Unicare Health Plans of the Midwest

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	February 20, 2007 through February 1, 2008
EXAMINATION OF:	Unicare Health Plans of the Midwest
LOCATION:	233 S. Wacker Drive Chicago, Illinois 60606
PERIOD COVERED BY EXAMINATION:	January 1, 2006 through December 31, 2006 – Claims January 1, 2005 through February 20, 2007 – Appeals, External Independent Reviews and Complaints
EXAMINERS:	C. Michael Hager Patricia Hahn David R. Bradbury – Examiner-in-Charge

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I. SUMMARY

1. The Company was criticized under Section 5/368a(c) of the Illinois Insurance Code for failure to process and pay claims within thirty (30) days. (See 215 ILCS 5/368a(c))

2. The Company was criticized under Section 5420.70(b) for failure to notify the claimants of the right to appeal when a partial payment or denial is sent to the insured/claimant. (See 50 Ill. Adm. Code 5420.70(b))

3. The Company was criticized under Section 5/154.6(d) of the Illinois Insurance Code for failure to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear. (See 215 ILCS 5/154.6(d))

4. The Company was criticized under Section 5/368a(c) of the Illinois Insurance Code for failure to pay interest on claims not paid within thirty (30) days. (See 215 ILCS 5/368a(c))

5. The Company was criticized under Section 5/154.6(f) for engaging in an activity which results in a disproportionate number of meritorious complaints filed with the Division of Insurance. (See 215 ILCS 5/154.6(f))

6. The Company was criticized under Section 134/45(c) of the Managed Care and Patients Rights Act for failure to make a decision within fifteen (15) business days on Appeals/Consumer Complaints. (See 215 ILCS 134/45(c))

7. The Company was criticized under Section 134/45(c) of the Managed Care and Patients Rights Act for failure to provide an oral notice of the decision on an appeal. (See 215 ILCS 134/45(c))

8. The Company was criticized under Section 5/356z.2 of the Illinois Insurance Code for failure to pay dental anesthesia claims as described in this Section. (See 215 ILCS 5/356z.2)

9. The Company was criticized under Section 134/45(f)(4) of the Managed Care and Patient Rights Act for failure to have a response from the external reviewer within the required five (5) days. (See 215 ILCS 134/45(f)(4))

10. The Company was criticized under Section 134/75(b) of the Managed Care and Patients Rights Act for failure to have minimum of eight (8) enrollees on the Consumer Advisory Committee. (See 215 ILCS 134/75(b))

11. The Company was criticized under Section 5/143 for failure to update both the large and small group policy forms since 2003. (See 215 ILCS 5/143)

12. The Company was criticized under Section 5/356w for including in the policy forms an incomplete definition of covered diabetic supplies and failure to provide for regular foot exams to diabetic members. (See 215 ILCS 5/356w)

13. The Company was criticized under Section 5/356r for the use of application forms limiting the age to eighteen (18) or greater before a female member may designate a woman's health care provider. (See 215 ILCS 5/356r)

II. BACKGROUND

Unicare HMO is a health benefits product offered by Unicare Health Plans of the Midwest. Unicare Health Plans of the Midwest and its parent, Unicare Illinois Services, Inc., an Illinois corporation, are separately formed and capitalized subsidiaries of WellPoint Health Networks, Inc., a Delaware corporation, and are part of the WellPoint Health Networks Inc. family of companies.

Unicare Health Plans of the Midwest, Inc. was formerly known as Rush-Prudential HMO, Inc. prior to its acquisition by WellPoint, et al. Rush-Prudential was an Illinois corporation formed in 1993 as a result of a merger of the managed care operations in Chicago between the Prudential Insurance Company of America and Rush-Presbyterian-St. Luke's Medical Center. Prudential previously operated a subsidiary of the Prudential Health Care Plan, Inc. called PruCare of Illinois while Rush-Presbyterian-St. Luke's Medical Center owned two HMOs with separate certificates of authority; Rush-Presbyterian-St.Luke's and Access Health, Inc. All members from the three previous HMOs were transferred to Rush-Prudential HMO, which began operations on August 1, 1993.

The company is a wholly owned subsidiary of Unicare Illinois Services, Inc. , which in turn is a wholly owned subsidiary of Unicare National Services, Inc. Unicare National Services, Inc. is a wholly owned subsidiary of Anthem Holding Corp., which is a wholly owned subsidiary of WellPoint, Inc.

III. QUALITY ASSURANCE - COMPLAINTS AND APPEALS

For prompt and equitable resolution of complaints, Unicare Health Plans of the Midwest, Inc. has established the following procedures:

Appeals

To initiate an appeal, the member must submit a request for an appeal in writing within thirty (30) days after receipt of a denial notice. Within three (3) business days of receipt of the request for a first appeal, the company will notify the party filing the appeal of all information required to evaluate the appeal. The company will render a determination on the first appeal within fifteen (15) business days after receipt of all required information and notify the member and all involved parties orally and in writing of the determination.

An expedited appeal may be requested, and if Unicare determines it to be appropriate, Unicare will request information required to be evaluated, and within twenty-four (24) hours of receipt of this information, render a decision. Unicare will notify the member and all involved parties of the decision orally and in writing.

If a covered person receives a denial of an appeal, he/she may either initiate a second level appeal to the Unicare Appeals Review Committee or an External Independent Review.

A request for review by Unicare's appeals review committee must be made within thirty (30) days of the first appeal denial letter. The appeal committee will meet within forty-five (45) days of receipt of this written request, unless this second appeal is expedited. Within five (5) days of this meeting, Unicare will provide written notification of the Committee's decision.

IV. METHODOLOGY

The Market Conduct Examination covered the business for the period of January 1, 2006 through December 31, 2006 for claims and January 1, 2005 through the start of the exam for appeals, complaints and external independent reviews. Specifically, the examination focused on a review of the following areas.

1. Sales, advertising and procedure files
2. Enrollment procedures
3. Claim procedures
4. Appeals, Division Complaints and External Independent Reviews

The review of the categories was accomplished through examination of appointed and terminated producer files, claim files and complaint files. Each of the categories was examined for compliance with Division Regulations and applicable State laws. The report concerns itself with improper practices performed with such frequency as to indicate general practices. Individual criticisms were identified and communicated to the HMO, but not cited in the report if not indicative of a general trend, except to the extent that underpayments and/or overpayments in claim surveys or undercharges and/or overcharges in underwriting surveys were cited in the report.

The following methods were used to obtain the required samples and to assure a methodical selection:

Producer Production

New business was reviewed to determine if solicitations had been made by duly licensed persons.

Claims

1. Paid Claims - Payment for claims made during the examination period.

2. Denied Claims - Denial of benefits during the examination period for losses not covered by certificate of coverage provisions.

All claims were reviewed for compliance with policy contracts and applicable Sections of the Illinois Insurance Code (215 ILCS 5/*et seq.*), the Health Maintenance Organization Act (215 ILCS 125/*et seq.*), the Managed Care Reform and Patient Rights Act (215 ILCS 134/*et seq.*) and 50 Illinois Administrative Code.

Median payment periods were measured from the date all necessary proofs of loss were received to the date of payment or denial to the member.

The period under review was January 1, 2006 through December 31, 2006.

Division Complaints and Consumer Appeals

The Company was requested to provide all files relating to complaints received via the Division of Insurance and those received directly from members. The Company was also requested to provide files of all member complaints and external independent reviews handled during the survey period.

Median periods were measured from the date of notification by the complainants to the date of response by the Company.

The period under review was January 1, 2005 through February 20, 2007.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	%REVIEWED
CLAIMS ANALYSIS			
Paid Group HMO	317247	119	.04
Denied Group HMO	54310	120	.20
Paid IPA Claims	395541	120	.03
DEPT COMPLAINTS, CONSUMER COMPLAINTS AND EXTERNAL INDEPENDENT REVIEWS			
Divisional Complaints	102	102	100
Consumer Complaints	466	466	100
External Independent Review	27	27	100
ADVERTISING AND POLICY FORMS ANALYSIS			
Policy Forms, Endorsements and Advertising	48	48	100
PRODUCERS ANALYSIS			
Producers/Applications	166/382	166/382	100
PROVIDER AGREEMENT ANALYSIS			
Provider Terminations	25	25	100

V. FINDINGS

A. Claims Analysis

1. Paid Group HMO

A review of the Paid Group HMO claim files produced no criticisms.

The median for payment was one (1) days.

2. Denied Group HMO

A review of the Denied Group HMO claim files produced seventeen (17) criticisms. A general criticism was written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to process claims within thirty (30) days of receipt of due written proof of loss. A second general criticism was written under Section 5420.70(b) of the Illinois Administrative Code (50 Ill Adm. Code 5420.70(b)) for failure to notify insureds of their rights to appeal if a claim is not paid in full. An individual criticism was written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for a claim underpayment in the amount of $424.22. Fourteen (14) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest on claims not paid within thirty (30) days. The total of the interest underpayments was $182.75. Many of the claims selected as part of this sample were eventually overturned and paid.

The median for denial was two (2) days.

3. Paid Group IPA Delegated

A review of the Paid PPO claim files produced three (3) individual criticisms. The individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest on claims not paid within thirty (30) days. The company made payment prior to completion of the examination. The total of the interest underpayments was $37.45.

The median for payment was thirteen (13) days.

B. Complaints, Appeals and External Independent Reviews

1. Division of Insurance Complaints

A review of the Division Complaints produced seventeen (17) criticisms. A general criticism was written under Section 5/154.6(f) of the Illinois Insurance Code (215 ILCS 5/154.6(f)) for engaging in an activity which resulted in a disproportionate number of meritorious complaints against the insurer by the Division of Insurance. An individual criticism was

written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for a claim underpayment in the amount of $3,109.47. This included subsequent interest due to late payment. Fifteen (15) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest on claims not paid within thirty (30) days. The total of the interest underpayments was $1123.81.

The median for response was twenty-one (21) days.

2. Appeals

A review of the Appeals produced forty-seven (47) criticisms. A general criticism was written under Section 134/45(c) of the Managed Care Reform and Patients Rights Act (215 ILCS 134/45(c)) for failure to render a decision on appeals within fifteen (15) business days after the receipt of the required information. The second general criticism was written under Section 134/45(c) of the Managed Care Reform and Patients Rights Act (215 ILCS 134/45(c)) for failure to notify orally the party filing the appeal, the enrollee's primary care physician, and any health care provider who recommended the health care service involved in the appeal of its decision. Four (4) individual criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for claim underpayments in the amount of $4955.29. This includes subsequent interest due to late payment. An individual criticism was written under Section 5/356z.2 of the Illinois Insurance Code (215 ILCS 5/356z.2) for failure to provide coverage for adjunctive services in Dental Care. The claim underpayment was $1247.16. This included subsequent interest due to late payment. Forty (40) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest claims not paid within thirty (30) days. The total amount of the interest underpayment was $3766.10.

The median for response was eleven (11) days.

3. External Independent Review

A review of the External Independent Reviews produced one (1) general criticism and two (2) individual criticisms. The general criticism was written under Section 134/45(f)(4) of the Managed Care Reform and Patient Rights Act (215 ILCS 134/45(f)(4)) for failure to have a response from the external reviewer within the required five (5) days. Two (2) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest for claims processed beyond thirty (30) days in the amount of $52.22.

C. Consumer Advisory Committee

A review of the meeting minutes for the Consumer Advisory Committee produced one criticism. A general criticism was written under Section 134/75(b) of the Managed Care Reform and Patient Rights Act (215 ILCS 134/75(b)) for failure to have eight (8) enrollees on the consumer advisory committee.

D. Policy Form Review

A review of the policy forms, applications and membership materials produced four (4) individual criticisms. The large group policy form was criticized under Section 5/143 of the Illinois Insurance Code (215 ILCS 5/143) for failure to meet the minimum coverage and mandated benefit requirements. The small group policy form was also criticized under Section 5/143 of the Illinois Insurance Code (215 ILCS 5/143). No updates have been made since late 2003. An amendment to the small group policy form was also criticized under Section 5/356w of the Illinois Insurance Code (215 ILCS 5/356w) for failure to provide to diabetic enrollees required regular foot exams and it contained an incomplete definition of required diabetic supplies. The enrollment form in use was criticized under Section 5/356r of the Illinois Insurance Code (215 ILCS 5/356r) for imposing an age limitation of eighteen (18) before a female enrollee may designate a woman's principal health care provider as well as a primary care provider. No such age limitation is allowed.

E. Producer Analysis

A review of the producer licensing files and first year commissions produced no criticisms.

F. Provider Termination

A review of the Terminated Providers produced no criticisms.

VI. INTERRELATED FINDINGS

A. Ambulance Claim Underpayments

Examiners noted that air ambulance claims were underpaid. One (1) claim was criticized under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for not attempting in good faith to effectuate prompt, fair and equitable settlement in which liability has become reasonably clear. The underpayment amount was $6,379.26 and includes statutory interest due to late payment. One claim was criticized under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest in the amount of $31.75 for claims processed beyond thirty (30) days.

B. Eligibility Underpayments

Examiners noted that many claims had an explanation of benefits code stating that the insured did not have coverage when in fact they were eligible on the date of service. Fifteen (15) claims were criticized under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for not attempting in good faith to effectuate prompt, fair and equitable settlement in which liability has become reasonably clear. The underpayment amounts totaled $20,875.96 ($18,605.77 in claim underpayments and $2,270.19 in interest).

Three (3) explanation-of-benefit denial codes (R11250, R01030, and R11010) were identified. Unicare Health Plans of the Midwest should reopen and adjudicate correctly all processed June 1, 2004 to date and provide a report to our Division.

Six (6) claims were criticized under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for failure to pay interest for claims processed beyond thirty (30) days in the amount of $172.63.

C. Company Cooperation

During the examination, while the Company made efforts to facilitate the examination process, it was inadequate. The data, information, files, and responses to citations were not received in a timely manner. The median number of days to respond to the 144 criticisms and requests for information was 18 days.

Populations requested were incorrect. This was only found after examiners made sample selections from the data Unicare provided. For instance, the population for Denied Group was presented as 181,377. When samples were provided, it was found that 91 of 120 were actually paid claims. The examiners revised the data set and the true population of denied claims was 54,310. The final sample selection was made from this data.

Policy forms were requested January 24, 2007 and not provided until April 3, 2007. Upon review of the small group policy forms it was found that Unicare failed to incorporate changes pursuant to discussions they had with our Division after the last exam that concluded in June of 2004. The large group form also was not in compliance.

VII. TECHNICAL APPENDICES