, fair, and equitable settlement of claims, and denied claims without conducting a reasonable investigation.

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

2. Denied Claims – 2005 Pre-Existing

Field Size:	946
Type of Sample:	Random
Sample Size:	25
Number of Errors:	1
Error Ratio:	4%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

According to Criticism #176, the Company denied a claim incurred more than 12 months after the effective date of coverage as a pre-existing condition. The Company spent six months investigating this claim before inappropriately denying it. The Company reconsidered the claim and applied benefits to the deductible during the course of the examination.

In its actions, the Company misrepresented to claimants and insureds relevant facts or policy provisions regarding pre-existing conditions contract language, failed to adopt and implement reasonable standards for the prompt settlement of claims under its policies, and failed to pay a claim without first conducting a reasonable investigation.

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

3. Denied Claims – 2006 Pre-Existing

Field Size:	1,216
Type of Sample:	Random
Sample Size:	28
Number of Errors:	2
Error Ratio:	7.1%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) According to Criticism #180, the Company denied a claim as involving a pre-existing condition although the documentation in the claim file fails to show that the condition existed during the 12 month period immediately prior to the policy effective date. The Company informed the examiners that adequate documentation no longer exists to maintain their original denial. Accordingly, the Company reprocessed and paid this claim with appropriate interest during the course of the examination.

The Company failed to maintain its books, records, documents and other business records in a manner so that its claim handling and payment practices may be readily ascertained during market conduct examinations, misrepresented to claimants and insureds relevant facts or policy provisions regarding pre-existing conditions contract language, failed to adopt and implement reasonable standards for the prompt settlement of claims under its policies and failed to pay a claim without first conducting a reasonable investigation.

Reference: §375.1007(1), (3), and (6), RSMo, and 20 CSR 300-2.200(2) [as replaced by 20 CSR 100-8.040, eff. 07/30/08]

- b) According to Criticism #185, the Company denied a claim as a pre-existing condition without considering prior creditable coverage. In its response to the criticism, the Company explained that a data input error was responsible for the Company's oversight. Because the information as to prior creditable coverage was not properly reflected in the Company's computer system, the claims department conducted a pre-existing condition investigation and denied the claim as subject to the pre-existing condition exclusion. The Company corrected its system and readjudicated the claim when this error was brought to the Company's attention prior to the examination. The allowed amount was applied to the insured's deductible.

Because the Company initially improperly denied this claim, the Company misrepresented to claimants and insureds relevant facts or policy provisions regarding pre-existing conditions contract language and failed to pay the claim without first conducting a reasonable investigation.

Reference: §375.1007(1) and (6), RSMo

I. Compliance with Interest Payment Requirements for Short-Term Major Medical Claims – 2004 through 2006

The examiners reviewed the Company's adherence to the interest payment requirements of §376.383.5, RSMo, for short-term major medical claims paid in calendar years 2004 through 2006. The examiners reviewed claims paid more than 45 days after receipt for these three calendar years as a group, rather than reviewing each year separately.

In a review of 1,633 short-term major medical insurance claim lines, the examiners noted in Criticism #184 that the Company underpaid interest due on 382 claim lines and failed to pay any interest on 903 claim lines. In its response, the Company reiterated the position taken in its responses to Criticism #010 noted above that it is not obligated to pay interest on claims that are paid within 15 days of the receipt of any additional information (i.e., a "clean claim" standard). Nevertheless, the Company conceded that interest was payable for many of the claim lines and indicated that it had sent them to its "Adjustment Department" for processing.

Reference: §§376.383.5, and 376.384, RSMo

III. COMPLAINTS AND GRIEVANCES

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

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

A. Consumer Complaints Sent Directly to the Company

The Company recorded receipt of 623 written complaints from members during 2004, 2005, and 2006. The examiners selected and reviewed a sample of 326 of these complaints and noted the following errors in this review:

1. According to Criticisms #020, 021, 022, 023, 024, 029, 038, and 083, the Company improperly denied 20 claims involving complications of pregnancy based on the Company's policy language narrowly defining complications of pregnancy. The nondiscrimination provisions of §375.995, RSMo, prohibit insurers from "treating complications of pregnancy differently from any other illness or sickness under the contract." To determine compliance with this statute, the Department utilizes those ICD-9 diagnostic codes identified as complications of pregnancy by the Department's external review organization.

In its response, the Company took the position that the coverage was not required to comply with §375.995, RSMo, because the master policy had been issued to an association situated in Illinois. The Department interprets this provision as applying to any coverage provided to residents of Missouri.

The claims involved in Criticisms #021, 022, 029, and 038 were appealed, and the Company determined that some of the health conditions involved fit within its narrow definition of complications of pregnancy. As a result, the Company paid some of these claims prior to the examination, but it did not pay any interest on those claims. The Company's response to the criticisms reiterated its argument that no interest was due since the denials had been made within 45 days of its receipt of the claims.

By denying these claims, the Company misrepresented relevant facts or policy provisions related to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refused to pay the claim without conducting a reasonable investigation.

Reference: §§375.995.4(6), 375.1007(1), (3), (4), and (6), and 376.383.5, RSMo.

2. According to Criticism #021, some of the claims the Company denied as not being complications of pregnancy also involved the provision of emergency services. In its response to the criticism, the Company argued that it was not subject to §376.1367, RSMo, because its plan was not a "managed care plan" as defined in §376.1350(24), RSMo, as it did not contract directly with the network providers. The Department's interpretation, however, is that a contract with a PPO network intermediary meets the definition's description of the providers being "under contract with ... the health carrier."

Reference: §§375.995.4(6), 376.1350(12) and (24), and 376.1367, RSMo

3. According to Criticism #040, the Company denied two claims as involving a pre-existing condition. The condition had been disclosed on the insured's application. Under the terms of the policy, any pre-existing condition disclosed on the application and not specifically excluded by the Company would not be subject to the pre-existing condition exclusion. The Company failed to follow the terms of its policy in denying this claim. In response to an appeal filed on 09/24/04, the Company reconsidered these claims and applied the covered amounts to the insured's 2004 deductible on 10/09/04.

By improperly denying these claims when first submitted, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

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

4. According to Criticism #042, the Company denied a claim as involving a pre-existing condition without documentation that the condition was excluded under the terms of the policy's pre-existing condition exclusion. The provider listed ICD-9 code 692.9 (contact dermatitis) as the primary diagnosis related to the office visit. The consumer complaint file does not contain copies of any medical records from the provider, showing that this condition existed prior to the effective date of coverage (i.e., between 08/08/03 and 08/08/04). Three diagnosis codes were listed in box 21 of the electronic claim form; however, only one diagnosis (692.9) was identified in box 24 E, as related to the claim. The denial appears to have been related to a condition not identified with this claim.

The Company reprocessed and paid this claim in the amount of \$49.41 on 01/08/05, 79 days after receipt, but did not pay any interest on the claim.

Reference: §§375.1007(1), (3), and (4), and 376.383.5, RSMo

5. According to Criticism #148, the Company improperly denied three claims as involving pre-existing conditions. In its response to Formal Request #061, the Company explained that it had again reviewed the medical records in its file upon receipt of an appeal on 06/29/04 and determined that the prescriptions were not for pre-existing conditions. As a consequence, the Company reconsidered the claims on 07/30/04 and applied benefits to the insured's deductible.

Because the insured did not have a pre-existing condition, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §375.1007(1) and (4). RSMo

6. According to Criticism #158, the Company incorrectly denied two claims as being subject to the policy's pre-existing condition exclusion. In response to the criticism, the Company agreed that the claims were denied in error, since the diagnosis given for the claims had been disclosed on the application for coverage. Both claims were reconsidered and paid prior to the examination, 223 days and 190 days after receipt, respectively. The Company did not, however, pay the statutorily required interest.

By incorrectly denying these claims, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue and did not effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), and 376.383.5., RSMo

7. The Company improperly denied six claims listed in Criticism #159 based on a determination that the claims for prescription drugs were related to pre-existing conditions. The Company replaced another insurer on this insured's employer group plan. Due to a mistake by the prior carrier, the insured was not listed as a plan participant in the prior carrier's bill that the Company used to determine who was covered under the prior plan.

For six months after the Company took over the group, the insured submitted claims for prescription drugs that she had been taking for years. The Company applied these amounts to the plan deductible and reimbursed the insured from her medical savings account. When the insured eventually reached her deductible, the Company decided the drug claims should be denied as subject to the pre-existing condition exclusion based solely upon the insured's answers in her enrollment form, which disclosed health conditions that the insured had at the time the Company's coverage began.

The insured appealed the Company's determination to deny benefits. At the same time, the producer who had written the case corresponded with the Company as to why a pre-existing condition exclusion was being imposed against the insured when

she had been covered under the employer's plan for many years. When the Company indicated that its records did not reflect this, the producer supplied documentation to show that she had been covered under the prior plan. As a result, the Company reversed its denial and paid the claims but did not pay the statutorily required interest, even though the payment was made more than 45 days after the claims were first received. In its response to the criticism, the Company reiterated its position that no interest was due since it had paid the claims within 15 days of receiving additional information.

The examiners believe the Company should have done more to investigate this claim and verify whether this insured was eligible for a pre-existing condition exclusion waiver in this plan replacement situation. If she was not, the Company should have obtained medical records to document that the drugs related to conditions subject to the pre-existing condition exclusion. By failing to do so, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and refused to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(1), (4), and (6), 376.383.5, and 376.441, RSMo

8. According to Criticism #027, the Company improperly denied payment of a claim for ambulance services based on its determination that "benefits are not available for the expenses submitted." Since the claim file includes reference to treatment at an emergency room for medical conditions of an emergent nature, it is unclear why the Company initially denied the claim. In response to the criticism, the Company paid this claim with appropriate interest during the course of the examination.

By improperly denying this claim, the Company misrepresented relevant facts or policy provisions related to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refused to pay the claim without conducting a reasonable investigation.

Reference: §§375.1007(1), (3), and (4), 376.1367, and 376.1350(12), RSMo, and 20 CSR 100-1.050(1)(A)

9. According to Criticisms #030 and 032, the Company improperly denied four claims for charges incurred for mandated colorectal cancer screening. In response to the criticisms, the Company paid both claims with appropriate interest during the course of the examination.

The denial of these claims misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue by failing to cover mandated benefits, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), and 376.1250.1(3), RSMo

10. According to Criticism #033, the Company improperly denied a claim for physician services. The EOB stated that the condition was not covered, and that the expenses would be submitted to the insured's Fortis Insurance MSA USA account; however, none of the diagnoses on the claim form were for the conditions excluded by the policy.

On appeal, additional information concerning the insured's diagnoses was received. The Company had its Health Management Services ("HMS") Department complete a medical review, which resulted in the original denial being reversed, the claim approved, and benefits applied to the insured's deductible. No investigation was conducted prior to the initial denial of the claim to obtain medical records in support of the Company's action as evidenced by the lack of any additional records in the Company's consumer complaint file other than the physician's appeal on behalf of the insured.

By improperly denying this claim, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue by stating that the diagnoses submitted were related to an excluded condition, without supporting medical records, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

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

11. According to Criticisms #048 and 050, the Company failed to pay interest on three claims involving nine CPT codes that were paid more than 45 days after receipt. The Company declined to pay interest on these claims during the course of the examination.

Reference: §376.383.5, RSMo

12. According to Criticism #051, the Company denied a claim for charges for emergency care and related physician services for an insured who went to the emergency room with symptoms of a rapid heartbeat. The claim form submitted to the Company showed this as the admitting diagnosis, but gave "anxiety state" as the primary diagnosis after treatment. In processing the claim, the Company focused only on the "anxiety state" diagnosis and processed the claim under the policy's mental health benefits. The Company disregarded the diagnosis that prompted the insured to go to the emergency room. Rapid heartbeat is a symptom of sufficient severity that would lead a prudent layperson to believe that immediate medical care is required. A subsequent diagnosis that results from the emergency room treatment does not change the nature of the initial symptoms. Based upon the admitting diagnosis, the Company should have processed the claim as an emergency rather than as a claim for mental

illness, since the resulting services were necessary to screen and stabilize an enrollee within the meaning of §376.1367, RSMo

The Company subsequently paid the claims after receiving a complaint from the insured; however, the Company did not pay the statutorily required interest even though the payment was made more than 45 days after the claims were originally submitted. In its response to the criticism, the Company took the position that no interest was due since its original denial of the claims had been within 45 days of receipt. The Company also argued that its policy was not subject to §376.1367, RSMo, because it was not a "managed care plan," even though it utilizes a network.

Based upon the file documentation, the Company misrepresented relevant facts or policy provisions by processing the claims in a manner that limited benefits to mental illness claims as opposed to benefits allowable for medical emergency claims, failed to adopt and implement reasonable standards for prompt investigation and settlement of claims arising under its policies by failing to consider the admitting diagnosis in processing the hospital emergency room claim and the related claim for physician services, failed to make a prompt, fair, and equitable settlement of claims in which liability was reasonably clear, and failed to conduct a reasonable investigation prior to its determination of benefits by not investigating the claim until after a complaint was received.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(12), and 376.1367, RSMo

13. According to Criticism #052, the Company improperly denied a claim for a Pap test as involving a pre-existing condition. The insured visited her doctor for a well woman exam. Based on the insured's statement that her last menstrual cycle had been one year ago, the doctor conducted several diagnostic tests in addition to the Pap test. The Company denied the Pap test claim along with the other tests as involving the pre-existing condition of amenorrhea even though it was a routine screening and had nothing to do with the pre-existing condition. The insured appealed the denial, and the Company subsequently reconsidered and paid the claim. During the course of this examination, the Company also paid \$0.60 in interest that it had failed to pay when the claim was reconsidered.

The Company misrepresented the benefits available to its insured, failed to implement reasonable standards for prompt settlement of claims and failed to attempt in good faith to effect prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

References: §§375.1007(1), (3), and (4), 376.383.5, and 376.1250.1(1), RSMo

14. According to Criticism #079, the Company applied an out-of network deductible to a physician's charges for emergency room care. The insured was seen in a participating hospital emergency room by a non-participating physician and had no

choice in determining whether all necessary care was provided by a participating physician. After receiving an appeal, the Company overturned its prior decision and paid the physician charge of \$261.00.

The Company failed to pay this claim without first conducting a reasonable investigation, and owes interest on the claim payment since it paid the claim more than 45 days after its receipt.

Reference: §§375.1007(6) and 376.383.5, RSMo

15. According to Criticism #090, the Company reduced benefits for a mammogram claim without making a reasonable investigation. The insured received her mammogram at a participating hospital, but the hospital utilized a non-participating doctor to interpret the mammogram. As a consequence, the Company paid the claim at the reduced, out-of-network rate when it was filed.

The insured subsequently appealed the Company's decision to pay a reduced benefit. After further review, the Company reprocessed the claim, paid benefits at the in-network rate and applied benefits to the insured's deductible.

In its handling of this claim, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and did not attempt in good faith to effectuate prompt, fair, and equitable settlement of the claims in which liability was reasonably clear.

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

16. According to Criticism #093, the Company denied a claim for a 07/22/04 Pap test, stating that the services were subject to a one year wellness benefit waiting period according to the provisions of the policy. The insured was originally covered under a Kansas policy, effective 02/01/03, but the Company converted her to a Missouri policy, effective 08/01/03 when she moved to Missouri.

The insured appealed the Company's denial. She explained the situation with the move and that she had already satisfied the waiting period due to the continuous coverage between the Kansas and Missouri policies. The Company acknowledged its error and paid the claim prior to the examination. In responding to the criticism, however, the Company did not explain why it denied this Missouri mandated benefit in the first place.

The Company failed to conduct a reasonable investigation before denying the claim. The claim system either failed to pick up the original Kansas policy or the new Missouri policy. The claim was first denied and, only after the insured appealed the denial, was an investigation of the facts conducted. As such, the Company misrepresented to the insured relevant facts or policy provisions relating to coverage at issue. The Company also failed in good faith to effectuate prompt, fair, and

equitable settlement of claims by denying a legitimate claim and forcing the insured to appeal the denial thereby delaying payment to the provider.

Reference: §§375.1007(1), (4), and (6), and 376.1250.1(1), RSMo

17. According to Criticism #151, the Company denied a claim for eyelid surgery for a six year old boy with congenital defects. The Company originally paid for the services associated with this surgery, but the payment was reduced because pre-authorization was not obtained. The provider telephoned the Company to request reconsideration of the pre-authorization penalty indicating that the hospital had verified by telephone with the Company's HMS Department that pre-authorization was not required.

During reconsideration, the HMS Department indicated that the procedure did require pre-authorization and also determined that the Company should not have paid for the eyelid repair because it was not medically necessary. The Company requested a refund from the provider for the portion of the payment attributable to the eyelid repair and gave as the reason on the EOB that the treatment was experimental or investigational. The Company admitted in its response to the criticism that this denial code was in error, and the correct denial code should have stated that it was denied because the procedure was cosmetic.

In the ensuing months, the provider requested reconsideration of this new denial and filed first and second level appeals when the reconsideration was negative. During this time, the Company requested more medical records to verify prior history. Finally, sufficient medical records were received to satisfy the HMS Department that the procedure was medically necessary, and the Company reversed its denial. Although the Company subsequently paid the claim in full without any pre-authorization penalty, it did not pay the statutorily required interest. The Company initially declined to do so during the course of the examination.

Given the child's ongoing treatment for a congenital condition, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, did not attempt to effect prompt, fair, and equitable settlement of claims submitted in which liability was reasonably clear, and refused to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(1), (3), (4), and (6), and 376.383.5, RSMo

18. According to Criticism #025, the Company inappropriately denied a claim involving complications of pregnancy on the basis that it did not meet the policy's narrow definition of the term. Since the care was rendered in an emergency room, and the diagnosis indicated an emergent condition ("Unspecified antepartum hemorrhage of pregnancy") the Company also improperly denied an emergency claim.

In its response to the criticism, the Company reiterated its position that: (1) it was not required to comply with §375.995, RSMo, because its master policy was issued in Illinois; and (2) it was not required to comply with §376.1367, RSMo, because its policy was not a "managed care plan," even though it utilizes a PPO network.

By denying this claim, the Company misrepresented relevant facts or policy provisions related to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refused to pay the claim without conducting a reasonable investigation.

Reference: §§375.995.4(6), 375.1007(1), (3), and (6), 376.1350(12), and 376.1367, RSMo, and 20 CSR 100-1.030 (1) and (2)

19. According to Criticism #026, the Company denied a claim for a maternal fetal specialist consultation during a high risk pregnancy. The group policy and certificate included maternity coverage, and the denial reason given on the EOB was that "Expenses for total obstetrical care will be processed for claim consideration at the time of delivery." An appeal was filed, and additional information was provided. As a result, the Company reversed its decision and paid the claim with appropriate interest.

In response to the criticism, the Company argued that there was nothing about the original claim submission indicating "that the services were provided on the basis of other than prenatal management that would ordinarily be included in the global obstetrics charges submitted following delivery." The examiners felt, however, that the consultative language of the CPT code submitted should have put the Company on notice that further investigation was needed.

By initially denying this claim, the Company misrepresented relevant facts or policy provisions related to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and refused to pay the claim without conducting a reasonable investigation.

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

20. According to Criticism #028, the Company improperly denied a claim as involving a pre-existing condition without having documentation that the condition was validly subject to the policy's pre-existing condition exclusion provision. The Company reprocessed and paid this claim prior to the examination, but did not pay interest. When questioned by the examiners, the Company paid the appropriate interest during the course of the examination.

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

21. According to Criticism #039, the Company improperly denied claims from several providers for emergency room care without conducting a reasonable investigation.

Information provided by the Company indicates that the insured thought she might have had appendicitis when she went to the emergency room. As such, benefits under this claim should have been payable under Missouri's prudent layperson standards for emergency medical conditions.

Although the claims were reconsidered and paid with interest, the Company underpaid the amount of interest.

Reference: §§375.1007 (3), (4), and (6), 376.383.5, 376.1350(12) and 376.1367, RSMo

22. According to Criticism #049, the Company denied claims as involving a pre-existing condition without having documentation that the condition was validly subject to the policy's pre-existing condition exclusion provision. The condition treated was unrelated to a pre-existing condition which was treated five years earlier.

The Company reconsidered and paid the claims following its receipt of an appeal, but it did not pay any interest. When questioned by the examiners, the Company reiterated its position that Missouri law did not require it to pay interest because the original denials had been made within 45 days of claim receipt.

Reference: §§375.1007(3), (4), and (6), and 376.383.5, RSMo

23. According to Criticism #067, the Company improperly denied a claim as being subject to the policy's pre-existing condition exclusion provision even though the claim was incurred more than 12 months after the effective date of coverage. After receiving an appeal, the Company reprocessed and paid the claim; however, the Company did not initially pay the statutorily required interest. The Company acknowledged that interest was due, but declined to pay the interest during the course of the examination.

By denying a claim for services rendered beyond the 12 month pre-existing condition exclusion period, the Company misrepresented to claimants relevant policy provisions relating to coverages at issue; failed to implement reasonable standards for prompt settlement of claims; failed to attempt in good faith to effect prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and failed to pay claims without first conducting a reasonable investigation.

Reference: §§375.1007(1), (3), (4), and (6), and 376.383.5, RSMo

24. According to Criticism #095, the Company applied an out-of-network deductible to services provided by an out-of-network physician in a network hospital emergency room. After receiving an appeal by the insured's wife, the Company reprocessed and paid this claim within 45 days of receipt.

In its response to the criticism, the Company initially reiterated its argument that it was not subject to §376.1367, RSMo, because its plan was not a "managed care plan" even though it utilizes a PPO network. Despite this, the Company also stated that its standard process was to pay emergency room physician charges at the network rate when emergency services were delivered in a network hospital. Because the physician's bill was received prior to the hospital's bill, however, the Company argued that its claim system automatically processed the claim appropriately. The examiners felt that a reasonable investigation by the Company would have allowed this claim to be correctly processed when it was first received, given the diagnosis and place of service codes shown on the claim for the physician's services.

The Company failed to effectuate prompt, fair, and equitable settlement of claims by mishandling a legitimate claim and forcing the insured to appeal, thereby delaying payment to the provider. It also failed to conduct a reasonable investigation before processing the claim. The claim system failed to identify a claim for services incurred in an emergency room and/or failed to recognize the emergent nature of the claim, even though the claim form included sufficient information to alert the Company as to the nature of the claim, including the location where services were rendered and the diagnosis codes provided by the doctor. The claim was first improperly processed, and the investigation of the facts was not conducted until after the insured's wife filed an appeal.

Reference: §§375.1007(1), (4), and (6), 376.1350(12), and 376.1367, RSMo

25. According to Criticism #096, the Company applied an out-of-network deductible to services for treatment of two fractured fingers provided in an out-of-network physician's office. The insured appealed the Company's decision and explained that she had been sent to the physician's office by the emergency room she visited first. The Company reconsidered its original decision and paid the claim; however, it did not pay the statutorily required interest.

As above, the Company's response to the criticism reiterated its argument about not being subject to §376.1367, RSMo. The Company also argued that there was nothing in the original claim submission to indicate it was emergent in nature, and reiterated its position that no interest was due because it had denied the original claim within 45 days of receipt. The examiners felt, however, that the nature of the injury met the definition of an emergency medical condition in §376.1350(12), RSMo, and should have prompted further investigation by the Company.

The Company failed to conduct a reasonable investigation before initially processing the claim, failed in good faith to effectuate prompt, fair, and equitable settlement of the claim, and failed to conduct an investigation prior to denying the claim.

Reference: §§375.1007(1), (4), and (6), 376.383.5, 376.1350(12), and 376.1367, RSMo.

26. According to Criticism #097, the Company reduced payment of a claim for services related to a medical emergency due to the insured's failure to get preauthorization. The insured had been involved in an automobile accident and reported to the hospital's emergency room. The hospital admitted him through the emergency room for treatment of a possible concussion. After the Company applied a pre-authorization penalty to the hospital's claim, both the hospital and the insured requested a reconsideration of the claim; however, the Company maintained its original position after the reconsideration.

In response to the criticism, the Company reiterated its argument about not being subject to §376.1367, RSMo, and maintained that its actions were in accordance with its policy provision. Under the policy's provision for an "Emergency Confinement," the insured is required to "call within 24 hours, or as soon as reasonably possible, after an inpatient admission for Emergency Treatment." Despite this provision, the examiners felt that some or all of the charges for this emergency treatment should have been paid in full pursuant to §376.1367, RSMo.

The Company misrepresented to the insured relevant facts or policy provisions relating to coverage at issue, failed to effectuate prompt, fair, and equitable settlement of claims, and denied claims without conducting a reasonable investigation.

Reference: §§375.1007(1), (4), and (6), 376.1350(12), and 376.1367(1), RSMo

27. According to Criticism #099, the Company reduced the payment of claims by a total of \$1,000.00 for services related to a medical emergency due to the insured's failure to get pre-authorization. The insured in this case was a small boy with burns to his face, head, and neck. Upon arrival at the emergency room, the child was immediately taken to surgery. The parents gave the insurance information to the hospital and expected the hospital would take care of everything. When the Company eventually received the claims, it reduced the benefits because the inpatient stay had not been pre-authorized and submitted the uncovered amounts to the insured's MSA/HSA for payment. Although the insured parents appealed the pre-authorization, the Company did not change its position.

The Company took the same position with regard to this case as they did with regard to Criticism #097 above. As above, the examiners felt that some or all of the charges for this emergency treatment should have been paid in full pursuant to §376.1367, RSMo.

The Company misrepresented to the insured relevant facts or policy provisions relating to coverage at issue, failed to effectuate prompt, fair, and equitable settlement of claims, and denied claims without conducting a reasonable investigation.

Reference: §§375.1007(1), (4), and (6), 376.1350(12), and 376.1367, RSMo

28. According to Criticism #100, the Company reduced payment of a claim for services related to a medical emergency because a preauthorization was not obtained. The

insured reported to the hospital's emergency room due to a fall from a horse, and the hospital admitted the insured from the emergency room for treatment of a spinal fracture and sprain. Upon receipt initial receipt of the claim, the Company requested additional information and determined that a pre-authorization penalty should be applied. The hospital appealed on the basis that the insured had been admitted for emergency care from the emergency room. The Company, however, maintained its payment reduction was correct.

In its response to the criticism, the Company argued that its handling of the claim was in accord with its policy language. The Company also reiterated its position that it was not required to comply with the requirements of §376.1367, RSMo, because its plan was not a "managed care plan" even though it utilizes a PPO network.

By applying a preauthorization penalty for emergency care, the Company misrepresented to the insured relevant facts or policy provisions relating to coverage at issue, failed in good faith to effectuate prompt, fair, and equitable settlement of claims, and failed to conduct a reasonable investigation before reducing benefits payable for a claim.

Reference: §§375.1007(1), (4), and (6), 376.1350(12), and 376.1367, RSMo

29. According to Criticism #101, the Company improperly denied a second claim for the same procedure on the same day as a duplicate due to inadequacies in the Company's claim system. Although billed under the same Federal Tax Identification Number, the two charges were billed by two different physicians. The Company improperly denied this claim by failing to consider the names of the physicians in processing the two claims.

In its response to the criticism, the Company explained that its claim system was not capable of determining that this procedure was performed twice on the same date by two different providers submitting claims under the same Federal Tax Identification Number, even though this information was included when the claim was submitted. This response suggests that the Company routinely follows this practice and that other similar claims may have been improperly denied or delayed.

The claim was eventually reconsidered and paid 429 days after receipt, but the statutorily required interest was not paid.

Because the Company improperly denied the claim, the Company misrepresented relevant facts relating to the claim, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear

Reference: §§375.1007(1), (3), and (4), and 376.383.5, RSMo

30. According to Criticism #135, the Company improperly denied claims for three ultrasound tests related to a complication of pregnancy. After receiving and reviewing medical records, the Company reversed its denial and paid the claims with interest; however, the interest was underpaid since it was based on the Company's position that interest did not begin to accrue until 15 days after its receipt of additional information. The Company declined to pay any additional interest during the course of the examination.

In its initial denial, the Company misrepresented relevant facts or policy provisions related to coverages at issue and failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.995.4(6), 375.1007(1) and (4), and 376.383.5, RSMo

31. According to Criticism #161, the Company denied claims for an insured treated at a hospital emergency room for appendicitis without making a reasonable investigation. The insured's coverage was issued with a "Special Exception Rider" excluding coverage for "Irritable bowel syndrome/spastic colon, including but not limited to any diagnostic procedures, treatment, surgery, underlying causes or complications thereof." Although the diagnosis on emergency room claim indicated it was for abdominal pain, it also indicated that the pain was in the right lower quadrant. This is a classic symptom of appendicitis and should have prompted the Company to request additional information rather than automatically denying the claim as subject to the exclusionary rider.

After receiving an appeal, the Company reconsidered and paid these claims, but it did not pay any interest, although the claims were paid more than 45 days after receipt. When requested by the examiners, the Company declined to pay any interest because the initial denials had been within the 45 day period.

In its initial denial, the Company misrepresented relevant facts or policy provisions related to coverages at issue, failed to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear, and denied a claim without conducting a reasonable investigation.

Reference: §§375.1007(1), (4), and (6), 376.383.5, 376.1350(12), and 376.1367(1), RSMo

32. According to Criticism #006, the insured called the Company regarding coverage for an office physical exam. He was told by the Company's customer service representative that he would be covered, subject to his co-payment. The insured went to his physician for the exam but later received an EOB denying his claim. Upon complaining to the Company, he was told the exam was not covered because he had previously used his two network office visits for the year. The Company investigated what was told to the insured and discovered he was given inaccurate information.

The Company resolved the complaint by overturning the original denial and paying the claim, subject to the co-pay.

The Company misrepresented benefits due to the insured by its failure to fully disclose to claimants all pertinent benefits, coverages or other provisions of its insurance policy.

Reference: §375.1007(1), RSMo, and 20 CSR 100-1.020 (1)

33. According to Criticism #008, the Company misrepresented benefits to a provider about an insured's plan. The provider's assistant called the Company regarding coverage for an outpatient surgery scheduled for 10/11/05. A Pre-Certification Data Sheet was completed by the provider's assistant. The Company's customer service representative indicated that benefits would be paid at 75% after the deductible was met, and the insured's obligation would be 25%. Based on this information, the surgery was performed as scheduled. Later the insured received an EOB indicating he owed 75% of the cost, rather than the 25% as originally explained by the Company.

Upon receiving this complaint, the Company reviewed the facts and the telephone log of the conversation between the office assistant and the Company's customer service representative. The Company discovered that its representative failed to inform the assistant and claimant that there was a \$2,500 outpatient calendar year maximum. Based on this information, The Company reconsidered the allowed services for the outpatient surgery beyond the \$2,500 calendar year maximum and paid benefits based on the original explanation.

The Company failed to fully disclose to claimants all pertinent benefits, coverages or other provisions of its insurance policy.

Reference: §375.1007 (1), RSMo, and 20 CSR 100-1.020 (1)

34. According to Criticism #011, the Company denied claims for treatment of back pain as involving a pre-existing condition without having documentation that the condition was validly subject to the policy's pre-existing condition exclusion provision. The policy was effective 03/15/05, the insured's initial visit was 01/04/06, and the claims were received 02/03/06. The Company denied the claims on 03/16/06 without conducting a reasonable investigation.

The Company subsequently received a letter from the insured's primary physician stating that the onset of the insured's back pain symptoms did not manifest until about July of 2005, after the policy effective date. Based on this information, the Company reversed its initial denial and applied the allowed amount to the insured's deductible.

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

35. According to Criticism #012, the Company improperly denied two claims as involving a pre-existing condition without having documentation that the condition was validly subject to the policy's pre-existing condition exclusion provision. According to the file documents, the policy was effective 01/01/05, and the insured's initial visit for stomach pain was not until 5/26/05. At this initial visit, he complained that the stomach pain had been ongoing for several months. Following denial of the claims, the physician appealed. The Company's investigation after receipt of the appeal showed that the condition was not pre-existing.

In its response to the criticism, the Company stated that it did not receive the physician's appeal letter dated 12/07/05 until 01/11/06. The letter from the physician, however, does not have a date stamp confirming the date the letter was received. Therefore, the Company's claim file contained documentation pertinent to the investigation and/or denial of a claim that was not date-stamped.

Reference: §375.1007 (2), (3), (4), and (6), RSMo, and 20 CSR 300-2.100 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08]

36. According to Criticism #102, the Company denied six claim lines for pathology services without conducting a reasonable investigation. The provider billed for 12 tests, but the tests were submitted as two claims of six tests each. When the Company received the claims, the Company's claim system auto-adjudicated and denied one of the claims as a duplicate and applied the other to the insured's deductible.

The Company subsequently received a request for reconsideration from the provider that included the pathology report establishing that the 12 tests performed on 6/6/02 were billed under two separate claims. The Company agreed that benefits for the additional six units were warranted and paid the claims, but the Company did not pay the statutorily required interest. In its response to the criticism, the Company again asserted the position that it was not required to pay interest since the claims had been readjudicated within 15 days of its receipt of additional information.

The Company response did not contain copies of the provider's request for reconsideration of services performed on 06/02/06, nor did the file contain copies of the pathology reports received by the Company. Consequently, the claim file was incomplete.

Reference: §§375.1007(1), (3), and (4), and 376.383.5, RSMo and 20 CSR 300-2.100 [as replaced by, 20 CSR 100-8.040, eff. 07/30/08]

37. According to Criticism #103, the Company reduced payment by \$1,500 on a claim for medical expenses associated with emergency room and ICU care incurred from 01/15/06 through 01/17/06 because it did not have a preauthorization on file. The insured was admitted to the hospital through the emergency room for a heart attack. When the Company received the claim, it noted that it had no pre-authorization for the admission and applied a penalty to the amount paid the hospital.

The hospital subsequently appealed the payment reduction, explaining that it had been unable to request pre-authorization because the insured did not have her insurance information with her when she reported to the emergency room. Despite this additional explanation, the Company maintained its position.

In response to the criticism, the Company continued to argue that its actions were correct based upon its policy provisions and reiterated its position that its plan was not a "managed care plan," despite its use of a PPO network.

By denying the full payment of these benefits, the Company misrepresented relevant facts or policy provisions relating to coverages at issue, and failed effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

Reference: §§375.1007(1) and (4), 376.1350(12) and (24), and 376.1367(1), RSMo.

B. DIFP Consumer Complaints

The examiners reviewed 109 complaints made through the DIFP's Division of Consumer Affairs for calendar years 2004, 2005, and 2006 to determine the Company's handling of the complaints and its adherence to requirements of Missouri's laws that relate to complaints or related issues.

The examiners noted the following errors in this review:

1. According to Criticism #145, the Company improperly denied a claim as involving a pre-existing condition without having documentation that the condition was validly subject to the pre-existing condition exclusion. The Company subsequently reconsidered and paid the claim; however, the Company initially did not pay interest on the claim, even though it was paid more than 45 days after receipt. In its response to the criticism, the Company acknowledged that interest was due.

In its handling of this claim, the Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies and refused to pay claims without conducting a reasonable investigation.

Reference: §§375.1007(3) and (6), and 376.383.5, RSMo

2. According to Criticism #004, the Company reduced payment by 25% on a claim for emergency room care for a patient admitted for chest pain because the care was not pre-authorized. Upon the conclusion of the DIFP investigation, the pre-authorization penalty was removed.

The Company improperly denied benefits on a claim where a sudden, unexpected

onset of a health condition manifested by symptoms of sufficient severity would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required. In addition, the Company failed to effectuate prompt, fair, and equitable settlement of claims in which liability had become reasonably clear.

Reference: §§375.1007(4), 376.1350(12), and 376.1367(1), RSMo

3. The Company improperly denied 12 claim lines, shown in Criticism #014, as involving a pre-existing condition, even though the expenses were incurred more than one year after the effective date of the insured's certificate. The certificate's limitation for pre-existing conditions states that after an insured has been continuously insured under the plan for 12 months, benefits will be paid for a pre-existing condition on the same basis as any other condition, unless the condition has been specifically excluded from coverage. None of the conditions for which these claims were filed were specifically excluded from coverage.

Eleven of the 12 claims were subsequently reprocessed and paid with appropriate interest on 05/06/05 after the Company received an appeal. One claim was reprocessed and paid on 04/16/05, but the Company initially failed to pay interest on that claim. As a result of Criticism #014, the Company paid appropriate interest on that claim during the course of this examination.

In its handling of this claim, the Company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue, failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, and failed to attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability had become reasonably clear.

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

IV. CRITICISM AND FORMAL REQUEST TIME STUDY

This study shows the amount of time taken by the Company to respond to criticisms and requests submitted by the examiners. (Note: The sum of percentages may exceed 100% due to rounding.)

A. CRITICISM TIME STUDY

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
Received within time-limit,		
Without Extension	51	23.18%
Received By Extension Date	132	60.00%
No Response	0	0.00%
Total Timely Responses	183	83.18%
Received outside time-limit,		
Without Extension	5	2.27%
Received After Extension Date	32	14.55%
No Response	0	0.00%
Total Late Responses	37	16.82%
Total All Criticisms	220	100.00%

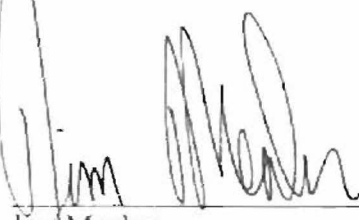
B. FORMAL REQUEST TIME STUDY

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
Received within time-limit,		
Without Extension	34	24.82%
Received By Extension Date	87	63.50%
No Response	0	0.00%
Total Timely Responses	121	88.32%
Received outside time-limit,		
Without Extension	4	2.92%
Received After Extension Date	16	11.68%
No Response	0	0.00%
Total Late Responses	20	14.60%
Total All Requests	137	100.00%

The examiners are not aware of any indications that the Company intentionally delayed or refused to respond to criticisms or requests for documents.

V. EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Time Insurance Company (NAIC #69477), Examination Number 0706-08-TGT. This examination was conducted by Gary W. Kimball, William D. Schneider (retired), and Randy Kemp. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated May 17, 2010. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.



Jim Mealer

Chief Market Conduct Examiner

7/9/13

Date



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August 1, 2013

Mr. Stewart Freilich
Missouri Department of Insurance, Financial Institutions
and Professional Regulation
Market Conduct Section
301 West High Street, Room 350
Jefferson City, MO 65102

Re: Time Market Conduct Examination #0706-08-TGT

Dear Mr. Freilich:

We have reviewed the July 8, 2013 Final Market Conduct Examination Report of our company. The following remarks are offered to provide our understanding of two of the major Findings reflected in the Report.

Among the Findings that occupied much of our discussion with the Department regarding Missouri law was the Department's position that the Childhood Immunization mandate found in §376.1215 RSMo. applied to policies of insurance issued in states other than Missouri. We have agreed to accept the Department's position and reprocessed identified claims for Childhood Immunizations to comport with that understanding. However, it remains our position that the childhood immunization mandate is not legally required for out-of-state certificates. § 376.1215 RSMo. only applies to "individual and group health insurance policies." It does not apply to certificates because the definition of "individual and group health insurance policies" does not reference "certificates" or "out-of-state policies." In contrast, there are numerous Missouri statutes that specifically reference certificates or mandate extraterritorial jurisdiction. In addition, as we noted in prior correspondence with the Department regarding this issue that the vast majority of the immunization claims at issue during the exam period (approximately 82%) were in fact paid consistent with the provisions of the mandate under the wellness provision of the plans. Of the 18% of the

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

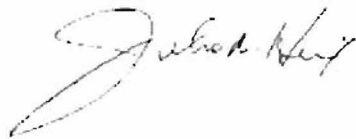
Page 2

Time Insurance Company immunization claims that were denied, 11.3% were denied as a duplicate claim submission or coverage was not inforce.

Another issue that was resolved early in discussions with the Department involved the practice of requiring contracted PPO providers to submit claims for repricing to the address that appeared on the insured's insurance card, which is contracting network. If claims were submitted directly to the carrier, the carrier denied the claim and directed the provider to submit the claim to their contracting PPO network, consistent with the terms of their agreement with the respective network and the address on the insurance card. We provided evidence to the Department that this is common throughout the industry and providers receiving such denials are aware that the remedy is to resubmit the claim to the appropriate network repricing vendor. We nonetheless agreed to discontinue this claim practice in view of the Department's position. It remains noteworthy, however, that repricing denials played a prominent role in the Department's designation of claim errors.

Time Insurance Company remains committed to complying with all requirements of Missouri law. We appreciate the courtesy and professionalism demonstrated by the Department as we worked to resolve any and all issues that arose during this Examination. In closing, we thank you for providing the opportunity to comment on the Examination Report and the ultimate outcome of the examination.

Sincerely,

A handwritten signature in dark ink, appearing to read "Julia Hix-Royer", with a stylized, flowing script.

Julia Hix-Royer
Vice-President Regulatory Compliance
Assurant Health Compliance Officer

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



FINAL MARKET CONDUCT EXAMINATION REPORT
Of the Life and Health Business of

UNION SECURITY INSURANCE COMPANY
NAIC #70408

MISSOURI EXAMINATION #0706-09-TGT

NAIC EXAM TRACKING SYSTEM #MO268-M20

July 8, 2013

Home Office
501 West Michigan Street
Milwaukee, WI 52302

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FOREWORD

This is a targeted market conduct examination report of the Union Security Insurance Company, (NAIC Code # 70408). This examination was conducted at the offices of Union Security Insurance Company, located at 501 West Michigan Street, Milwaukee, Wisconsin and 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.

Wherever used in the report:

- “AMA” refers to the American Medical Association;
- “Company” or “USIC” refers to Union Security Insurance Company, Inc.;
- “CSR” refers to Code of State Regulations;
- “DIFP” or “Department” refers to Department of Insurance, Financial Institutions and Professional Registration;
- “EOB” refers to Explanation of Benefits;
- “NAIC” refers to the National Association of Insurance Commissioners;
- “PPO” refers to Preferred Provider Organization;
- “RSMo” refers to Revised Statutes of Missouri;

SCOPE OF THE EXAMINATION

The DIFP has authority to conduct this examination pursuant to, but not limited to, §§374.045, 374.110, 374.205, 375.445, 375.938 and 375.1009, RSMo. In addition, §447.572, RSMo grants authority to the DIFP to determine compliance with the Uniform Disposition of Unclaimed Property Act.

The purpose of this examination was to determine if the Company complied with Missouri statutes and DIFP regulations and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review is January 1, 2004, through December 31, 2006, unless otherwise noted. Errors outside of this time period discovered during the course of the examination, however, may also be included in the report.

The examination was a targeted examination involving the following business functions and lines of business: underwriting and rating practices, claim practices, mandated benefit claims practices, and complaints and grievances.

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

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

COMPANY PROFILE

The following Company profile was provided to the examiners by the Company:

Montana Life Insurance Company was incorporated in 1910 under the laws of the State of Montana and operated as a Montana domiciled life insurance company from 1910 to 1962. The Company changed its name to Western Life Insurance Company on February 8, 1938. In 1962, the Company changed its state of domicile by establishing a Minnesota domiciled life insurance company and merging the Montana domiciled life insurance company into it. The Company then reincorporated pursuant to Minnesota statutes.

On December 31, 1984, Western Life was acquired by N.V. AMEV, a Dutch financial services company located in Utrecht, The Netherlands. During 1994, N.V. AMEV became Fortis AMEV. The Company changed its name, effective January 1, 1992, from Western Life Insurance Company to Fortis Benefits Insurance Company (FBIC). Effective September 8, 2005, the Company changed its name to Union Security Insurance Company. The Company redomesticated from Minnesota to Iowa, effective October 1, 2004, and from Iowa to Kansas, effective September 30, 2009.

The Company acquired the Group Operations of Mutual Benefit Life Insurance Company on October 1, 1991. It also acquired 99% ownership of Dental Health Alliance, L.L.C. on February 20, 1997, and the remaining 1% was assigned to it from Assurant, Inc. on December 31, 2006. The former Pierce National Life Insurance Company, a California corporation, merged into the Company effective July 1, 2001.

The long term care business was sold to John Hancock Financial Services effective March 1, 2000. The variable insurance and mutual fund division, named Fortis Financial Group, was sold to Hartford Life, Inc. effective April 1, 2001.

Union Security Insurance Company's direct parent is Interfinancial Inc., which in turn, is controlled by Assurant, Inc., in New York, New York. The U.S. operations were known as Fortis, Inc., which were renamed Assurant, Inc., when it became a publicly traded company on the New York Stock Exchange through an Initial Public Offering (IPO) on February 5, 2004.

The Company is currently licensed by the DIFP under Chapter 376, RSMo. and authorized to write life insurance, annuities, endowments, accident and health insurance, and variable contracts as set forth in its Certificate of Authority.

EXECUTIVE SUMMARY

The DIFP conducted a targeted market conduct examination of Union Security Insurance Company. The examiners found the following principal areas of concern:

I. UNDERWRITING AND RATING PRACTICES

Small Employer Group Underwriting and Rating

The Company failed to maintain complete policy file records for 10 small employer groups out of a sample of 50 contrary to §374.205.2(2), RSMo, and 20 CSR 300-2.200(3)(A) [replaced by 20 CSR 100-8.040(3)(A), eff. 07/30/08]. *(Page 9)*

II. CLAIM PRACTICES

A. Unfair Claim Practices – Denied Claims for Cancer Screenings

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1) and (4), 376.383.5 and 9, and 376.1250.1(3), RSMo, were noted by the examiners in the Company's processing of 13 claims out of a sample of 28 claims, yielding an error ratio of 46.4%. *(Page 11)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(3) and (6), and 376.383.5, RSMo, were noted by the examiners in the Company's processing of 1 claim out of a sample of 8 claims, yielding an error ratio of 12.5%. *(Page 12)*
- 2006 Claims: No errors were noted by the examiners in their review of a sample of 3 claims. *(Page 12)*

B. Unfair Claim Practices – Denied Claims for Childhood Immunizations

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.1215, RSMo, were noted by the examiners in the Company's processing of 21 claims out of a sample of 138 claims, yielding an error ratio of 15.2%. *(Page 13)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.1215, RSMo, were noted by the examiners in the Company's processing of 34 claims out of a sample of 134 claims, yielding an error ratio of 25.4%. *(Page 15)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1), (3), and (4), 376.383.5, and 376.1215, RSMo, were noted by the examiners in the Company's processing of 40 claims out of a sample of 134 claims, yielding an error ratio of 29.9%. *(Page 15)*

C. Unfair Claim Practices – Paid Claims for Childhood Immunizations – Benefits Applied to Deductibles or Co-Payments

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1) and (4), and 376.1215.2, RSMo, were noted by the examiners in the Company's processing of all 4 claims out of a census of 4 claims, yielding an error ratio of 100%. *(Page 16)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1) and (4), and 376.1215.2, RSMo, were noted by the examiners in the Company's processing of all 24 claims out of a census of 24 claims, yielding an error ratio of 100%. *(Page 17)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1) and (4), and 376.1215.2, RSMo, were noted by the examiners in the Company's processing of 1 claim out of a census of 4 claims, yielding an error ratio of 25%. *(Page 17)*

D. Unfair Claim Practices – Denied Claims for Emergency Room and Ambulance Services

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5 and 9, 376.1350(12) and (13), and 376.1367, RSMo, were noted by the examiners in the Company's processing of 27 claims out of a sample of 91 claims, yielding an error ratio of 29.7%. *(Page 18)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(12) and (13), and 376.1367, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 7 claims out of a sample of 47 claims, yielding an error ratio of 14.9%. *(Page 20)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(12) and (13), and 376.1367, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 4 claims out of a sample of 53 claims, yielding an error ratio of 7.5%. *(Page 21)*

E. Unfair Claim Practices – Denied Claims for Mammograms

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.782, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 5 claims out of a sample of 36 claims, yielding an error ratio of 13.9%. *(Page 22)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), and 376.782, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 1 claim out of a sample of 18 claims, yielding an error ratio of 5.6%. *(Page 23)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4) and (6), and 376.782 RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 1 claim out of a sample of 6 claims, yielding an error ratio of 16.7%. *(Page 23)*

F. Unfair Claim Practices – Denied Claims for Pap Smears

- 2004 Claims: Errors contrary to the provisions of §§375.1007(3) and (6), and 376.1250.1(1), RSMo, were noted by the examiners in the Company's processing of 9 claims out of a sample of 54, yielding an error ratio of 16.7%. *(Page 24)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5 and 9, and 376.1250.1(1), RSMo, were noted by the examiners in the Company's processing of 9 claims out of a sample of 31, yielding an error ratio of 29%. *(Page 25)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), 376.383.5 and 9, and 376.1250.1(1), RSMo, were noted by the examiners in the Company's processing of 5 claims out of a sample of 18, yielding an error ratio of 27.8%. *(Page 25)*

G. Unfair Claim Practices – Denied Claims for PSA Tests

- 2004 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4) and (6), 376.383.9, and 376.1250.1(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 9 claims out of a sample of 33, yielding an error ratio of 27.3%. *(Page 26)*
- 2005 Claims: Errors contrary to the provisions of §§375.1007(1), (3), (4), and (6), and 376.1250(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 3 claims out of a sample of 26, yielding an error ratio of 11.5%. *(Page 27)*
- 2006 Claims: Errors contrary to the provisions of §§375.1007(1), (3), and (4), and 376.1250(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050 were noted by the examiners in the Company's processing of 2 claims out of a sample of 8, yielding an error ratio of 25%. *(Page 27)*

III. COMPLAINTS AND GRIEVANCES

A. Consumer Complaints Sent Directly to the Company

The examiners noted that the Company erred in processing claims related to 10 consumer complaints and grievances out of a sample of 125 for calendar years 2004 through 2006. *(Page 29)*

B. DIFP Consumer Complaints – 2004 through 2006

The examiners found no errors in a review of 36 complaints made through the DIFP's Division of Consumer Affairs for calendar years 2004 through 2006. *(Page 33)*

EXAMINATION FINDINGS

I. UNDERWRITING AND RATING PRACTICES

This section of the report details the examiners' review of the Company's underwriting and rating practices. Such practices may include the filing and use of policy forms, adherence to underwriting guidelines, assessment of premiums for coverage, and procedures used to decline, non-renew, or terminate coverage. The examiners performed a limited review of the Company's underwriting practices for small groups. To minimize the duration of the examination, while still achieving an accurate evaluation of underwriting and rating practices, the examiners reviewed a statistical sample of the policy files. The DIFP defines a policy file, in the context of a sampling unit, as a contract between the Company and the insured. A policy file includes all of the obligations of the parties to the contract. The percentage of files found to be in error is the most appropriate statistic to measure compliance with Missouri law regarding rating, underwriting, rescissions or terminations.

The DIFP defines an underwriting or rating error according to NAIC guidelines, which define an error as any of the following:

- A miscalculation of premium;
- An improper acceptance of an application;
- An improper rejection of an application;
- An improper termination of coverage;
- A misapplication of the Company's underwriting guidelines; or
- Any other underwriting or rating action that violates Missouri laws.

Small Employer Group Underwriting and Rating

The examiners chose a sample of 50 small employer groups to review. The Company provided the examiners with a copy of its underwriting guidelines for small employer groups, but it was only able to produce employer applications for 40 of the groups in the sample. The examiners noted no errors in their review of the underwriting guidelines and the 40 employer applications. The Company's failure to maintain records for the other 10 small employers in the sample, however, does not appear to comply with Missouri's record retention requirements.

Reference: §374.205.2(2), RSMo, and 20 CSR 300-2.200(3)(A) [replaced by 20 CSR 100-8.040(3)(A), eff. 07/30/08]

II. CLAIM PRACTICES

The examiners reviewed the Company's claim practices in order to determine its efficiency of handling, accuracy of payment, adherence to contract provisions and compliance with Missouri law and regulations. . Because this was a targeted examination, the examiners' review was limited to claims involving certain benefits mandated by Missouri law. This included a review of paid and denied claims for childhood immunizations, denied claims for emergency services, and denied claims for mammography, colon, Pap smear and PSA cancer screening services.

To accomplish this review, claims meeting these criteria were extracted from data provided by the Company, which consisted of claims closed on an annual basis between January 1, 2004, and December 31, 2006. In those instances where the number of extracted claims in a particular area was deemed too large for a census review, a statistical sampling was extracted and reviewed.

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

This market conduct examination was conducted in conjunction with market conduct examinations of the Company's affiliates that also operate under the Assurant Health name, Time Insurance Company and John Alden Life Insurance Company. As with the examination for Time Insurance Company, the examiners noted many claims during the Company's examination where interest was not paid or underpaid under the standard imposed by §376.383.5, RSMo, and the Company continued to maintain its position that subsections 2, 3, and 4 of §376.383 allow it 15 days from the date any requested additional information is received in which to pay the claim before any interest begins to accrue (i.e., applying a "clean claim" standard). Further discussion regarding this issue can be found in the Time Insurance Company report.

Because the Company continued to regard this issue as "open" during the course of this examination, this report notes many instances where the Company has declined to pay a claim plus interest or has declined to pay additional interest pending a final determination of issues at the conclusion of the examination.

A. Unfair Claim Practices – Denied Claims for Cancer Screenings

The examiners reviewed the Company's adherence to claim handling requirements for denied cancer screening claims under §376.1250.1(3), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Cancer Screenings

Field Size:	52
Type of Sample:	Random
Sample Size:	28
Number of Errors:	13
Error Ratio:	46.4%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #056: The Company improperly denied a claim for cancer screening on the basis that services were not rendered by a participating provider. After subsequently learning that its initial denial was incorrect because the provider was participating, the Company reconsidered and paid the claim, but failed to pay interest. In response to the criticism, the Company paid the interest that was due.

Reference: §§375.1007(1) and (4), 376.383.5, and 376.1250.1(3), RSMo

- b) Criticism #070: The Company improperly denied 12 cancer screening claims for a variety of reasons. Eleven of the claims were denied as not being covered, but the denial reason for six of the claims failed to identify the specific policy limitations or exclusions upon which the denials were based. One claim was denied on the basis that services were not rendered by a participating provider.

The Company reprocessed all of the claims during the course of the examination with allowed amounts either applied to deductibles or paid with interest.

Reference: §§375.1007(1) and (4); 376.383.5 and 9; and 376.1250.1(3), RSMo

2. Denied Claims – 2005 Cancer Screenings

Field Size:	37
Type of Sample:	Random
Sample Size:	8
Number of Errors:	1
Error Ratio:	12.5%
Within DIFP Guidelines?	No

The examiners noted the following error in this review:

Criticism #055: The Company improperly denied a claim the first two times it was received because the provider failed to submit it through the PPO network intermediary for network fee discount information. The third time it was submitted through the network intermediary, but the Company suspended the claim due to an ongoing preexisting condition investigation. When the Company eventually paid the claim prior to the examination, it did so without paying any interest.

In their criticism, the examiners indicated that: (1) a reasonable investigation by the Company required the Company to request network fee discount information from the network intermediary rather than just denying it and sending it back to the provider and the insured; and (2) interest was due on the claim since it had been paid more than 45 days after it was first received. The Company responded that: (1) its denial of the claim for network fee discount information was a reasonable request for additional information pursuant to §376.383.2(2); and (2) no interest was due since it had paid the claim within 15 days of receiving additional information regarding the preexisting condition investigation.

Reference: §§375.1007(3) and (6), and 376.383.5, RSMo

3. Denied Claims – 2006 Cancer Screenings

Field Size:	14
Type of Sample:	Random
Sample Size:	3
Number of Errors:	0
Within DIFP Guidelines?	Yes

The examiners found no errors in this review.

B. Unfair Claim Practices – Denied Claims for Childhood Immunizations

The examiners reviewed the Company's adherence to claim handling requirements for denied childhood immunization claims under §376.1215, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Childhood Immunizations

Field Size:	313
Type of Sample:	Random
Sample Size:	138
Number of Errors:	21
Error Ratio:	15.2%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #011: The Company improperly processed four claims for childhood immunizations. Two claims were denied because the providers did not submit the claims through the PPO network intermediary for network fee discount information, one claim was initially paid as out of network even though the services were delivered by a network provider, and one claim was denied on the incorrect basis that the dependent's coverage had terminated. The claims were subsequently paid prior to the examination, but the payments were made more than 45 days after the dates they were first received.

With regard to the two claims denied for failing to submit them through the network intermediary, the Company reiterated its argument that its denial for network fee discount information constituted a reasonable request for additional information, and that no interest was due because the Company had paid the claim within 15 days of receiving the discount information. The Company also argued that no interest was due on the claim it had initially paid as out of network since it had paid the additional network benefits within 15 days of receiving discount information. For the claim it had initially denied for coverage termination, the Company noted that interest was paid when it paid the claim.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.1215, RSMo

- b) Criticism #076: The Company improperly denied five claims for childhood immunizations as not being covered benefits. The Company paid all five claims with interest during the course of the examination.

Reference: §§375.1007(1) and (4), and 376.1215, RSMo

- c) Criticism #077: The Company improperly denied four childhood immunization claims giving as its reason for denial that, "This benefit is based on the amount for which Medicaid is responsible." In its response to the criticism, the Company acknowledged that it had denied the claims in error and asserted that it does not take the position that its coverage is secondary to Medicaid under any circumstances. The Company added, however, that it did not believe §376.1215 applied to these claims because the group master policy was issued in Mississippi rather than Missouri. Although the Company paid the claims with interest during the course of the examination, it stated in its response that it was doing so because it was a covered benefit under the plan, not because of §376.1215.

Reference: §§375.1007(1), (4), and (6), and 376.1215, RSMo

- d) Criticism #079: The Company improperly denied a claim for the administration of a childhood immunization. The provider had submitted claims for immunizations under separate claim numbers, but the corresponding claims for administration of each immunization were all submitted under a single claim number. The Company failed to match one of the administration charges with its corresponding immunization and denied it as not being covered. The examiners felt that a reasonable investigation would have matched the two charges.

In its response to the criticism, the Company agreed that the claim was payable since it was a covered benefit under the plan, but it attributed the error to the provider's billing practices. The Company reconsidered and paid the claim with interest during the examination.

Reference: §§375.1007(3), (4), and (6), and 376.1215, RSMo

- e) Criticism #080: The Company denied seven claims for childhood immunizations because the providers failed to submit them through the PPO network intermediary for network fee discount information. None of the claims were resubmitted to the Company after their denial. As noted previously in this examination report, the examiners believe such denials are an abrogation of the Company's responsibility to investigate. Furthermore, the Company's actions may have resulted in the insureds paying for benefits that were covered under their plans since the claims were never resubmitted.

In its response to the criticism, the Company reiterated its argument that its actions constitute an appropriate request for additional information pursuant to §376.383.3. The Company declined to make any payment on the claims during the examination.

Reference: §§375.1007(3), (4), and (6), and 376.1215, RSMo

2. Denied Claims – 2005 Childhood Immunizations

Field Size:	296
Type of Sample:	Random
Sample Size:	134
Number of Errors:	34
Error Ratio:	25.4%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #012: The Company denied five claims for childhood immunizations because the providers failed to submit them through the PPO network intermediary for network fee discount information. The claims were subsequently resubmitted through the network intermediary and paid, but the Company did not pay any interest even though the claims were paid more than 45 days after their initial receipt. The Company's response to the criticism reiterated its argument that its actions were consistent with §376.383, so no interest was due.

Reference: §§375.1007(3), (4), and (6), 376.383.5, and 376.1215, RSMo

- b) Criticism #s 015, 017, 018, 019, 020, 021, 022, 023, 024, 025, 026, 027, 028, 029, 030, 031, and 034: The Company initially denied 29 claims for childhood immunizations giving as a reason that they were subject to a copayment. The Company reprocessed and paid all 29 with interest during the course of the examination. In response to criticisms regarding the handling of the 29 claims, the Company acknowledged that the claims had been initially misprocessed because its policy contained a benefit for immunizations that matched the benefit under §376.1215, but it reiterated its argument that the statute does not apply because the master policy was issued to a trust in Mississippi.

Reference: §§375.1007(1) and (4), and 376.1215, RSMo

3. Denied Claims – 2006 Childhood Immunizations

Field Size:	244
Type of Sample:	Random
Sample Size:	134
Number of Errors:	40
Error Ratio:	29.9%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #033: The Company denied 35 claim lines giving a variety of reasons (i.e., subject to a copayment, code review denial, or an uncovered preventive care service). The Company reprocessed and paid all of the claims during the course of the examination and included interest. As with claims noted above, the Company acknowledged that the claims had been misprocessed based upon the benefits under the group policy, but disagreed that the group policy was subject to §376.1215.

Reference: §§375.1007(1), (3), and (4), 376.383.5, and 376.1215. RSMo

- b) Criticism #s 036 and 039: The Company denied five claim lines for childhood immunizations because the Company's system had conflicting information as to whether dependent coverage was effective. The Company discovered the error and reprocessed and paid all five claim lines prior to the examination. When it reprocessed and paid the five claim lines, the Company paid appropriate interest on one claim line, underpaid interest on one claim line, and failed to pay interest on the other three claim lines. In response to the examiners criticisms, the Company paid interest on the four claims lines for which interest had not been paid or had been underpaid.

Reference: §§375.1007(1) and (4), 376.383.5, and 376.1215. RSMo

C. Unfair Claim Practices – Paid Claims for Childhood Immunizations – Benefits Applied to Deductibles or Co-Payments

The examiners reviewed the Company's adherence to claim handling requirements for paid childhood immunization claims under § 376.1215.2., RSMo, for calendar years 2004 through 2006. In the following cases, claims were paid, but the Company imposed deductibles and/or copayments on the benefits, contrary to Missouri law.

1. Paid Claims – 2004 Childhood Immunizations – Deductible / Co-Payments

Field Size:	4
Type of Sample:	Census
Number of Errors:	4
Error Ratio:	100%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Criticism #014: The Company improperly applied benefits to deductibles on four childhood immunization claim lines from two claim numbers. The Company reprocessed and paid all four claim lines with interest during the course of the examination. In response to the criticism, the Company reiterated that the claims had been incorrectly processed initially based upon the benefits under the group

policy, but disagreed that the group policy was required to comply with §376.1215. **EXHIBIT 16**

Reference: §§375.1007(1) and (4), and 376.1215.2., RSMo

2. **Paid Claims – 2005 Childhood Immunizations – Deductible / Co-Payments**

Field Size:	24
Type of Sample:	Census
Number of Errors:	24
Error Ratio:	100%
Within DIFP Guidelines?	No

Criticism #s 035, 037, 038, 041, 042, 043, and 044: The Company improperly applied benefits to deductibles on 24 childhood immunization claim lines. The Company caught its error on one of the claim lines prior to the examination, and reprocessed and paid the claim. The Company paid the remaining 23 claim lines with interest during the course of the examination. In response to the criticisms, the Company reiterated the rationale noted above.

Reference: §§ 375.1007(1) and (4), and 376.1215.2., RSMo

3. **Paid Claims – 2006 Childhood Immunizations – Deductible / Co-Payments**

Field Size:	4
Type of Sample:	Census
Number of Errors:	1
Error Ratio:	25.0%
Within DIFP Guidelines?	No

Criticism #032: The Company improperly applied a copayment to a claim for childhood immunization services. The Company reprocessed and paid this claim with interest during the course of the examination, but it reiterated the above rationale in response to the criticism.

Reference: §§375.1007(1) and (4), and 376.1215.2, RSMo

D. Unfair Claim Practices – Denied Claims for Emergency Room and Ambulance Services

The examiners reviewed the Company's adherence to claim handling requirements for denied emergency room and ambulance claims under §§ 376.1350, and 376.1367, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Emergency Room / Ambulance

Field Size:	228
Type of Sample:	Random
Sample Size:	91
Number of Errors:	27
Error Ratio:	29.7%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #052: The Company improperly denied 12 claims for emergency room services for a variety of reasons:
- Three of the claim lines were denied because the provider failed to submit the claims through the provider's network intermediary. The Company subsequently paid all three claim lines when they were resubmitted through the network intermediary prior to the examination, but failed to pay interest. The Company declined to pay any interest during the examination when requested by the examiners on the basis that payment had been made within 15 days of receipt of additional information.
 - Five claim lines were denied for reasons that the examiners did not believe were sufficiently clear and specific. The Company subsequently paid the claim lines after additional information was submitted prior to the examination, but interest was paid on only three of the claim lines. While the Company paid additional interest on the remaining two claim lines during the examination, the amount was insufficient based upon the examiners' calculations.
 - Two of the claim lines were denied as duplicates, but the Company acknowledged that it had failed to pay interest on the original claim. The Company reprocessed and paid interest on this claim during the examination.
 - Two of the claim lines were denied because the Company mistakenly believed coverage was not in effect. When the Company was notified of its mistake prior to the examination, it paid both claim lines, but did not pay any interest. At the request of the examiners, the Company paid interest during the course of the examination.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5 and 9, 376.1350(12) and (13), and 376.1367, RSMo

- b) Criticism #054: The Company improperly denied two claims for emergency services based upon reasons that the examiners did not believe were sufficiently clear and specific. One of the claims was denied based upon the Company's mistaken belief that the benefits were not covered, and the other claim was denied based upon the mistaken belief that coverage for the dependent was not in effect. The Company acknowledged both errors and reprocessed the claims by applying benefits to the insureds' deductibles during the course of the examination.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.9, 376.1350(12) and (13), and 376.1367, RSMo

- c) Criticism #057: The Company improperly denied two claims for emergency services based upon reasons that the examiners did not believe were sufficiently clear and specific. Both claims were denied under the mistaken belief that they were subject to a policy exclusion. The Company acknowledged the claims were denied in error and reprocessed and paid both claims with interest during the course of the examination.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.9, 376.1350(12) and (13), and 376.1367, RSMo

- d) Criticism #063: The Company improperly denied a claim from Missouri Medicaid on the mistaken basis that coverage had terminated. The Company reprocessed the claim during the course of the examination applying a portion to the insured's deductible and paying a portion with interest.

Reference: §§375.1007(1) and (4), RSMo

- e) Criticism #064: The Company improperly denied three claim lines because the provider did not submit the claims through a network intermediary. Although the claims were subsequently submitted with the network intermediary's discounted fee information, the Company continued to deny them. The Company acknowledged its error and reprocessed and paid the claims with interest during the course of the examination.

Reference: §§375.1007(1) and (4), and 376.383.5, RSMo

- f) Criticism #066: The Company improperly denied three claims for emergency services as pre-existing conditions based upon documentation in the claim files that the examiners did not believe was sufficient to justify such a finding. The Company reprocessed and paid the claims with interest during the course of the examination.

Reference: §§375.1007(3), (4), and (6), 376.383.5, 376.1350(12) and (13) and 376.1367, RSMo

g) Criticism #069 The Company improperly paid one emergency claim without interest after its initial denial and improperly denied three claims for emergency services as follows:

- One claim was denied because the Medicare EOB had not been received. The Company subsequently received the Medicare EOB and paid the claim without interest even though the payment was more than 45 days after it was first received. The Company declined to pay any interest when requested by the examiners because they had paid the claim within 15 days of receiving the additional information.
- One claim was denied because the provider had not submitted it through the network intermediary. Upon discovering that the provider was not a network provider when the claim was resubmitted, the Company denied it again because its system incorrectly noted the dependent as terminated. The Company reprocessed and paid the claim with interest during the course of the examination.
- Two ambulance claims were denied as not being covered under the policy. When the Company eventually realized it had denied these claims in error after they were resubmitted, it reprocessed and paid the claims, but it only paid part of one of the claims because it mistakenly thought a portion of the claim was a duplicate of the other claim. The Company reprocessed and paid the unpaid part with interest during the examination.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5., and 376.1367, RSMo

2. Denied Claims – 2005 Emergency Room / Ambulance

Field Size:	160
Type of Sample:	Random
Sample Size:	47
Number of Errors:	7
Error Ratio:	14.9%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

a.) Criticism #045: The Company improperly denied a claim for ambulance services based on the reason that the diagnosis did not meet the policy's definition of emergency, even though the Company also received a hospital claim incurred by the same patient indicating treatment of an injury sustained in an automobile accident. The Company reprocessed this claim during the examination and applied the benefits to the insured's deductible.

Reference: §§375.1007(1) and (4), 376.1350(12) and (13), and 376.1367, RSMo, and 20 CSR 100-1.050(1)

- b.) Criticism #046: The Company improperly denied an ambulance claim, stating that the transport was not for an emergency based upon the service codes submitted with the claim. The examiners believed the claim diagnosis code of cardiac palpitations should have alerted the Company to investigate further rather than just deny the claim. The Company reconsidered and paid the claim prior to the examination as the result of a provider appeal, but the Company did not pay interest even though the claim was paid more than 45 days after it was first received. When the examiners requested that the Company pay interest, it paid an inadequate amount based upon its interpretation that §376.383.3 did not require it to pay interest until 15 days after it had received additional information on the claim.

Reference: §375.1007(4) and 376.383.5, RSMo

- c.) Criticism #s 047, 048, 049, 050, and 051: The Company improperly denied five claims for emergency care because the providers had not submitted the claims through a network intermediary even though the providers were not participating in the network. The Company reprocessed and paid the claims when it discovered its error during the examination, but it only paid interest on three of the five.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

3. Denied Claims – 2006 Emergency Room / Ambulance

Field Size:	155
Type of Sample:	Random
Sample Size:	53
Number of Errors:	4
Error Ratio:	7.5%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a.) Criticism #058: The Company improperly denied a claim for emergency services. Although the claim was submitted through the provider's network intermediary, the Company denied it on the basis that it had not. When the Company discovered its error during the examination, it reprocessed the claim and applied the benefits to the insured's deductible.

Reference: §§375.1007(1), (4), and (6), 376.1350(12) and (13), and 376.1367, RSMo, and 20 CSR 100-1.0200 and 20 CSR 100-1.050.

- a.) Criticism #s 059 and 060: The Company improperly denied two claims for emergency services from nonparticipating providers on the basis that they needed to be submitted through the network intermediary. When the claims were subsequently resubmitted, the Company denied them because they were submitted more than 15 months after expenses were incurred. The Company reprocessed and paid the claims with interest during the course of the examination.

Reference: §§375.1007(1), (4), and (6), 376.1350(12) and (13), and 376.1367, RSMo. and 20 CSR 100-1.0200 and 20 CSR 100-1.050

- b.) Criticism #061: The Company improperly denied a claim for emergency services because the Company mistakenly thought the provider was a participating network provider and the claim had not been submitted through the network intermediary. When the Company eventually realized its error after the claim was resubmitted two more times, it reprocessed the claim applying a portion of the allowed amount to the deductible and paying the remainder. The Company did not pay interest, however, and declined to do so when requested by the examiners.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, 376.1350(12) and (13) and 376.1367, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

E. Unfair Claim Practices – Denied Claims for Mammograms

The examiners reviewed the Company's adherence to claim handling requirements for denied mammogram claims under § 376.782, RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Mammograms

Field Size:	136
Type of Sample:	Random
Sample Size	36
Number of Errors:	5
Error Ratio:	13.9%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #067: The Company improperly denied four claim lines (from two claim numbers) for mammography screening services because they had not been submitted through the network intermediary. The claims were never resubmitted and remain unpaid at the time of this examination report.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.782, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

- b) Criticism #068: The Company improperly denied a claim for mammography expenses because it had not been submitted through the network intermediary. When the claim was subsequently resubmitted through the network intermediary, the Company immediately paid the claim, but it did not pay any interest. The Company declined to pay interest when requested by the examiners.

Reference: §§375.1007(1), (3), (4), and (6), 376.383.5, and 376.782, RSMo and 20 CSR 100-1.020 and 20 CSR 100-1.050

2. Denied Claims – 2005 Mammograms

Field Size:	96
Type of Sample:	Random
Sample Size:	18
Number of Errors:	1
Error Ratio:	5.6%
Within DIFP Guidelines?	Yes

The examiners noted the following errors in this review:

Criticism #065: The Company improperly denied a claim for mammography screening services because it had not been submitted through the network intermediary. The claim was subsequently resubmitted through the network intermediary, and the Company reprocessed the claim and applied the allowed amount to the deductible.

Reference: §§375.1007(1), (3), (4) and (6), and 376.782, RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

3. Denied Claims – 2006 Mammograms

Field Size:	50
Type of Sample:	Random
Sample Size:	6
Number of Errors:	1
Error Ratio:	16.7%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Criticism #062: The Company improperly denied a claim for screening mammography services on the basis that the claim needed to be submitted

through the network intermediary. The claim was denied a second time for the same reason when it was subsequently resubmitted. When it was resubmitted a third time through the network intermediary, the Company failed to recognize that the claim had been submitted previously and denied the claim on the basis that the claim was for services that were more than 15 months old.

When the Company discovered its error during the course of the examination, it reprocessed and paid the claim with interest. In responding to the criticism, the Company explained that, "Claims procedures have been amended to ensure that the initial submission of a claim is recognized, preventing recurrence of inappropriate denials of corrected claims for timely filing rules."

Reference: §§375.1007(1), (3), (4) and (6), and 376.782 RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

F. Unfair Claim Practices – Denied Claims for Pap Smears

The examiners reviewed the Company's adherence to claim handling requirements for denied Pap smear claims under § 376.1250.1(1), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 Pap Smears

Field Size:	219
Type of Sample:	Random
Sample Size:	54
Number of Errors:	9
Error Ratio:	16.7%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Criticism #075: The Company improperly denied nine claims because the provider did not submit the claims through the network intermediary. The nine claims were never resubmitted and remain unpaid at the time of this examination report.

Reference: §§375.1007(3) and (6), and 376.1250.1(1), RSMo

2. Denied Claims – 2005 Pap Smears

Field Size:	118
Type of Sample:	Random
Sample Size:	31
Number of Errors:	9
Error Ratio:	29%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #087: The Company improperly denied a claim for Pap smears for a reason that the examiners did not believe was sufficiently clear and specific, i.e., "Benefits are not available for the expenses submitted." In response to the criticism, the Company indicated that coverage for this individual had terminated prior to the incurred date for the claim, and the Company's current processes would have generated a more accurate message.

Reference: §375.1007(3) and 376.383.9., RSMo

- b) Criticism #089: The Company improperly denied eight Pap smear claims because the provider had not submitted the claims through the network intermediary. Two of the claims were subsequently resubmitted and paid without required interest prior to the examination, but the remaining six were never resubmitted and remain unpaid.

Reference: §§375.1007(1), (4), and (6), 376.383.5, and 376.1250.1(1), RSMo

3. Denied Claims – 2006 Pap Smears

Field Size:	75
Type of Sample:	Random
Sample Size:	18
Number of Errors:	5
Error Ratio:	27.8%
Within DIFP Guidelines?	No

- a) Criticism #083: The Company improperly denied three claims for Pap smears by giving reasons that were not sufficiently clear and specific. In its response to the criticism, the Company indicated that coverage for these individuals had terminated prior to the claim being incurred; however, this was not the explanation given by the Company on the EOB when denying the claim.

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

- b) Criticism #084: The Company improperly denied a Pap smear on the basis that it was for the separate professional component of the test even though this was inconsistent with the CPT code submitted with the claim. The Company acknowledged that it had denied this claim in error and paid the claim with interest during the course of the examination.

Reference: §§375.1007(6) and 376.1250.1(1), RSMo

- c) Criticism #085: The Company improperly denied a Pap smear claim because the provider did not submit the claim through the network intermediary. When the claim was subsequently submitted through the network intermediary, the Company paid the claim, but it did not pay required interest. The Company declined to pay interest during the examination on the basis that it had paid the claim within 15 days of receiving additional information.

Reference: §§375.1007(1), (4), and (6), 376.383.5, and 376.1250.1(1), RSMo

G. Unfair Claim Practices – Denied Claims for PSA Tests

The examiners reviewed the Company's adherence to claim handling requirements for denied PSA test claims under § 376.1250.1(2), RSMo, for calendar years 2004 through 2006.

1. Denied Claims – 2004 PSA Claims

Field Size:	78
Type of Sample:	Random
Sample Size:	33
Number of Errors:	9
Error Ratio:	27.3%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

- a) Criticism #s 074, 081, and 086: The Company improperly denied three claims for PSA testing. Two of the claims were initially denied for reasons that the examiners did not believe were sufficiently clear and specific. The remaining claim was initially denied on the basis that the provider had not submitted it through the network intermediary, even though the provider had done so. The Company reprocessed and paid all three claims with interest during the examination, but it only acknowledged that one had been incorrectly denied.

Reference: §§375.1007(1), (3), (4) and (6), 376.383.9, and 376.1250.1(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

- b) Criticism #082: The Company improperly denied six claim lines for expenses related to PSA tests because the provider did not submit the claims through the network intermediary. None of the claims were ever resubmitted, so the claims remain unpaid as of the date of this examination report.

Reference: §§375.1007(1), (3), (4), (6), 376.1250(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050.

2. Denied Claims – 2005 PSA Claims

Field Size:	54
Type of Sample:	Random
Sample Size:	26
Number of Errors:	3
Error Ratio:	11.5%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Criticism #073: The Company improperly denied three claim lines for PSA tests because the provider did not submit the claims through the network intermediary. None of the claims were ever resubmitted, so the claims remain unpaid as of the date of this examination report.

Reference: §§375.1007(1), (3), (4), and (6), and 376.1250(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

3. Denied Claims – 2006 PSA Claims

Field Size:	23
Type of Sample:	Random
Sample Size:	8
Number of Errors:	2
Error Ratio:	25%
Within DIFP Guidelines?	No

The examiners noted the following errors in this review:

Criticism #072: The Company improperly denied two claims on the basis that the providers had not submitted the claims through the network intermediary, even though the provider had done so for one of the claims. For the claim that had been submitted through the network intermediary, the Company acknowledged its mistake and reprocessed and paid the claim with interest during the course of the examination. The other claim was never resubmitted and remains unpaid.

Reference: §§375.1007(1), (3), and (4), and 376.1250(2), RSMo, and 20 CSR 100-1.020 and 20 CSR 100-1.050

III. COMPLAINTS AND GRIEVANCES

This section of the report details the examiners' 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.

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

A. Consumer Complaints Sent Directly to the Company

The Company recorded receipt of 164 written complaints from members during 2004, 2005, and 2006. The examiners requested a sample of 125 of the complaint files for review (94 for 2004-2005 and 31 for 2006). In this review, the examiners noted the following errors in the handling of the complaints or in the handling of the claims that prompted the complaints:

1. Criticism #001: The Company improperly denied a claim for reconstructive surgery following a mastectomy that was required to be covered pursuant to §376.1209, RSMo. Although an operative report that justified coverage was submitted with the claim, the Company initially denied it with an explanation that expenses were not covered under the policy without identifying a specific policy exclusion or limitation to support the denial. The Company subsequently paid the claim within 45 days of receipt after the provider requested reconsideration of the initial denial.

In its response to the criticism, the Company acknowledged that the claim should have been paid pursuant to §376.1209 when it was first submitted, but it disagreed that its actions constituted a violation of §375.1007(4) and (6).

Reference: §§375.1007(4) and (6), 376.383.9, and 376.1209, RSMo, and 20 CSR 100-1.050(1)(A)

2. Criticism #002: The Company received a claim for x-rays on both the right and left legs of an insured. The Company's claim system failed to recognize the "right" and "left" modifiers to the CPT codes submitted and improperly denied the expenses for one of the x-rays as being included in the payment for the other. Upon appeal by the provider, the Company recognized the error and paid the claim for the previously denied x-ray.

In its response to the criticism, the Company acknowledged that the claim should have been paid when it was first submitted, but it disagreed that its actions constituted a violation of §375.1007(1) and (4).

Reference: §§375.1007(1) and (4), RSMo

3. Criticism #003: The Company received a claim with CPT codes indicating the introduction of a catheter in the superior or inferior vena cava and the interruption of the inferior vena cava by suture, ligation, or other means. Both of these CPT codes were submitted with a modifier indicating that they were separate procedures. The Company did not request additional information to further investigate the claim; it just paid for the interruption procedure and denied the catheter procedure stating that the catheter procedure was included in the interruption procedure "based on AMA guidelines and the information provided."

The provider appealed the initial denial of the catheter procedure by supplying the Company with the operative report and noting that Medicare's National Correct Coding Initiative did not regard these two CPT codes as being bundled. As a result, the Company reversed its denial and paid for the catheter procedure, but it did not pay required interest. In response to the criticism, the Company declined to pay interest on the basis that it had originally denied the claim within 45 days of receipt.

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

4. Criticism #004: The Company received a claim with line item CPT codes for a carpal tunnel operation and the excision of a tumor or vascular malformation in the hand or finger. The latter CPT code also had a modifier indicating that it was an unrelated procedure. The Company requested the operative report from the provider. After reviewing the report, the Company decided the excision procedure should be considered to be included in the carpal tunnel procedure and improperly denied payment for the excision procedure. The provider appealed this determination and again provided the operative report for the Company to review. Upon further review, the Company reversed its initial decision and paid the claim without required interest.

In response to the criticism, the Company agreed that interest was due on the claim. The Company took the position, however, that the interest should be calculated from 15 days after it received additional information (i.e., the operative report) rather than from 45 days after it first received the claim. As a result, the Company underpaid interest during the course of the examination.

References: §§375.1007(1) and (4), and 376.383.5, RSMo

5. Criticism #005: The Company improperly denied a claim for a physician's evaluation and management services during an office visit in which a bladder ultrasound procedure was performed. The CPT code for the evaluation and management services included a modifier denoting a separate service from the bladder ultrasound procedure included in the claim. Instead of conducting a

reasonable investigation and requesting additional information from the provider, the Company just denied the evaluation and management charge as included in the bladder ultrasound procedure for which it paid. Upon receipt of office notes when the provider appealed the initial denial, the Company concluded that its denial was incorrect and paid for the evaluation and management service.

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

6. Criticism #006: The Company improperly denied two claims for in-hospital anesthesia for dental services on a three year-old child required to be covered pursuant to §376.1225, RSMo, even though it had previously pre-authorized the services. Company notes made at the time pre-authorization was requested by the provider indicate the Company was aware of the Missouri law requiring coverage for these services. The Company recognized its error and reprocessed the claims after the provider appealed the initial denial. The allowable expenses for one claim were applied to the insured's deductible and the other claim was paid, but without required interest.

In responding to the criticism, the Company acknowledged that it had made an error in failing "to recognize that the services had been duly authorized and were payable" when the claims were first presented, but the Company disagreed that its actions violated §376.1225 since the Company interpreted the statute as only applying to contracts issued in Missouri. The Company also agreed that interest was payable on the claim, but declined to pay any interest during the examination.

References: §§ 375.1007(1), (3), (4), and (6), 376.383.5, and 376.1225, RSMo

7. Criticism #007: The Company improperly denied a claim for a circumcision that was performed subsequent to the baby's discharge from the hospital rather than while the baby was still in the hospital immediately after birth. In denying the claims, the Company gave a reason that the examiners did not feel was sufficiently clear and specific (i.e., "According to your policy this is not a covered expense. Please refer to the exclusions and limitations section of your policy for details.") Had the procedure been done during the initial confinement, the Company would have paid the claim. The examiners felt that the Company denied this claim without making a reasonable investigation to determine why the procedure was being done shortly after the baby had been discharged.

The Company did not reverse its position and pay the claim until after the insured had filed a complaint with the Department. When it finally paid the claim, the Company did so without including required interest. When requested to pay interest by the examiners, the Company declined on the basis that it had denied the initial claim within 45 days of receipt.

References: §§375.1007(4) and (6), and 376.383.5 and 9, RSMo

8. Criticism #008: The Company improperly processed a claim for the services of a nurse assisting in hospital emergency care as out-of-network when the hospital and the physician were in-network. Upon appeal by the provider, the Company recognized its error and reprocessed and paid the claim with interest.

References: §§ 375.1007(4) and (6), and 376.1350(12) and (13), RSMo

9. Criticism #009: The Company received a surgical claim with two CPT codes indicating the insured had undergone a procedure involving the creation of an arteriovenous fistula along with a subsequent return to the operating room during the postoperative period for removal of blood clots that had formed as a result of the first procedure. Rather than conducting a reasonable investigation to verify that these were two different procedures as coded, the Company improperly denied the claim for the follow up procedure to remove blood clots as being included in the other procedure. The provider appealed the initial decision and supplied the Company with the operative report demonstrating that the procedures were different, but the Company again improperly denied the claim. The Company finally realized its error after the provider appealed a second time. In finally paying the claim, however, the Company failed to pay required interest.

In responding to the criticism, the Company acknowledged that it had erroneously denied the claim when it was appealed the first time, and acknowledged that interest was due. The Company subsequently underpaid interest during the examination because it calculated interest from the 15th day of receiving the operative report on the first appeal rather than calculating it from the 45th day from initially receiving the claim.

Reference: §§375.1007(1), (4), and (6), and 376.383.5. RSMo

10. Criticism #010: In December of 2005, the Company received a claim for an office visit with a diagnosis code of "Elderly primagravida complicating pregnancy antepartum condition or complication." The Company denied this claim on the basis that it would be included as part of the global charge for obstetrical care paid at the time of delivery, even though the Company had previously paid claims for office visits with the same diagnosis code. The insured's coverage subsequently terminated at the end of 2005, and the provider appealed the initial denial of the office visit claim after the termination date. Although the Company's processing guidelines require it to reconsider such a claim denied prior to insurance termination if delivery occurs after termination, the Company improperly continued its denial of the claim. It was not until the provider notified the Company of the baby's birth seven months later that the Company finally reconsidered and paid the claim without required interest.

In response to the criticism, the Company defended its actions as "consistent with maternity billing practices." The Company did not explain, however, why it was appropriate to continue denying a payable claim after the insured's coverage had

terminated. The Company declined to pay any interest on the basis that it had paid the claim within 15 days of being notified of the baby's birth.

References: §§ 375.995.4(6), 375.1007(1), and (4), and 376.383.5.. RSMo

B. DIFP Consumer Complaints – 2004 - 2006

The examiners reviewed 36 complaints made through the DIFP's Division of Consumer Affairs for calendar years 2004 through 2006 to determine the Company's handling of the complaints and its adherence to requirements of Missouri's laws that relate to complaints or related issues.

The examiners found no errors in this review.

IV. CRITICISM AND FORMAL REQUEST TIME STUDY

This study shows the amount of time taken by the Company to respond to criticisms and requests submitted by the examiners.

A. CRITICISM TIME STUDY

The examiners sent 90 criticisms to the Company, but five of these criticisms were subsequently withdrawn. For the remaining 85 criticisms, the Company responded in the following manner:

<u>Calendar Days</u>	<u>Number of Criticisms</u>	<u>Percentage</u>
Received within time-limit,		
Without Extension	64	75.3%
Received By Extension Date	20	23.5%
No Response	0	0.0%
Total Timely Responses	74	98.8%
Received outside time-limit,		
Without Extension	0	0.0%
Received After Extension Date	1	1.2%
No Response	0	0.0%
Total Late Responses	1	1.2%
Total All Criticisms	85	100.0%

The Company failed to respond to one criticism (#004) within the time limit extension as required by §§374.205.2(2), RSMo, and 20 CSR 300-2.200 [replaced by 20 CSR 100-8.040, eff. 07/30/08].

B. FORMAL REQUEST TIME STUDY

<u>Calendar Days</u>	<u>Number of Requests</u>	<u>Percentage</u>
Received within time-limit,		
Without Extension	18	34.0%
Received By Extension Date	32	60.3%
No Response	0	0.0%
Total Timely Responses	50	94.3%
Received outside time-limit,		
Without Extension	0	0.0%
Received After Extension Date	3	5.7%
No Response	0	0.0%
Total Late Responses	3	5.7%
Total All Requests	53	100.00%

The Company failed to respond to three requests (#003, #030 and #031) within the time limit extensions as required by §§374.205.2(2), RSMo, and 20 CSR 300-2.200 [replaced by 20 CSR 100-8.040, eff. 07/30/08].

V. EXAMINATION REPORT SUBMISSION

Attached hereto is the Division of Insurance Market Regulation's Final Report of the examination of Union Security Insurance Company (NAIC #70408), Examination Number 0706-09-TGT. This examination was conducted by Gary W. Kimball, Michael D. Gibbons, William D. Schneider, Walter Guller and Randy Kemp. The findings in the Final Report were extracted from the Market Conduct Examiner's Draft Report, dated September 29, 2011. Any changes from the text of the Market Conduct Examiner's Draft Report reflected in this Final Report were made by the Chief Market Conduct Examiner or with the Chief Market Conduct Examiner's approval. This Final Report has been reviewed and approved by the undersigned.



Jim Mealer
Chief Market Conduct Examiner

7/9/13

Date



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August 1, 2013

Mr. Stewart Freilich
Missouri Department of Insurance, Financial Institutions and
Professional Regulation
Market Conduct Section
301 West High Street, Room 350
Jefferson City, MO 65102

Re: Union Security Market Conduct Examination #0706-09-TGT

Dear Mr. Freilich:

We have reviewed the July 8, 2013 Final Market Conduct Examination Report of our company. The following remarks are offered to provide our understanding of two of the major Findings reflected in the Report.

Among the Findings that occupied much of our discussion with the Department regarding Missouri law was the Department's position that the Childhood Immunization mandate found in §376.1215 RSMo. applied to policies of insurance issued in states other than Missouri. We have agreed to accept the Department's position and reprocessed identified claims for Childhood Immunizations to comport with that understanding. However, it remains our position that the childhood immunization mandate is not legally required for out-of-state certificates. § 376.1215 RSMo. only applies to "individual and group health insurance policies." It does not apply to certificates because the definition of "individual and group health insurance policies" does not reference "certificates" or "out-of-state policies." In contrast, there are numerous Missouri statutes that specifically reference certificates or mandate extraterritorial jurisdiction. In addition, as we noted in prior correspondence with the Department regarding this issue that the vast majority of the immunization claims at issue during the exam period (approximately 80%) were in fact paid consistent with the provisions of the mandate under the wellness provision of the plans.

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

Another issue that was resolved early in discussions with the Department involved the practice of requiring contracted PPO providers to submit claims for repricing to the address that appeared on the insured's insurance card, which is contracting network. If claims were submitted directly to the carrier, the carrier denied the claim and directed the provider to submit the claim to their contracting PPO network, consistent with the terms of their agreement with the respective network and the address on the insurance card. We provided evidence to the Department that this is common throughout the industry and providers receiving such denials are aware that the remedy is to resubmit the claim to the appropriate network repricing vendor. We nonetheless agreed to discontinue this claim practice in view of the Department's position. It remains noteworthy, however, that repricing denials played a prominent role in the Department's designation of claim errors.

Union Security Insurance Company remains committed to complying with all requirements of Missouri law. We appreciate the courtesy and professionalism demonstrated by the Department as we worked to resolve any and all issues that arose during this Examination. In closing, we thank you for providing the opportunity to comment on the Examination Report and the ultimate outcome of the examination.

Sincerely,

A handwritten signature in dark ink, appearing to read "Julia Hix-Royer", written in a cursive style.

Julia Hix-Royer
Vice-President Regulatory Compliance
Assurant Health Compliance Officer