Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

April 28, 2014

Ms. Linda L. Laugges
Director of Regulatory Compliance
Coventry Health & Life Insurance Company
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141-5818

Re: Coventry Health & Life Insurance Company
Market Conduct Examination Report – Closing Letter

Dear Ms. Laugges;

The company has submitted proofs of compliance with Order # 1 through Order # 10 and has submitted the $50,000 civil forfeiture as outlined in the Stipulation and Consent Order issued by the Department. These proofs of compliance have been reviewed and are satisfactory.

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.

Sincerely,

Lysa Saran
Acting Deputy Director
Consumer Outreach and Protection
Illinois Department of Insurance
122 S. Michigan Avenue, 19th Floor
Chicago, IL 60603
Phone: 312-814-1767
Cell: 312-833-4396
E-mail: Lysa.Saran@Illinois.gov

Coventry Health and Life
Insurance Company

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	May 18, 2009 through October 16, 2009
EXAMINATION OF:	Coventry Health and Life Insurance Company NAIC # 81973
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
EXAMINERS:	Pat Hahn Mike Hager David Bradbury, Examiner-in-Charge

INDEX

		Page
I.	SUMMARY	1
II.	BACKGROUND	2
III.	METHODOLOGY	3-5
IV.	FINDINGS	6-8

A. Claims Analysis
1. Paid Individual Health
2. Denied Individual Health
3. Paid Group Health
4. Denied Group Health

B. Department of Insurance and Consumer Complaints Analysis
1. Department of Insurance Complaints
2. Consumer Complaints

C. Policy Forms and Advertising Material Analysis

D. Producer Licensing and Production Analysis

V.	INTERRELATED FINDINGS	9-10

A. Emergency Room Physicians

B. Eligibility Underpayments

C. Pre-Certification Penalties

VI.	APPENDICES	11

I. SUMMARY

The Illinois Department of Insurance conducted a Market Conduct Examination of the Illinois individual and group health insurance business written by Coventry Health and Life Insurance Company. The Department's findings are as follows:

1. The Company was criticized under 215 ILCS 5/368a(c) for failure to pay all claims and indemnities concerning health care services other than for any periodic payment within 30 days after receipt of due written proof of such loss.

2. The Company was criticized under 215 ILCS 5/368a(c) for the underpayment of interest when a claim remains unpaid for more than 30 days.

3. The Company was criticized under 50 Ill. Adm. Code 2051.310(a)(6)(H), formerly Part 2051.55(e)(10)(A), for the underpayment of claims when the insured has made a good faith effort to use the services of a contracted provider but one was unavailable.

4. 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.

5. The Company was criticized under 215 ILCS 97/20 for the use of policy forms that violate the creditable coverage provisions of that Section.

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

7. The Company was criticized for use of policy forms that fail to comply with 215 ILCS 5/356k Coverage for Organ Transplantation Procedures.

8. The Company was criticized under 215 ILCS 5/143(1) and Title 50 Illinois Administrative Code Part 2001.20 for the use of policy forms that include language that is ambiguous in the denial of claims.

9. 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.

10. The Company was criticized under 215 ILCS 5/500-80 for payment of commissions to unlicensed producers.

II. BACKGROUND

Coventry Health and Life Insurance Company (Company) was incorporated in 1968 under the laws of the State of Texas as a stipulated premium company with the name of American Service Life Insurance Company. The Company was converted by a charter restatement in 1984 as an old line legal reserve life insurance company operating under the provisions of Chapter 3 of the Texas Insurance Code.

The Company's Articles of Incorporation and By-Laws were amended in December 1995 to change the name of the Company from American Service Life Insurance Company to its present name, Coventry Health and Life Company.

As a Texas domiciled company, the Company was originally admitted by the state of Delaware on December 30, 1982 to transact the business of life insurance, including Annuities and Health. A new Certificate of Authority was issued on August 26, 1999, which stated that the Company was originally admitted on December 30, 1982, as a Texas corporation and that effective May 14, 1999 the Company re-domesticated from Texas to Delaware.

The Certificate of Domestication was filed with the Secretary of State of the State of Delaware on May 14, 1999 under which the Company re-domesticated from Texas to Delaware. A Certificate of Incorporation and Restated Certificate of Incorporation were also filed with the Secretary of State of the State of Delaware on May 14, 1999.

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

	Accident & Health Premiums	Medicare Title XVIII	Total
2008	23,792,524	3,417,165	27,209,689
2009	43,921,631	26,065,178	69,986,809

III. METHODOLOGY

The Market Conduct Examination places emphasis on evaluating an insurer's system and procedures used in dealing with insured and claimants. The following categories are the general areas examined:

1. Claims Analysis
2. Department of Insurance and Consumer Complaints Analysis
3. Policy Forms and Advertising Material Analysis
4. Producer Licensing and Production Analysis

The review of these categories is accomplished through examination of producer files, individual and group health insurance claim files, Department of Insurance complaint files, policy forms and advertising material. Each of these categories is 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 business practices. Individual criticisms are identified and communicated to the insurer, but not cited in the report if not indicative of a general trend, except to the extent that there were underpayments in claim surveys or undercharges and/or overcharges in underwriting surveys. The following methods were used to obtain the required samples and to assure a methodical selection:

Claims Analysis

Claim surveys were selected using the following criteria:

1. Paid Claims - Payment for a coverage made during the examination period.
2. Denied Claims - Denial of benefits for losses not covered by policy provisions.
3. Individual or Franchise Claims - Determine whether the contracts were issued on an individual or franchise basis.

All claims were reviewed for compliance with policy provisions and applicable sections of the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the Illinois Health Insurance Portability and Accountability Act, (215 ILCS 97/1 *et seq.*) the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 *et seq.*) and Title 50 Illinois Administrative Code.

All 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.

The examination period for the claims review was April 1, 2008 through March 31, 2009.

Department of Insurance and Consumer Complaints Analysis

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 period for Department of Insurance complaints was April 1, 2007 through April 15, 2009.

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.

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.

SELECTION OF SAMPLE

Survey	Population	Reviewed	% Reviewed
CLAIMS ANALYSIS			
Paid Individual Health	492	46	9
Denied Individual Health	245	55	22
Paid Group Health	10,180	122	1
Denied Group Health	10,201	123	1
DEPARTMENT OF INSURANCE AND CONSUMER COMPLAINTS ANALYSIS			
Department of Insurance Complaints	6	6	100.00
Consumer Complaints	2	2	100.00
POLICY FORMS AND ADVERTISING MATERIAL ANALYSIS			
Policy Forms	7	7	100.00
PRODUCER LICENSING AND PRODUCTION ANALYSIS			
Producer	349 Producers	349 Producers	
	163 policies	163 Policies	

IV. FINDINGS

A. Claims Analysis

1. Paid Individual Health

A review of 46 paid individual health claims produced three (3) criticisms:

One (1) general criticism was written under 215 ILCS 5/368a for failure to pay a claim within thirty (30) days when liability is reasonably clear. Five (5) files or 11% of the files reviewed were cited for failure to pay claims within 30 days after receipt of due written proof of loss. Prior to the examiners' departure, as required by 215 ILCS 5/368a(c), the Company paid interest on the claims where interest equaled or exceeded one dollar ($1.00). Details on these five claims are below:

Claim #	Date due proof of loss complete	Date claim paid	# days	Claim allowed	Interest due
	2-10-09	3-16-09	34	$15,340.00	$15.13
	2-5-09	3-16-09	39	$926.40	$2.06
	2-11-09	3-16-09	33	$308.00	<$1.00
	1-29-09	3-16-09	46	$10.10	<$1.00
	2-11-09	3-16-09	33	$317.00	<$1.00

The median for payment was six (6) days.

Two (2) individual criticisms were written under Title 50 Ill. Adm. Code 2051.55(e)(10)(A), currently 2051.310(a)(6)(H), for improper denial and subsequent underpayment of claims in the amount of $452.01. According to the referenced regulation where an insured has made a good faith effort to use the services of a contracted provider and there is insufficient access to such provider(s), it is the insurer's 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.

2. Denied Individual Health

A review of 55 denied individual health claims produced two (2) criticisms. One (1) individual criticism was written under 215 ILCS 5/154.6(d) for underpayment of claims when liability is reasonably clear. The amount of the underpayment was $53.31. This included interest due to late payment. The Company made this interest payment prior to completion of the examination. This interest payment is not included in the table of claims in "Section IV-B-1 -- "Findings, Claims

Analysis, Paid Individual Health" which were paid more than thirty days after a complete proof of loss was received by the Company.

The second criticism was for a claim that had been denied based on a pre-existing condition. The examiner determined that the insured claimant had had creditable coverage which negated the denial based on a pre-existing coverage. The claim was resubmitted and paid by the Company with interest. This interest payment is included in the table of claims in "Section IV-B-1 -- "Findings, Claims Analysis, Paid Individual Health" which were paid more than thirty days after a complete proof of loss was received by the Company.

The median for denial was 15 days.

3. Paid Group Health

A review of 122 paid group health claims produced seven (7) individual criticisms. Four (4) criticisms were written under 50 Ill. Adm. Code 2051.55(e)(10)(A), currently 2051.310(a)(6)(H), for improper denial and subsequent underpayment of the claims in the amount of $897.21. According to the referenced regulation where an insured has made a good faith effort to use the services of a contracted provider and there is insufficient access to such provider(s), it is the insurer's 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.

Three (3) criticisms were written under 215 ILCS 5/154.6(d) for underpayment of claims when liability is reasonably clear. The amount of the underpayments was $455.84. This included interest due to late payment. The Company made payment on all amounts due prior to completion of the examination.

The median for payment was four (4) days.

4. Denied Group Health

A review of 123 denied group health claims produced one (1) criticism. An individual criticism was written under 215 ILCS 5/154.6(d) for failure to pay a claim when liability was reasonably clear. The claim was denied based on a pre-existing condition exclusion. However, the insured had prior coverage which made the pre-existing condition exclusion inapplicable. The examiners noted this and brought it to the Company's attention. The amount due (which included the amount of the claim plus interest) totaled $1,252.70. The Company made the payment on the amount due prior to completion of the examination.

The median for denial was two (2) days.

B. Department of Insurance and Consumer Complaints Analysis

1. Department of Insurance Complaints

A review of six (6) Department of Insurance Complaint files produced one (1) individual criticism. A criticism was written under 215 ILCS 5/154.6(d) for failure to pay a claim when liability was reasonably clear. The claim in question was properly submitted but the Company initially processed it under the wrong policy number. The examiners noted this and brought it to the Company's attention. The amount that should have been paid, claim plus interest, was $36.21 and was made prior to completion of the examination.

The median for response to the Department of Insurance was 18 days.

2. Consumer Complaints

A review of two (2) consumer complaint files produced no criticisms.

The median for response to the consumer could not be established.

C. Policy Forms and Advertising Material Analysis

1. Policy Forms

A review of the policy forms, applications and membership materials produced six (6) individual criticisms:

(i) Two (2) policy forms were criticized under 215 ILCS 97/20 and 215 ILCS 5/143(1) for excluding allowances for creditable coverage.

(ii) One (1) policy form was criticized under 215 ILCS 5/143(1) and Title 50 Illinois Administrative Code Part 2001.20 for use of the use of an ambiguous term "indirectly" to define an exclusion of a non-covered service.

(iii) Two (2) individual A&H 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.

(v) One (1) individual A&H policy form was criticized under 215 ILCS 5/356z.2 for failure to comply with the maximum age requirement of six (6) years old for dental anesthesia. The statute requires coverage for "a child age 6 or under". The Company's policy form provided coverage for children under the age of 6. This resulted in no coverage for a six year old child.

(vi) Three (3) policies were criticized under 215 ILCS 5/356k and 215 ILCS 5/143(1) for excluding coverage for organ transplantation procedures as experimental or investigational. The policy language differed from and was more restrictive than 215 ILCS 5/356k.

D. Producer Licensing and Production Analysis

1. Producer Licensing

A review of the producer licensing files and first year commissions produced one (1) criticism. A general criticism was written under 215 ILCS 5/500-80 of the Illinois Insurance Code for payment of commissions to an unlicensed producer. Three (3) unlicensed agents received $166.61 in commission.

V. INTERRELATED FINDINGS

A. Emergency Room Physicians

Examiners noted during the claims review surveys that portions of the claims for emergency room physicians were being denied as out-of-network but the hospital was in fact in-network. The examiners determined that while the hospital was in-network, the physicians in the hospital's emergency room were employed by an emergency room staffing firm which was out-of-network. All such claims for services provided by an out-of-network emergency room staffing firm at an in-network hospital's emergency room were reviewed. Thirty-five or 100% of the files reviewed were criticized under Title 50 Illinois Administrative Code Part 2051.310(a)(6)(H), formerly Part 2051.55(e)(10)(A), for improper denial and subsequent underpayment of claims in the amount of $8080.75. According to the referenced regulation, where an insured has made a good faith effort to use the services of an in-network provider and there is insufficient access to such provider(s), it is the insurer's responsibility to ensure that the covered person be provided covered services at no greater cost than if such services had been provided by an in-network provider. The Company agreed to all 35 criticisms and made payment with interest prior to the completion of the examination. These interest payments are not included in the table of claims in "Section IV-B-1 -- "Findings, Claims Analysis, Paid Individual Health" which were paid more than thirty days after a complete proof of loss was received by the Company.

B. Eligibility Underpayments

Examiners found that claims processed during the lapse period of one group were denied as ineligible. The group policy had lapsed due to non-payment of premium. While the policy was in non-pay lapse status, the Company would deny claims submitted. After the late premium payment was paid, the group coverage was re-instated retroactive to the date the group policy had lapsed. When the policy was

reinstated, the Company failed to adjudicate the claims correctly, i.e., it did not go back and pay the claims that had been denied during the lapse status period.

The effects of this on group members can be seen in this scenario:

- The Company receives and denies claims.
- The Company tells the participating provider that the claimant is no longer an insured.
- The participating provider is instructed that it is released from the hold harmless clause and is free to bill the claimant for 100% of charges.
- The claimant/insured pays the claim at 100% of the charged rate.
- The Company receives the premium due and reinstates the policy retroactive to the date the group policy had lapsed. However, the Company fails to re-adjudicate claims which occurred during the grace period.

For the 12-month period under review, examiners found $665.68 in underpayments on four (4) claims. The Company 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. Prior to completion of the examination, the Company made payment on all amounts due including any interest due to late payment.

C. Pre-Certification Penalties

Claims that had a pre-certification penalty applied were reviewed. Examiners did not note excessive pre-certification penalties, however, underpayments 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 underpayment amount totaled $3,711.25 and included interest due to late payment.

Three (3) individual criticisms were written under Title 50 Illinois Administrative Code 310(a)(6)(H), formerly Part 2051.55(e)(10)(A) for improper denial and subsequent underpayment of the claims in the amount of $1104.06. According to the referenced regulation where an insured has made a good faith effort to use the services of a contracted provider and there is insufficient access to such provider(s), it is the insurer's 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 payment on all amounts due prior to completion of the examination including any interest due to late payment.

VI. APPENDICES

None.

STATE OF ILLINOIS)
) ss
COUNTY OF COOK)

David Bradbury, 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 Coventry Health and Life Insurance Company, NAIC # 81973, (the "Company") of Wilmington, Delaware,

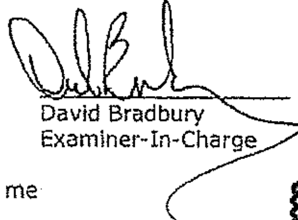
That, as Examiner-In-Charge, he was directed to make a full and true report to the Director of the examination with a full statement of the condition and operation of the business and affairs of the Company with any other information as shall in the opinion of the Examiner-In-Charge be requisite to furnish 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 he nor any other persons designated as examiners 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 policyholders, and that neither he nor any other persons designated as examiners 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 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.



David Bradbury
Examiner-In-Charge

Subscribed and sworn to before me
this 7th day of July, 2011.

Notary Public

IN THE MATTER OF:
COVENTRY HEALTH AND LIFE INSURANCE COMPANY
NAIC # 81973
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, Coventry Health and Life Insurance Company ("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, 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; 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; and

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 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 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 paying all claims and indemnities concerning health care services other than for any periodic payment within 30 days after receipt of due written proof of such loss as required by 215 ILCS 5/368a(c).

2. 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).

3. 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).

4. 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).

5. Institute and maintain procedures whereby the Company ensures the policy forms used by the Company comply with the creditable coverage provisions of 215 ILCS 97/20.

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

7. Institute and maintain procedures whereby the Company ensures the policy forms used by the Company include coverage for Organ Transplantation Procedure as required by 215 ILCS 5/356k.

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

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

10. 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.

11. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above ten (10) Orders within 30 days of receipt of this Stipulation and Consent Order.

12. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $50,000 to be paid within 30 days of the execution of this Stipulation and Consent Order.

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 AND LIFE INSURANCE COMPANY:

____
Signature

Frank D'Antonio
Name

President
Title

Subscribed and sworn to before me this
10th day of July A.D. 2013.

Marta Anderson
Notary Public

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE July 25, 2013

Andrew Boron

Andrew Boron
Director