Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

September 23, 2014

Linda Laugges
Compliance Director
Coventry Health Care
2110 Fox Drive, Suite A
Champaign, IL 61820

Re: Group Health Plan, Inc.
Market Conduct Examination Report Closing letter

Dear Ms. Laugges:

The Department has reviewed your company's proof of compliance and deems it adequate and sufficient. Therefore, the 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.

If you have any questions, my contact information is listed below.

Sincerely,

Miryam Ramirez
Acting Deputy Director
Consumer Outreach and Protection
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603
Phone: 312-814-2117
E-mail: Miryam.Ramirez@Illinois.gov

STATE OF ILLINOIS

Department of Financial and Professional Regulation
Division of Insurance

IN THE MATTER OF
THE EXAMINATION OF

GROUP HEALTH PLAN, INC.
550 MARYVILLE CENTRE DRIVE, SUITE 300
ST. LOUIS, MISSOURI 63141-5818

MARKET CONDUCT EXAMINATION WARRANT

I, the undersigned, Director of Insurance of the State of Illinois, pursuant to Sections 5/131.21, 5/132, 5/401, 5/402, 5/403 and 5/425 of the Illinois Insurance Code (215 ILCS 5/131.21, 5/132, 5/401, 5/402 and 5/425) do hereby appoint David Bradbury, Examiner-In-Charge, Mike Hager, Pat Hahn and associates as the proper persons to examine the insurance business and affairs of Group Health Plan, Inc. of St. Louis, Missouri, and to make a full and true report to me of the examination made by them of Group Health Plan, Inc. with a full statement of the condition and operation of the business and affairs of Group Health Plan, 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 persons so appointed shall also have the power to administer oaths and to examine any person concerning the business, conduct, or affairs of Group Health Plan, Inc.

IN TESTIMONY WHEREOF,

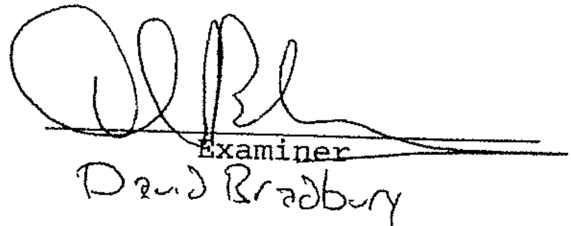
I hereto set my hand and cause to be affixed the Seal of my office. Done at the City of Springfield, this 23rd. day of March, 2009.

Michael T. McRaith

Michael T. McRaith — *Director*

STATE OF ILLINOIS)
) SS
COUNTY OF SANGAMON)

I personally served a copy of the within Warrant by leaving said copy with Anita Carter, at the hour of 3:16 PM on June 22, A.D., 2009.



Examiner

David Bradbury

Group Health Plan, Inc.

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	May 18, 2009 through October 16, 2009
EXAMINATION OF:	Group Health Plan, Inc., NAIC #96377
LOCATION:	550 Maryville Centre Drive, Suite 300 St. Louis, Mo. 63141-5818
PERIOD COVERED BY EXAMINATION:	April 1, 2008 through March 31, 2009 – Claims April 1, 2007 through April 15, 2009 – Complaints, Appeals and External Independent Review
EXAMINERS:	C. Michael Hager Patricia S. Hahn David R. Bradbury – Examiner-in-Charge

INDEX

	PAGE
I. SUMMARY	1-2
II. BACKGROUND	3
III. METHODOLOGY	4-6
IV. FINDINGS	7-13
A. Claims Analysis	
1. Paid Group HMO	
2. Denied Group HMO	
3. Paid Individual HMO	
4. Denied Individual HMO	
5. Paid Point of Service	
6. Denied Point of Service	
B. Complaints, Appeals and External Independent Review Analysis	
1. Department of Insurance Complaints	
2. Appeals	
3. External Independent Review	
C. Consumer Advisory Committee Analysis	
D. Policy Form Analysis	
E. Advertising Material Analysis	
F. Producer Analysis	
G. Provider Agreement Analysis	
V. INTERRELATED FINDINGS	14-15
A. Emergency Room Physicians	
B. Eligibility Underpayments	
C. Pre-Certification Penalties	
VI. TECHNICAL APPENDICES	16

I. SUMMARY

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

2. The Company was criticized under 50 Ill. Adm. Code 2051.55(e)(10)(A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for the underpayment of claims when the insured has made a good faith effort to use the services of a contracted provider even though there is not equitable access to such provider.

3. The Company was criticized under 215 ILCS 5/368a(c) for failure to process and pay interest on claims not paid within 30 days.

4. The Company was criticized under 215 ILCS 134/45(f) at the time of the Examination for failure to give the member information concerning their right to an external independent review when a denied claim is upheld upon appeal. The Section governing external independent review is currently 215 ILCS 180/20.

5. The Company was criticized under 215 ILCS 134/45(b), (c), (e) and (f) for failure to include in the notice to the members that accompanies all complete or partial claim denials that an appeal can be submitted orally or in writing, failure to comply to state that the HMO will notify all concerned parties orally and in writing, and failure to comply with the External Independent review requirements as stated in this Section, specifically the joint selection process of an external independent reviewer and finality of the decision. The requirement for joint selection has been amended and requirements are outlined in 215 ILCS 180.

6. The Company was criticized under 215 ILCS 5/370r, currently 213 ILCS 356z.7, for failure to comply with the cancer off-label drug use for cancer treatment requirements.

7. The Company was criticized under 215 ILCS 5/143(1) for the use of policy forms that include result language that is ambiguous and for the use of a prohibited phrase.

8. The Company was criticized under 215 ILCS 5/356z.2 for the use of policy forms that fail to comply with the age requirement for dental anesthesia.

9. The Company was criticized under 215 ILCS 134/45(f) at the time of the exam for use of policy forms containing language that fail to meet the five (5) day timeline for notification to the complainant as to the result of an external independent review. This Section has been amended to 215 ILCS 180/35 and imposes different timelines.

10. The Company was criticized for the use of policy forms that fail to comply with 215 ILCS 5/356x requiring coverage for all exams and lab tests for colorectal cancer examination.

11. The Company was criticized for the use of policy forms that fail to comply with 215 ILCS 134/20 requiring at least 60 days notice to the member of non-renewal or termination of health care providers.

12. The Company was criticized for use of policy forms that fail to comply with 215 ILCS 125/4-5 regarding experimental and investigational organ transplantation.

13. The Company was criticized under 50 Ill. Adm. Code 2002.70 (a) (2) for use of the term "comprehensive" to describe its product.

14. The Company was criticized under 50 Ill. Adm. Code 2002.60 for use of an acronym without it being defined and for stating the insured "should never have any trouble finding a participating provider."

15. The Company was criticized under 215 ILCS 5/500-80 for payment of commissions to an unlicensed producer.

16. The Company was criticized under 215 ILCS 134/20 for failure to give notice to the member of the termination of their providers.

II. BACKGROUND

Group Health Plan, Inc. (Company) was founded on March 2, 1978 as Group Health Plan of Greater St. Louis, a non-profit health services corporation. The Company became operational in January of 1982 as a staff model HMO with one (1) medical center serving St. Louis, St. Louis County, and a portion of Jefferson County. In 1985, the Company was licensed as a for-profit corporation and changed its name to Group Health Plan, Inc. On October 19, 2011, Group Health Plan, Inc. changed its name to Coventry Health Care of Missouri, Inc.

In 1990, the Company added a network of community physicians to its system, becoming a mixed model HMO with the new IPA network operating alongside the staff model already in place. The Company remained a mixed model HMO until 1997, when it sold its nine (9) medical centers to BJC health system.

During the late 1990's and early 2000's, the Company strengthened its presence within the marketplace by merging with two (2) other health maintenance organizations within the St. Louis area. Today, the Company's service area has grown to include not only the St. Louis area, but also Mid-Missouri, Central Illinois, and Southern Illinois. The Company's significant growth in recent years has positioned it as one of the largest health plans in the St. Louis market with over 300,000 members.

The Company is a wholly owned subsidiary of Coventry Health Care, Inc. Headquartered in Bethesda, Maryland, Coventry provides health benefits and services to a broad section of employer and government-funded groups in all 50 states and Puerto Rico. The Company is incorporated under the laws of the State of Missouri. The Company is licensed in the State of Illinois as a foreign for profit health maintenance organization. Effective October 19, 2011 the Company changed its name to Coventry Health Care of Missouri, Inc.

The Company's 2008 and 2009 Annual Statement Schedules T reflects the following Illinois direct premium:

	Accident & Health Premiums	Medicare Title XVIII	Total
2008	51,749,611	79,181,244	130,930,855
2009	41,082,173	73,650,123	114,732,296

This Department conducted a Market Conduct Examination for the period 2001 to 2003. The Company and the Director executed a Stipulation and Consent Order in 2004 relating to various findings of the Market Conduct Examination Report.

III. METHODOLOGY

The Market Conduct Examination covered the business for the period of April 1, 2008 through March 31, 2009 for claims and April 1, 2007 through the April 15, 2009 for complaints, appeals, and external independent reviews. Specifically, the examination focused on a review of the following areas.

1. Claims Analysis
2. Complaints, Appeals and External Independent Review Analysis
3. Consumer Advisory Committee Analysis
4. Policy Form Analysis
5. Advertising Material Analysis
6. Producer Analysis
7. Provider Agreement Analysis

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 Department 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 Company, 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:

Claims Analysis

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 5/1 *et seq.*), the Illinois Health Insurance Portability and Accountability Act, (215 ILCS 97 *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 Title 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 April 1, 2008 through March 31, 2009.

Complaints, Appeals and External Independent Review Analysis

The Company was requested to provide all files relating to complaints received via the Department 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 April 1, 2007 through April 15, 2009.

Consumer Advisory Committee Analysis

The Company was requested to provide all quarterly meeting minutes for the period under review.

Policy Form Analysis 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.

Producer Analysis

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

Provider Agreement Analysis

The Company was requested to provide a listing of all providers that terminated their contract with the Company along with proof of notification to the Providers member panel. The notification review was limited to Primary Care Physicians.

SELECTION OF SAMPLE

SURVEY	POPULATION	# REVIEWED	%REVIEWED
CLAIMS ANALYSIS			
Paid Group HMO	16,894	118	0.7
Denied Group HMO	2,623	58	2.2
Paid Individual HMO	3,220	55	1.7
Denied Individual HMO	1,797	55	3.1
Paid Point of Service	99,626	170	0.2
Denied Point of Service	26,716	167	0.6
COMPLAINTS, APPEALS AND EXTERNAL INDEPENDENT REVIEW ANALYSIS			
Department of Insurance Complaints	9	9	100
Appeals	50	50	100
External Independent Review	0	0	0
POLICY FORM ANALYSIS			
Policy Forms, Endorsements	7	7	100
ADVERTISING MATERIAL ANALYSIS			
Advertising	50	50	100
PRODUCERS ANALYSIS			
Number of Producers	99	99	100
Number of Applications	138	138	100
PROVIDER AGREEMENT ANALYSIS			
Provider Terminations	5	5	100

IV. FINDINGS

A. Claims Analysis

1. Paid Group HMO

A review of 118 of the 16,894 paid group HMO claim files produced no criticisms.

The median for payment was three (3) days.

2. Denied Group HMO

A review of 58 of the 2,623 Denied Group HMO claim files produced six (6) individual criticisms. Two (2) individual criticisms were written under 215 ILCS 5/154.6(d) for a claim underpayment in the amount of $2,528.68 for the first and $287.00 that was reprocessed and applied to the member's deductible for the second. The Company made the underpayments prior to the completion of the examination. This included interest due to late payment.

Two (2) criticisms were written under 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for improper denial and subsequent underpayment of two (2) claims in the amount of $1305.59. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a) (6) (H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the underpayments prior to the completion of the examination. This included interest due to late payment.

Two (2) individual criticisms were written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days. The total of the interest underpayments was $25.25. The company agreed and paid this interest prior to the completion of the exam.

The median for denial was four (4) days.

3. Paid Individual HMO

A review of 55 of the 3220 Paid Individual HMO claim files produced three (3) individual criticisms. Two (2) individual criticisms were written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days. The Company made payment prior to completion of the examination. The total of the interest underpayments was $67.39.

One (1) individual criticism was written under 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for improper denial and subsequent underpayment of two (2) claims in the amount of $435.37. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a) (6) (H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the underpayments prior to the completion of the examination. This included interest due to late payment.

The median for payment was four (4) days.

4. Denied Individual HMO

A review of 55 of the 1797 Denied Individual HMO claim files produced nine (9) individual criticisms. Six (6) individual criticisms were written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days after receipt of due written proof of such loss. The Company denied claims for which sufficient due written proof of loss had been submitted. The total of the interest underpayments was $38.63. The Company made payment prior to the completion of the examination.

One (1) individual criticism was written under 215 ILCS 5/154.6(d) for underpayment of a claim in the amount of $1,201.17. The Company made payment prior to the completion of the examination. This included interest due to late payment.

Two (2) individual criticisms were written under 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for

improper denial and subsequent underpayment of two (2) claims in the amount of $1335.19. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a) (6) (H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the underpayments prior to the completion of the examination. This included interest due to late payment.

The median for denial was three (3) days.

5. Paid Point of Service

A review of 170 of the 99,626 Paid Point of Service claim files produced five (5) individual criticisms. Two (2) individual criticisms were written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days. The total of the interest underpayments was $6.42. The Company made payment prior to the completion of the examination.

Three (3) individual criticisms were written under 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for improper denial and subsequent underpayment of two (2) claims in the amount of $530.69. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a)(6)(H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the underpayments prior to the completion of the examination. This included interest due to late payment.

The median for payment was four (4) days.

6. Denied Point of Service

   A review of 167 of the 26,716 Denied Point of Service claim files produced six (6) individual criticisms. The Company made payment prior to the completion of the examination. Four (4) individual criticisms were written under 215 ILCS 5/154.6(d) for underpayment of a claim in the amount of $179.59. The Company made payment prior to the completion of the examination. This included interest due to late payment. One (1) individual criticism was written under 50 Ill. Adm. Code 2051.55(e) (10) (A) , currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for improper denial and subsequent underpayment of two (2) claims in the amount of $104.58. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a)(6)(H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the payment prior to the completion of the examination. This included interest due to late payment.

   An individual criticism was written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days after receipt of due written proof of such loss. The Company denied claims for which sufficient due written proof of loss had been submitted. The total of the interest underpayments was $74.43. The Company made payment prior to the completion of the examination.

   The median for denial was two (2) days.

B. Complaints, Appeals and External Independent Review Analysis

   1. Department of Insurance Complaints

      A review of all nine (9) Department complaints produced no criticisms.

      The median for response was 20 days.

2. Appeals

A review of all 50 appeals produced seven (7) criticisms. A general criticism was written under 215 ILCS 134/45(f) for failure to give the member information concerning his right to an external independent review. Of the 25 claim denials that were upheld on appeal, none included information concerning the right to elect an external independent review or a description of the joint selection process. The external independent review process is currently governed by 215 ILCS 180/20.

The second general criticism was written under 215 ILCS 134/45(b), (c), (e) and (f) for failure to include in the notice to the members that accompanies all complete or partial claim denials that an appeal can be submitted orally or in writing, failure to comply with state that the HMO will notify all concerned parties orally and in writing, and does not comply with the External Independent review requirements as stated in this Section, specifically the joint selection process of an external independent reviewer and finality of the decision. The requirement for joint selection has been amended and requirements are outlined in 215 ILCS 180.

One (1) individual criticism was written under 215 ILCS 5/154.6(d) for claim underpayments in the amount of $15.00.

Three (3) individual criticisms were written under 215 ILCS 5/368a(c) for failure to pay interest on claims not paid within 30 days after receipt of due written proof of such loss. The Company overturned and paid previously denied claims for which sufficient due written proof of loss had been submitted. The total amount of the interest underpayments were $16.35.

One (1) individual criticism was written under 215 ILCS 5/370r, currently 213 ILCS 356z.7, for failure to investigate off-label drug use for cancer treatment. The Company denied a claim based on the insured's policy language. This policy language had not been revised to reflect the requirements of 215 ILCS 5/370r at the time of the exam. The citation has been changed and is currently 213 ILCS 356z.7. All underpayments were made prior to completion of the examination.

The median for response was five (5) days.

3. External Independent Review

The Company did not have a single external independent review. All requests for further review were instead processed and reviewed by a clinical peer health professional without notice of the use of a mechanism of joint selection of this reviewer. No assessment by the clinical peer was

binding. 215 ILCS 134/45(f) required external independent review and provides that the decision of independent reviewer is final. The requirements for this have been changed and are outlined in 215 ILCS 180/45.

C. Consumer Advisory Committee Analysis

A review of the meeting minutes for the Consumer Advisory Committee produced no criticisms.

D. Policy Form Analysis

A review of the seven policy forms, applications and membership materials produced eight (8) individual criticisms.

Six (6) of seven (7) policy forms were criticized under 215 ILCS 97/20 and 215 ILCS 5/143(1) for excluding allowances for creditable coverage. All reconstructive surgeries not related to injury while covered by the HMO were excluded pursuant to the policy language.

Six (6) of the seven (7) policy forms were criticized under 215 ILCS 5/143(1) for use of ambiguous language, "indirectly", that is used to define an exclusion of a non-covered service and the use of the prohibited phrase "in the Plan's sole and absolute discretion."

Five (5) of the seven (7) policy forms were criticized under 215 ILCS 134/45(f) for failure to meet the five (5) day timeline for notification to the complainant the result of an external independent review. The Company states that the law does not require a specific timeframe to send written notice of the result. The intent of the section is clear in that resolution and notice be sent to the complainant within five (5) days. This requirement has been changed and timelines are now outlined under 215 ILCS 180/35.

Six (6) of the seven (7) policy forms were criticized under 215 ILCS 5/356x and 215 ILCS 5/143(1). The forms fail to provide coverage for all colorectal exams and lab tests for colorectal cancer examination and screening as prescribed by the primary care physician.

Three (3) of the seven (7) policy forms were criticized under Section 20 of the Managed Care Reform and Patients Rights Act 325 ILCS 134/20 and 215 ILCS 143(1) for failure to give at least 60 days notice of non-renewal or termination of health care providers to enrollees served by the health care provider. The forms states a 31-day notice will be given.

Four (4) of the seven (7) policy forms were criticized under 215 ILCS 5/356z.2 for failure to comply with the maximum age requirement of six (6) years old for dental anesthesia.

Three (3) of the seven (7) policy forms were criticized under 215 ILCS 125/4-5 and 215 ILCS 5/143(1) regarding organ transplants. The forms are contrary to the requirements used in the determination of 'experimental and investigational organ transplantation.'

E. Advertising Material Analysis

A review of approximately 50 pieces of advertising materials resulted in three (3) criticisms. A general criticism was written under 50 Ill. Adm. Code 2002.70 (a)(2) for the use of the term "comprehensive" to describe the product. Two (2) general criticisms were written under 50 Ill. Adm. Code 2002.60. The first was for the use of the acronym "UCR" in describing the product without defining it in the advertising material. The second was for stating "GHP's extensive area means that you should never have any trouble finding a participating provider or hospital near you." This statement has the capacity to mislead and is a false statement.

F. Producer Analysis

A review of the 99 producer licensing files and 138 first year commissions produced one (1) criticism. A criticism was written under 215 ILCS 5/500-80 for payment of commissions to an unlicensed producer. One (1) unlicensed agent received $50.98 in commission on one policy.

G. Provider Agreement Analysis

A review of Terminated Providers notices to members produced one (1) criticism. Five primary care providers terminated their contractual relationship during the period under review. A general criticism was written under 215 ILCS 134/20. This Section of the code requires the HMO to notify the member of the termination of its provider and give at least 60 days notice. The HMO could not produce any letters notifying the members of the termination of its providers. The HMO stated that it did not receive notice for one (1) provider and received notice of termination after it occurred on the other. Even if the 60 day notice was not possible, a notice should have been sent. To date, the members assigned to their panels have not been notified of the terminations. For the third provider, the HMO stated that letters were sent, but the HMO failed to maintain proof of the mailing or copies of any of the letters.

V. INTERRELATED FINDINGS

A. Emergency Room Physicians

Examiners noted that emergency room physician claims were underpaid. In each case, the insured received the services at an in-network hospital. The emergency room physicians were not employees of the in-network hospital. They were employed by an out of network emergency room staffing firm. The member had made a good faith effort to utilize an in-network provider when the member went to the in-network hospital. The Company did not ensure that the member was provided the service at no greater cost than if the emergency room service had been provided by an in network provider. The Company did not pay the emergency room bill in full. The emergency room staffing firm pursued the member for the unpaid balance.

One hundred sixty three claims were criticized under 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), for underpayment of claims for medical services directed by a network provider but still denied by the Company. The underpayment amount was $34,853.43 and includes statutory interest due to late payment. "In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a)(6)(H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. The Company made the underpayments prior to completion of the exam. This included interest due to late payment.

Nine (9) claims were criticized under 215 ILCS 5/368a(c) for failure to pay interest in the amount of $86.86 for claims processed beyond 30 days. The company made the payments prior to completion of the exam.

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 the insured was eligible on the date of service. Twenty-eight claims were criticized under 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 $3,079.82. This included interest due to late payment.

One (1) claim discovered was underpaid pursuant to 50 Ill. Adm. Code 2051.55(e) (10) (A), currently 50 Ill. Adm. Code 2051.310(a)(6)(H), in the amount of $784.02. In any case in which a beneficiary has made a good faith effort to utilize preferred providers for a covered service and it is determined the administrator does not have the appropriate preferred providers due to insufficient number, type or distance, the administrator shall ensure, directly or indirectly, by terms contained in the payor contract, that the beneficiary will be provided the covered service at no greater cost to the beneficiary than if the service had been provided by a preferred provider." 50 Ill. Adm. Code 2051.310(a)(6)(H). In all instances where an insured has made a good faith effort to use the services of a contracted provider and there is not equitable access to such provider(s), it is the insurer's contractual and statutory responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by a contracted provider. This included interest due to late payment. The Company made the underpayments prior to completion of the exam.

C. Pre-Certification Penalties

Claims that had a pre-certification penalty applied were reviewed. Examiners did not note any excessive precertification penalties; however, six (6) underpayment criticisms were noted.

One (1) claim was criticized under 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 underpayments totaled $176.80. This included interest due to late payment.

One (1) claim was underpaid pursuant to 50 Ill. Adm. Code 2051.55(e) (10) (A). currently 50 Ill. Adm. Code 2051.310(a)(6)(H), in the amount of $94.16.

Four (4) claims were criticized under 215 ILCS 5/368a(c) for failure to pay interest for claims processed beyond 30 days in the amount of $1,195.06.

The Company made payment on all the amounts due prior to the completion of the examination including interest due to late payment.

VI. TECHNICAL APPENDICES

None

STATE OF ILLINOIS)
) ss
COUNTY OF COOK)

David Bradbury, being first duly sworn upon his/her 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 Group Health Plan, Inc., (the "Company"), NAIC #96377, which on October 19, 2011, Group Health Plan, Inc., changed its name to Coventry Health Care of Missouri, Inc.,

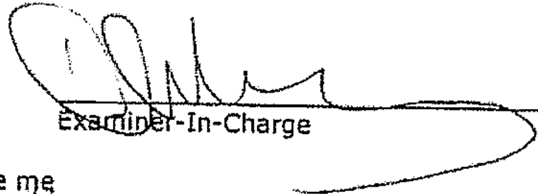
That the Examiner-In-Charge was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish the Director with a statement of the condition and operation of the Company's business and affairs and the manner in which the Company conducts its 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 Company nor any of the Company's affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment company, 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 Company pursuant to the authority vested in the Examiner-In-Charge by the Director of Insurance of the State of Illinois;

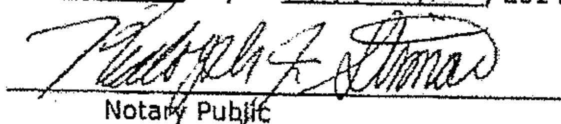
That she/he was the Examiner-In-Charge of said examination and the attached report of examination is a full and true statement of the condition and operation of the insurance business and affairs of the Company for the period covered by the Report as determined by the examiners;

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 Company.

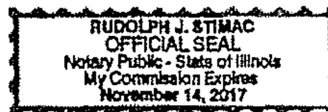


Examiner-In-Charge

Subscribed and sworn to before me this 6TH day of MARCH, 2014.



Notary Public



IN THE MATTER OF:
COVENTRY HEALTH CARE OF MISSOURI, INC.
NAIC #96377
550 MARYVILLE CENTRE DRIVE, SUITE 300
ST. LOUIS, MO 63141-5818

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, Group Health Plan, Inc. ("Company") is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS effective October 19, 2011, Group Health Plan, Inc. changed its name to Coventry Health Care of Missouri, Inc.; and

WHEREAS, a Market Conduct Examination of the Company was conducted by duly qualified examiners of the Department pursuant to Sections 132, 401, 402, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, and 5/425) covering the period of April 1, 2008 through March 31, 2009 for Claims and April 1, 2007 through April 15, 2009 for Complaints, Appeals and External Independent Review; and

WHEREAS, as a result of the Market Conduct Examination, the Department's examiners filed a Market Conduct Examination Report which is an official document of the Department; and

WHEREAS, said report cited various areas in which the Company was 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 Company 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 understands its 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 understands and agrees that by entering into this Stipulation and Consent Order, it waives 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. 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. 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 ensures it is effectuating prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear as required by 215 ILCS 5/154.6(d).

2. Institute and maintain procedures whereby the Company ensures it is paying the correct amount for claims when the insured has made a good faith effort to use the services of a contracted provider but one was unavailable as required by 50 Ill. Adm. Code 2051.310(a)(6)(H), formerly Part 2051.55(e)(10)(A).

3. Institute and maintain procedures whereby the Company ensures correct payment of interest when a claim remains unpaid for more than 30 days as required by 215 ILCS 5/368a(c).

4. Institute and maintain procedures whereby the Company ensures correct information is given to the member concerning their right to an external independent review when a denied claim is upheld upon appeal as required by 215 ILCS 180/20.

5. Institute and maintain procedures whereby the Company provides the notice to the members that accompanies all complete or partial claim denials that an appeal can be submitted orally or in writing, state that the HMO will notify all concerned parties orally and in writing, and comply with the External Independent review requirements as stated in 215 ILCS 180.

6. Institute and maintain procedures whereby the Company ensures compliance with cancer off-label drug use for cancer treatment requirements as required by 213 ILCS 356z.7.

7. Institute and maintain procedures whereby the Company ensures the policy forms utilized by the Company include language that is not ambiguous as required by 215 ILCS 5/143(1) and Title 50 Illinois Administrative Code Part 2001.20.

8. Institute and maintain procedures whereby the Company ensures the policy forms utilized by the Company comply with the age requirement for dental anesthesia as required by 215 ILCS 5/356z.2.

9. Institute and maintain procedures whereby the Company ensures the policy forms utilized by the Company include coverage for all colorectal exams and lab tests for colorectal cancer examination as required by 215 ILCS 5/356x.

10. Institute and maintain procedures whereby the Company ensures the policy forms utilized by the Company comply with 215 ILCS 134/20 requiring at least 60 day notice to the member of non-renewal or termination of health care providers.

11. Institute and maintain procedures whereby the Company ensures the policy forms utilized by the Company comply with 215 ILCS 125/4-5 regarding experimental and investigational organ transplantation.

12. Institute and maintain procedures whereby the Company ensures the advertising materials properly describe the product as required by 50 Ill. Adm. Code 2002.60 and 50 Ill. Adm. Code 2002.70.

13. Institute and maintain procedures whereby the Company ensures that commissions are paid only to duly licensed insurance producers and entities as required by 215 ILCS 5/500-80.

14. Institute and maintain procedures whereby the Company ensures it gives notice to the member of the termination of their providers as required by 215 ILCS 134/20.

15. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above thirteen (14) Orders within 30 days of receipt of these Orders.

16. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $55,000 to be paid within 30 days of the execution of these Orders.

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 COVENTRY HEALTH CARE OF MISSOURI, INC.:

Signature

FRANK J. D'ANTONIO

Name

President

Title

Subscribed and sworn to before me this
24 day of July A.D. 2014.

Notary Public

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 7-24-14

Andrew Boron
Director

7/31/14 Executed

PATRICIA S. HARRELL
My Commission Expires
November 30, 2017
Warren County
Commission #13603309