STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF THE EXAMINATION OF

HEALTH ALLIANCE MEDICAL PLANS, INC.
HEALTH ALLIANCE – MIDWEST, INC.
301 S. VINE STREET
URBANA, IL 61801-3347

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 132, 401, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402 and 5/425) do hereby appoint Examiner-In-Charge, Max Weaver and associates as the proper persons to examine the insurance business and affairs of Health Alliance Medical Plans, Inc, NAIC #77950, and Health Alliance – Midwest, Inc., NAIC #95513, and to make a full and true report to me of the examination made by them of Health Alliance Medical Plans, Inc. and Health Alliance – Midwest, Inc., with a full statement of the condition and operation of the business and affairs of Health Alliance Medical Plans, Inc. and Health Alliance – Midwest, Inc., with any other information as shall in their opinion be requisite to furnish me a statement of the condition and operation of its business and affairs and the manner in which it conducts its business. The costs of this examination shall be borne by the company.

The persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Health Alliance Medical Plans, Inc. and Health Alliance – Midwest, Inc.

IN TESTIMONY WHEREOF, I hereto set my hand and cause to be affixed this Seal.

Done at the City of Springfield, this 10th day of May, 2012.

Andrew Boron

Andrew Boron ***Director***

This Market Conduct Examination was conducted pursuant to Sections 5/132, 5/401, 5/402, 5/403, and 5/425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403 and 5/425). It was conducted in accordance with standard procedures of the Market Conduct Examination Section by duly qualified examiners of the Illinois Department of Insurance.

This report is divided into five parts. They are as follows: Summary, Background, Methodology, Findings and Technical Appendices. All files reviewed were reviewed on the basis of the files' contents at the time of the examination. Unless otherwise noted, all overcharges (underwriting) and/or underpayments (claims) were reimbursed during the course of the examination.

No company, corporation, or individual shall use this report or any statement, excerpt, portion, or section thereof for any advertising, marketing or solicitation purpose. Any company, corporation or individual action contrary to the above shall be deemed a violation of Section 149 of the Illinois Insurance Code (215 ILCS 5/149).

The Examiner-in-Charge was responsible for the conduct of this examination. The Examiner-in-Charge did approve of each criticism contained herein and has sworn to the accuracy of this report.

Joseph Clennon
Staff Attorney

HEALTH ALLIANCE MEDICAL PLANS, INC
HEALTH ALLIANCE MIDWEST, INC.

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	June 25, 2012 through October 25, 2012
EXAMINATION OF:	Health Alliance Medical Plans, Inc NAIC 77950 Illinois Midwest, Inc.
LOCATION OF EXAMINATION:	301 S. Vine Street Urbana, Illinois 61801
PERIOD COVERED BY EXAMINATION:	January 1, 2011 through December 31, 2011 January 1, 2009 through June 25, 2012 for Complaints and External Independent Reviews
EXAMINER:	Max R. Weaver Examiner-In-Charge

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I. SUMMARY

1. Health Alliance Medical Plans, Inc (Company) was criticized under 215 ILCS 5/500-80 of the Insurance Code for payments totaling $1,785.68 of first year commissions, on 9 applications, to one (1) individual and four (4) entities not duly licensed.

2. The Company was criticized under 50 Ill. Adm. Code 915.50 for failure to include the Notice of Availability of the Department with the denial of four (4) Group POS claims.

3. The Company was criticized under 215 ILCS 5/154.6(i) of the Illinois Insurance Code for the delay of a POS claim.

II. BACKGROUND

Health Alliance Medical Plans, Inc. (Company), which has its principal office at 301 South Vine Street Urbana, IL, is the successor to CarleCare, Inc.. Incorporated as an Illinois domestic stock company on November 17, 1989 and licensed on November 28, 1989, the Company is wholly owned by the Carle Holding Company (CHC), which is wholly owned by the Carle Foundation (Foundation). The Foundation is also the parent company to Carle Foundation Hospital (CHF) and Carle Physician Group (CPG). The Company is authorized to write accident and health insurance policies. The Company operates, primarily, as a licensed Health Maintenance Organization (HMO) in the state of Illinois. The Company also owns Health Alliance Midwest, Inc. (HAM), which offers prepaid health care services in Illinois and Iowa. The Company, owns 100% interest in Healthcare Horizons of Illinois, Inc. (HHI), a third party administrator.
The Company was originally founded by physicians.

III. HMO STRUCTURE

The Company is a network model health maintenance organization incorporated to do business in 101 Illinois counties. The Company offers HMO plans with optional riders for prescription drugs. The HMO product is marketed by an in-house staff and by brokers for small group business. At the time of the examination HAMS provided health care coverage to over 282,058 with 172,117 fully insured group members with 3,076 groups of which 2,880 were fully insured employer groups and 23 Medicare supplement groups with 1,746 individual members. The remaining members are Medicare Advantage or self-funded members. The Company contracted with 4,200 primary care physicians, 14,000 specialists, 169 hospitals and 130 medical groups with 10 or more physicians.

The Company has capitation arrangements with joint venture partners and varying compensation arrangements with individual participating physicians for HMO business.

An Administrative Review Committee reviews appeals of administrative decisions. Clinic peers, not involved in denial of coverage of health care services, review medical necessity appeals. The Company contracts with two external review organizations for external review when a member is not satisfied with the resolution of a complaint related to medical necessity. The Company has a Consumer Advisory Committee that meets quarterly to identify and review consumer concerns and makes advisory recommendations. The Consumer Advisory Committee also provides feedback to proposed changes in programs, materials and processes. The membership consists of 8 enrollees and reports to the Member's Rights and Responsibilities Committee.

IV. QUALITY ASSURANCE: COMPLAINT AND APPEALS

If a member chooses to request a reconsideration of a claim, he/she may call or write the Company and an authorized representative will attempt to address the concerns through informal discussions. If the issue is not resolved through informal discussions, the member may file a complaint with the Company.

For prompt and equitable resolution of complaints, the Company has established the following complaint review procedures:

Administrative Review

If a member or authorized representative chooses to appeal an administrative decision, he/she may call the Customer Service Department. The Company must notify the party filing an appeal, within 3 business days, of all information that the plan requires to evaluate the appeal. The Company will notify the party filing the appeal in writing of its decision within 15 business days after the date the information requested to complete the review is received.

Medical Review

If a member chooses to appeal a medical decision, the appeal is forwarded for review to a Clinical Peer not involved in the original denial of coverage for review. The Clinical Peer will make a decision within 5 days after the date that the information requested to complete the review is received. If the medical necessity appeal is denied, the member may request an external independent review. This request must be submitted in writing within 30 days to an external independent review organization. The independent reviewer will make a decision within 5 days after receipt of necessary information. The Company will provide oral and written notification of the independent reviewer's decision to all parties involved in the appeal.

Expedited Review

If the member or health care provider believes that the standard time to review the denial of coverage could significantly increase the risk to the member's health, an expedited review maybe requested orally or in writing. The party requesting the review will be contacted within 24 hours for information that is required to evaluate the appeal. A decision will be made within 24 hours after receipt of the required information. The Company will provide oral and written notification of the decision to all parties involved in the appeal.

V. POLICY FORMS

All plans, form letters and riders used in Illinois during the examination period were requested. These were reviewed for compliance as to format, content and terminology as required by Illinois law.

VI. METHODOLOGY

The Market Conduct Examination places emphasis on evaluating an insurer's systems and procedures used in dealings with insureds and claimants.

The following categories are the general areas examined:

1. Producer Production
2. Provider Contracts
3. Enrollment Procedures
4. Claim Procedures
5. DOI Complaints, Consumer Complaints, Appeals

The review of these categories is accomplished through examination of appointed and terminated producer files, provider contracts, enrollment procedures, claim files, appeals and Department of Insurance complaint files. Each of these categories is examined for compliance with Department of Insurance rules and regulations and applicable state law.

The report concerns itself with improper practices performed with such frequency as to indicate general business practices. Individual criticisms are identified and communicated to the insurer but are not cited in the report, if not indicative of a general trend, except if there were underpayments and/or overpayments in claims surveys or undercharges and/or overcharges in underwriting surveys.

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

Producer Licensing and Production Analysis

Populations for the producer file reviews were determined by whether or not the producers were licensed by the State of Illinois. New business listings were retrieved from company records selecting newly solicited insurance applications, which reflected Illinois addresses for the applicants.

Policy Forms and Advertising Material Analysis

The Company was requested to provide specimen copies of all policy forms and samples of all advertising material in use during the survey period.

Department of Insurance Complaints and Appeals Review

The Company was requested to provide all files relating to complaints which had been received via the Department as well as the Appeals received from insureds or his/her representative. A copy of the Company's complaint register was also reviewed. The survey period for Department complaints and appeals was January 1, 2009 through June 25, 2012.

Claims

Claim surveys were selected using the following criteria:

1. Paid Claims – Payment for coverage made during the examination period.

2. Denied Claims – Denial of benefits for losses not covered by policy provisions.

All claims were reviewed for compliance with policy contracts and applicable Sections of the Illinois Code [215 ILCS 5/1et al], the Health Maintenance Organization Act [215 ILCS 125], the Managed Care Reform and Patients Rights Act [215 ILCS 134] and 50 Illinois Administrative Code.

The median payment periods were measured from the date necessary proofs of loss were received to the date of payment or denial to the insured or the beneficiary.

Department of Insurance Complaints

The Company was requested to provide all files relating to complaints which had been received via the Department of Insurance as well as those received directly by the Company from the insured or his/her representative. A copy of the Company's complaint register was also reviewed

Median periods were measured from the date of notification of the complaint to the date of response to the Department of Insurance.

The examination periods for Department of Insurance complaints and Appeals were January 1, 2009 through June 25, 2012.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	% REVIEWED
Producers Analysis			
Producers/Applications	338/10,501	338/10,501	100
Terminated Agents	51	51	100
Provider Agreement Analysis			
Provider Agreements	12,465	173	1
Provider Terminations	186	186	100
Claims Analysis			
Paid Individual HMO	19,813	120	1
Denied Individual HMO	12,603	91	1
Paid Individual PPO	124,485	90	1
Denied Individual PPO	124,451	90	1
Paid Group HMO	993,986	125	1
Denied Group HMO	3302	106	1
Paid Il. Midwest Group HMO	3527	110	3
Denied Il. Midwest Group HMO	16	16	100
Paid Group PPO	330,279	117	1
Denied Group PPO	1090	90	8
Paid Group POS	250,693	107	1
Denied Group POS	508	65	13
Paid Plus Plan HMO	1,442	57	4
Denied Plus Plan HMO	3	3	100
Paid Coordinated Care Plan	37,238	97	1
Denied Coordinated Care Plan	112	55	49
Paid Medicare	64,816	125	1
Denied Medicare	549	55	10

DOI Complaints, Consumer Complaints, Appeals, External Independent Review

Department Complaints		84		84		100
Consumer Complaints-Appeals						
1. Expedited Appeals	56		46		82	
2. External Independent Appeals	74		37		50	
3. Administrative Appeals		748	69			9
4 Non-Expedited Appeals	565		168			30
Policy Forms – Advertising						
Policy Forms Review	163		163		100	
Advertising Review	97		97		100	

VII. FINDINGS

A. Provider Termination Analysis

A review of the 186 provider terminations indicated that none were terminated for cause and resulted in no criticisms.

B. Producer Analysis

1. Producer Terminations

A review of the 51 terminated producer files revealed none had been terminated for cause.

2. Producer Production

A review of the producer production files resulted in a criticism. A general criticism was made under 215 ILCS 5/500-80 for payments of commissions totaling $1,785.68 to four 4 entities and 1 individual, not duly licensed and for 9 applications.

C. Paid Individual HMO Claims Analysis

A review of 120 paid individual paid HMO claim files resulted in no criticisms.

The median for payment was 28 days.

D. Denied Individual HMO Claims Analysis

A review of 91 denied individual HMO claim files resulted in no criticisms.

The median for denial was 27 days.

E. Paid Group HMO Claims Analysis

A review of 125 paid group HMO claim files produced no criticisms.

The median for payment was 29 days.

F. Denied Group HMO Claims Analysis

A review of 106 denied group HMO claim files produced no criticisms.

The median for denial was 22 days.

G. Paid Individual PPO Claims Analysis

A review of 90 of the paid individual HMO files produced no criticisms.

The median for payment was 28 days.

H. Denied Individual PPO Claims Analysis

A review of 90 denied individual PPO claim files produced no criticisms.

The median for denial was 27 days.

I. Paid Illinois Midwest HMO Claims Analysis

A review of 110 Illinois Midwest HMO claim files produced no criticisms.

The median for payment was 27 days.

J. Denied Illinois Midwest HMO

A review of all 16 denied Illinois Midwest HMO claim files produced no criticisms.

The median for denial was 26 days.

K. Paid Group PPO Claims Analysis

A review of 117 paid group PPO claim files produced no criticisms.

The median for payment was 28 days.

L. Denied Group PPO Claims Analysis

A review of 90 denied group PPO claim files resulted in no criticisms.

The median for denial was 28 days.

M. Paid Group POS Claims Analysis

A review of 107 paid group POS claim files resulted in no formal criticisms. It was brought to the attention of the Company that one (1) claim was considered delayed under 215 ILCS 5/154.6(i).

The median for payment was 26 days.

N. Denied Group POS Claims Analysis

A review of 65 denied Group POS claim files produced a general criticism 50 Ill. Adm. Code 919.50 for failure to include Notice of Availability of the Department in their delay letters.

The median for denial was 28 days.

O. Paid HMO Plus Claims Analysis

A review of 57 paid HMO Plus claim files produced no criticisms.

The median for payment was 28 days.

P. Denied HMO Plus Plan Claims Analysis

A review of all three (3) of the denied HMO Plus plan claim files resulted in no criticisms.

No median for denial could be established.

Q. Paid Coordinated Care Plan Claims Analysis

A review of 97 of the paid CCP claim files produced no criticisms.

The median for denial was 27 days.

R. Denied Coordinated Care Plan Claims Analysis

A review of 55 of the denied CCP claims files produced no criticisms.

The median for denial was 25 days.

S. Paid Medicare Supplement Claims Analysis

A review of 125 paid Medicare supplement claim files produced no criticisms.

The median for payment was 28 days.

T. Denied Medicare Supplement Claims Analysis

A review of 55 of the 549 denied Medicare supplement claim files produced no criticisms.

The median for denial was 28 days.

U. Department of Insurance Complaints and Appeals Review Analysis

1. Department of Insurance Complaints

A review of all 84 Department of Insurance complaint files produced 2 criticisms. The criticisms were made under Section 4-6(b) of the Health Maintenance Organization Act (215 ILCS 125/4-6(b)) for failure to respond within 21 days after notification is sent.

The median for response was 14 days.

2. Consumer Complaints and Appeals

A review of 46 expedited appeals, 37 external independent review Appeals, 69 administrative appeals and 168 non-expedited medical appeals totaling 320 files produced no criticisms.

The median for reply was 2 days.

V. Policy Forms Review Analysis

A review of the policy forms produced no criticisms.

W. Advertising Review Analysis

A review of the advertising examples in use during the survey period produced no criticisms.

VI. INTERRELATED FINDINGS

The analysis of new business and the listings of first year commissions, paid to producers and entities, revealed several errors. Tax numbers transposed, incorrect tax numbers and company names. Therefore, a considerable amount of time was spent researching data, exchanging information with the Company and the producers to eliminate those individuals and entities properly licensed at the time solicitation. The results are outlined in the findings.

During the analysis of paid HMO claims, it was noted that providers having a negative remit balance have amounts posted to their account reflecting the word "SPOOLED". A check is not issued to that provider until enough positive payable amounts, from other claims, are posted to offset the recoup amounts.

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HEALTH ALLIANCE MEDICAL PLANS, INC
Address of Insurance Company
301 South Vine Street
Urbana, IL 61801-3347

STIPULATION AND CONSENT ORDER

WHEREAS, the Director (Director) of the Illinois Department of Insurance (Department) is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Health Alliance Medical Plans, Inc (Company) is authorized under the insurance laws of this State and by the Director as a LAH Domestic Stock insurance company, to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by duly qualified examiners appointed by the Director pursuant to Sections 132, 401, 401.5, 402, 403 and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/401.5, 5/402, 5/403 and 5/425); and

WHEREAS, the appointed examiners have filed an examination report as an official document of the Department as a result of the Market Conduct Examination; and

WHEREAS, said report cited various areas in which the Company were not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.)* and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company.

WHEREAS, the Company is aware of and understand their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407 and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understand and agree that by entering into this Stipulation and Consent Order, they waive any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order.

NOW, THEREFORE, IT IS agreed by and between the Company and the Director as follows:

1. That the Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code, and/or Department Regulations; and

2. That the Director and the Company consent to this order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code, and/or Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain procedures whereby the Company does not pay first year commissions to individuals and entities not duly licensed as required by Section 215 ILCS 500/80 of the Illinois Insurance Code.

2. Institute and maintain procedures whereby The Company provides "Notice of Availability" of the Department of Insurance as required by Section 919.50 of 50 Illinois Administrative Code.

3. The Company shall notify the Director of Insurance within 15 days of procedures for compliance with the above Orders.

4. The Company shall pay to the Director, within 15 days, a civil forfeiture in the amount of $2,000.00.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code, including but not limited to levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent order or any provisions of the Illinois Insurance Code or Department Regulations.

On behalf of:
Health Alliance Medical Plans, Inc

Signature

Jeffrey C. Ingram
Name

President + CEO
Title

Subscribed and sworn to before me this
22nd day of April A.D. 2013.

Gayle L. Huber
Notary Public

GAYLE L. HUBER
OFFICIAL SEAL
Notary Public - State of Illinois
My Commission Expires
August 29, 2016

DEPARTMENT OF INSURANCE of the
State of Illinois;

DATE May 6, 2013

Andrew Boron
Andrew Boron
Director

STATE OF ILLINOIS)
) ss
COUNTY OF MACON)

Max Weaver, being first duly sworn upon his oath, deposes and says:

That he was appointed by the Director of Insurance of the State of Illinois (the "Director") as Examiner-In Charge to examine the insurance business and affairs of Health Alliance Medical Plans, Inc., NAIC # 77950, and Health Alliance - Midwest, Inc., NAIC # 95513 (collectively the "Companies"), of Urbana, Illinois,

That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Companies with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Companies' business and affairs and the manner in which the Companies conducts their business;

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Companies nor any of the Companies' affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment Companies, and that neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is financially interested in any other corporation or person affected by the examination;

That an examination was made of the affairs of the Companies pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

That he was the Examiner-in-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Companies for the period covered by the Report as determined by the examiners;

That the Report contains only facts ascertained from the books, papers, records, or documents, and other evidence obtained by investigation and examined or ascertained from the testimony of officers or agents or other persons examined under oath concerning the business, affairs, conduct, and performance of the companies.

Examiner-In-Charge

Subscribed and sworn to before me
This 29th day of March,
A. D. 2013 .

Notary Public

"OFFICIAL SEAL"
ANGI D. COOPER
NOTARY PUBLIC, STATE OF ILLINOIS
MY COMMISSION EXPIRES 07-17-2016

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

July 8, 2013

Jeffrey Ingrum
President
Health Alliance Medical Plans, Inc.
301 South Vine Street
Urbana, IL 61801-3347
Springfield, IL 62704

sent via USPS certified mail
return receipt requested

Re: ***Health Alliance Medical Plans, Inc***
Market Conduct Examination Report

Dear Mr. Ingrum:

This is in response to your June 27, 2013 letter on this subject.

The proofs of compliance you have submitted have been reviewed and are satisfactory.

Accordingly, this Department is closing its file on this exam. I intend to ask the Director to make the Examination Report available for public inspection as authorized by 215 ILCS 5/132.

Cordially,

Joseph T. Clennon
Staff Attorney

320 West Washington St.
Springfield, Illinois 62767-0001
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