Illinois Department of Insurance

JB PRITZKER
Governor

KEVIN FRY
Acting Director

VIA ELECTRONIC MAIL
VIA USPS

February 15, 2019

Mr. John Snyder
President
Health Alliance Medical Plans, Inc.
3310 Fields South Drive
Champaign, IL 61822

Re: Health Alliance Medical Plans, Inc., NAIC 77950
Market Conduct Examination Report Closing Letter

Dear Mr. Snyder:

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 and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Assistant Deputy Director - Market Conduct
Illinois Department of Insurance
320 West Washington St., 5th Floor
Springfield, IL 62767
Phone: 217-782-1790
E-mail: Erica.Weyhenmeyer@Illinois.gov

ILLINOIS DEPARTMENT OF INSURANCE
MENTAL HEALTH PARITY MARKET CONDUCT EXAMINATION OF

HEALTH ALLIANCE MEDICAL PLANS, INC.

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	April 16, 2018 through August 22, 2018
EXAMINATION OF:	Health Alliance Medical Plans, Inc. (NAIC #77950)
LOCATION:	3310 Fields South Drive Champaign, IL 61822
PERIOD COVERED BY EXAMINATION:	January 1, 2017 through December 31, 2017
EXAMINERS:	Victor M. Negron, CIE, FLMI, MCM, Examiner-in-Charge Michael Currier, MCM Ryan Gillespie, CIE, MCM Timothy D. Kelley, CIE, MCM, JD

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I. SUMMARY

A targeted market conduct examination of Health Alliance Medical Plans, Inc. was performed to determine compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Illinois statutes, and the Illinois Administrative Code.

The following represents general findings, however specific details are found in each section of the report.

TABLE OF VIOLATIONS

Crit #	Statute/Rule	Description of Violations	Findings Section	Population	Files Reviewed	Number of Violations	Error %
1	215 ILCS 134/45(c)	Appeals - The Company failed to render a decision on an appeal within 15 business days after receipt of the required information.	E.	42	13	1	8%
2	50 Ill. Adm. Code 919.50(a)(1)	Claims (Mental Health/Substance Use Disorder ("MH/SUD") Denied – Outpatient/Out-of-network) The Company failed to provide the insured with a reasonable written explanation for a claim denial.	D.10.	21	21	7	33%
3	215 ILCS 5/368a(c)	Claims (MH/SUD Paid – Outpatient/In-network) The Company incorrectly assessed a deductible, resulting in an underpayment of $69.46.	D.4.	8,209	103	1	1%
4	215 ILCS 5/368a(c)	Claims (MH/SUD Paid – ER) The Company incorrectly calculated the member's in-network out of pocket maximum, resulting in an underpayment of $250.00.	D.1.	145	10	1	10%
5	215 ILCS 5/368a(c)	Claims (Medical/Surgical Denied – Outpatient/In-network) The Company incorrectly denied the member's in-network benefit for a routine adult eye exam, resulting in an underpayment of $147.43.	D.19.	4,610	89	1	1%
6	215 ILCS 5/368a(c)	Claims (Medical/Surgical Denied – Outpatient/In-network) The Company incorrectly denied the member's in-network benefit for late filing, as the claim was submitted to the Company within the required 90 days.	D.19.	4,610	89	1	1%

TABLE OF VIOLATIONS							
Crit #	Statute/Rule	Description of Violations	Findings Section	Population	Files Reviewed	Number of Violations	Error %
7	215 ILCS 5/368a(c)	Claims (Additional Sample MH/SUD – Admissions/ Readmissions.) The Company incorrectly denied the member for two (2) separately claimed days of inpatient care (out-of-network) based upon lack of preauthorization, even though the member was already admitted for inpatient services for 19 days with prior approval on file.	D.22.	34	34	2	6%

II. BACKGROUND

Health Alliance Medical Plans, Inc. ("Company") is domiciled in Urbana, IL. The Company was founded in 1989 and is a wholly owned subsidiary of Carle Holding Company, which is wholly owned by CHA Holding, Inc. ("CHA"), a taxable, not for profit subsidiary of The Carle Foundation ("Foundation"). CHA is also the sole member of Health Alliance Connect, Inc., an Illinois taxable, not-for-profit corporation operating as an Health Maintenance Organization ("HMO"). The Foundation is also the sole member of the Carle Foundation Hospital, an acute care inpatient facility, and the Carle Physician Group. Both the Carle Foundation Hospital and Carle Physician Group are included in the Health Alliance provider network.

The Company writes accident and health insurance policies as defined in Section 4 of the Illinois Insurance Code. It operates primarily as a licensed HMO in the state of Illinois. The Company is a provider-sponsored, for-profit health insurance company that offers a wide range of flexible benefit options to fully insured, self-funded employer groups and individuals in the states of Illinois, Iowa, Nebraska and Washington.

The Company's corporate offices are located at 301 South Vine, Urbana, IL 61801.

Year	Total Written Premium in Illinois (Per Schedule T of the Annual Statement)	Illinois Market Share
2017	$1,212,174,300	6%

III. METHODOLOGY

The market conduct examination places emphasis on a company's systems and procedures used in dealing with insureds and claimants. The period under review was January 1, 2017 through December 31, 2017. The following were the general areas examined:

A. Operations and Management
B. Complaint Handling
C. Marketing and Sales
D. Claims
E. Appeals
F. Utilization Review
G. External Review
H. Pharmacy Review
I. Mental Health Parity Review

The review of these categories was accomplished through examination of claim files, Company procedures, written interrogatories, and interviews with the Company's personnel. Each area was examined for compliance with Illinois Department of Insurance rules and regulations, and applicable state and federal health insurance laws as they relate to policies written by the Company in the state of Illinois during the scope period.

Criticisms were provided to the Company addressing violations discovered in the review process. All valid criticisms were incorporated into this report.

The following methods were used to obtain the required samples and to assure a statistically accurate and methodical selection. The samples were developed from Company-generated data. The sample size was based on the most recent NAIC *Market Regulation Handbook* guidelines. Random samples were generated using Audit Command Language software and the selected samples were provided to the Company for retrieval.

A. Operations and Management

The review of the Company's Operations and Management is designed to determine how the Company operates. Examiners reviewed both publicly available documents, such as prior market conduct examinations and annual statements, and internal documents, such as the Company's policies, procedures, third party administrator ("TPA") agreements, internal and external audits. The review of these documents focused on compliance with MHPAEA requirements.

B. Complaint Handling

The Company was requested to provide files relating to complaints, which had been received via the Department as well as those received directly by the Company from the insured or his/her representative. The Company classifies all grievances as complaints, therefore the review of grievances was completed within the Complaints Handling section. In addition, provider complaints were also reviewed. The review of these files focused on compliance with MHPAEA requirements.

C. Marketing and Sales

The Marketing and Sales portion of the examination is designed to evaluate the representations made by the Company about its products and services to consumers. Items requested for this category consisted of all sales and advertising materials used during the examination period. The materials were reviewed for compliance with applicable MHPAEA requirements.

D. Claims

Paid and denied claims samples were selected based on settlements occurring within the examination period and reviewed for compliance with policy contracts and applicable sections of the Illinois Insurance Code (215 ILCS 5/1 et seq.) and the Illinois Administrative Code (50 Ill. Adm. Code 101 et seq.) and compliance with applicable MHPAEA requirements. The samples were divided into the following classifications: Inpatient/In-network, Outpatient/In-network, Inpatient/Out-of-network, Outpatient/Out-of-network, and ER. An additional sample for MH/SUD claims involving Admissions/Readmissions was also reviewed.

E. Appeals

The Company was requested to provide its written appeals policies and procedures as well as a list of all appeals received during the scope period. The review of these documents focused on compliance with MHPAEA requirements.

F. Utilization Review

The Company was requested to provide its written utilization review policies and procedures and a list of all utilization reviews performed during the scope period. The materials and a sample of utilization reviews were reviewed. The review of these documents focused on compliance with MHPAEA requirements.

G. External Review

The Company was requested to provide its written external review policies and procedures and a list of all external reviews performed during the scope period. The review of these documents focused on compliance with MHPAEA requirements.

H. Pharmacy Review

The Pharmacy Review portion of the examination is designed to evaluate the Company's practices in applying drug classifications, restrictions, and requirements. The following documents were reviewed to ensure compliance with applicable MHPAEA requirements.

- Essential Health Benefit Drug Count Tool results;
- Clinical Appropriateness Tool results;
- Treatment Protocol Calculator results;
- Formulary Outlier Review results;
- Drug formularies;
- Medical/surgical policies;
- Mental health/substance use disorder policies;
- Medical/surgical and MH/SUD Pharmacy and Therapeutics ("P&T") notes; and
- A summary of changes made during the examination period.

The review also included a sample review of paid and denied pharmacy claims. These were reviewed for compliance with policy contracts and applicable sections of the Illinois Insurance Code (215 ILCS 5/1 et seq.), the Illinois Administrative Code (50 Ill. Adm. Code 101 et seq.) and compliance with applicable MHPAEA requirements. The samples were divided into the following types: mental health, and all other medical/surgical claims.

I. Mental Health Parity Review

The purpose of this review was to verify compliance with MHPAEA, Illinois Department of Insurance rules and regulations, and applicable state and federal laws. MHPAEA requires that group health plans and health insurance issuers that provide coverage for mental health and substance use disorder benefits shall not impose benefit limitations on MH/SUD benefits that are less favorable than those imposed on medical/surgical benefits. The review included verification that the Company was not applying any financial requirement or quantitative treatment limitation on MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation ("QTL") of that type applied to substantially all medical/surgical benefits in the same classification.

The review also included verification that the Company was not imposing a non-quantitative treatment limitation ("NQTL") with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification.

In addition, the review included verification that the Company was not applying any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.

The review of the Company's marketing and plan documents was performed to determine parity between Mental Health and Substance Use Disorder and Medical/Surgical benefits. The reviews were based upon member enrollment by Plan Marketing Name for calendar year 2017 (31 total plans). The examination included, but was not limited to, a review of the following:

- Member policies;
- Actuarial analysis of plans;
- Plan and Benefits Templates;
- Descriptions of Coverage;
- Summary of Benefits and Coverage;
- Advertising;
- Utilization review policies and procedures;
- Quality & medical management program;
- Inpatient medical necessity review process;
- Medical/surgical policies vs MH/SUD policies;
- Medical/surgical, MH/SUD Pharmacy and Therapeutics (P&T) Notes;
- Inpatient rehabilitation admission criteria;
- Map of medical/surgical and MH/SUD services;
- Medical necessity guidelines (InterQual); and
- Outpatient preauthorization benefit listing

IV. SELECTION OF SAMPLES

Survey	Population	# Reviewed	% Reviewed
Operations and Management			
Internal/External Audits	32	16	50%
TPA Agreements	17	6	35%
Complaint Handling			
Department of Insurance Complaints	3	3	100%
Consumer Complaints	49	15	31%
Provider Complaints	209	66	32%
Marketing and Sales			
Advertising Materials	5	5	100%
Claims			
MH/SUD Claims Paid – ER	145	10	7%
MH/SUD Claims Paid – Inpatient/In-network	207	10	5%
MH/SUD Claims Paid – Inpatient/Out-of-network	29	10	34%
MH/SUD Claims Paid – Outpatient/In-network	8,209	103	1%
MH/SUD Claims Paid – Outpatient/Out-of-network	122	10	8%
MH/SUD Claims Denied – ER	1	1	100%
MH/SUD Claims Denied – Inpatient/In-network	3	3	100%
MH/SUD Claims Denied – Inpatient/Out-of-network	12	12	100%
MH/SUD Claims Denied – Outpatient/In-network	158	43	27%
MH/SUD Claims Denied – Outpatient/Out-of-network	21	21	100%
Medical/Surgical Claims Paid – ER	1,513	10	1%
Medical/Surgical Claims Paid – Inpatient/In-network	592	10	2%
Medical/Surgical Claims Paid – Inpatient/Out-of-network	6	6	100%
Medical/Surgical Claims Paid – Outpatient/In-network	108,920	177	<1%
Medical/Surgical Claims Paid – Outpatient/Out-of-	1,919	10	1%
Medical/Surgical Claims Denied – ER	75	10	13%
Medical/Surgical Claims Denied – Inpatient/In-network	39	10	26%
Medical/Surgical Claims Denied – Inpatient/Out-of-	28	10	36%
Medical/Surgical Claims Denied – Outpatient/In-network	4,610	89	2%
Medical/Surgical Claims Denied – Outpatient/Out-of-	838	16	2%
Additional Claims Sample – Colonoscopy/Pathology	45	45	100%
Additional Sample – MH/SUD –	34	34	100%

Survey	Population	# Reviewed	% Reviewed
Appeals			
Appeals	42	13	31%
Utilization Review			
Utilization Review	87	27	31%
External Review			
External Review	14	10	71%
Pharmacy Review			
MH/SUD Pharmacy Paid Claims	26,571	92	<1%
Medical/Surgical Pharmacy Paid Claims	108,581	92	<1%
MH/SUD Pharmacy Denied Claims	5,555	55	1%
Medical/Surgical Pharmacy Denied Claims	24,581	54	<1%

V. FINDINGS

A. Operations and Management

1. Internal/External Audits

   No violations were noted.

2. TPA Agreements

   No violations were noted.

B. Complaint Handling

1. Department of Insurance Complaints

   No violations were noted.

2. Consumer (Non-Department of Insurance) Complaints

   No violations were noted.

3. Provider Complaints

   No violations were noted.

C. Marketing and Sales

1. Advertising Materials

   No violations were noted.

D. Claims

1. MH/SUD Claims Paid – ER

   In one (1) instance, the Company failed to ensure the claim was properly paid as required by 215 ILCS 5/368a(c). The Company incorrectly calculated the member's in-network out of pocket maximum, resulting in an underpayment of $250.00.

2. MH/SUD Claims Paid – Inpatient/In-network

   No violations were noted.

3. MH/SUD Claims Paid – Inpatient/Out-of-network

   No violations were noted.

4. MH/SUD Claims Paid – Outpatient/In-network

   In one (1) instance, the Company failed to ensure the claim was properly paid as required by 215 ILCS 5/368a(c). A deductible was assessed in error, resulting in an underpayment of $69.46.

5. MH/SUD Claims Paid – Outpatient/Out-of-network

   No violations were noted.

6. MH/SUD Claims Denied – ER

   No violations were noted.

7. MH/SUD Claims Denied – Inpatient/In-network

   No violations were noted.

8. MH/SUD Claims Denied – Inpatient/Out-of-network

   No violations were noted.

9. MH/SUD Claims Denied – Outpatient/In-network

   No violations were noted.

10. MH/SUD Claims Denied – Outpatient/Out-of-network

    In seven (7) instances, the Company failed to provide the insured with a reasonable written explanation for a claim denial as required by 50 Ill. Adm. Code 919.50(a)(1).

11. Medical/Surgical Claims Paid – ER

    No violations were noted.

12. Medical/Surgical Claims Paid – Inpatient/In-network

    No violations were noted.

13. Medical/Surgical Claims Paid – Inpatient/Out-of-network

    No violations were noted.

14. Medical/Surgical Claims Paid – Outpatient/In-network

    No violations were noted.

15. Medical/Surgical Claims Paid – Outpatient/Out-of-network

    No violations were noted.

16. Medical/Surgical Claims Denied – ER

    No violations were noted.

17. Medical/Surgical Claims Denied – Inpatient/In-network

    No violations were noted.

18. Medical/Surgical Claims Denied – Inpatient/Out-of-network

    No violations were noted.

19. Medical/Surgical Claims Denied – Outpatient/In-network

    In one (1) instance, the Company failed to ensure the claim was properly paid as required by 215 ILCS 5/368a(c). The Company incorrectly denied the member's in-network benefit for a routine adult eye exam, resulting in an underpayment of $147.43.

    In one (1) instance, the Company failed to ensure the claim was properly paid as required by 215 ILCS 5/368a(c). The Company denied the member's in-network benefit due to late filing; however, the claim was submitted to the Company within the required 90 days. This error resulted in an underpayment of $117.00.

20. Medical/Surgical Claims Denied – Outpatient/Out-of-network

    No violations were noted.

21. Additional Claims Sample – Colonoscopy/Pathology Services

    No violations were noted.

22. Additional Sample – MH/SUD –Admissions/Readmissions

    In two (2) instances, the Company failed to ensure a claim was properly paid as required by 215 ILCS 5/368a(c). The Company incorrectly denied two (2) separately claimed days of inpatient care (out-of-network) payments based upon lack of preauthorization, even though the member was already admitted for inpatient services for 19 days with prior approval on file. These errors resulted in underpayments totaling $1,620.50.

E. Appeals

In one (1) instance, the Company failed to render a decision on an appeal within 15 business days after receipt of all necessary information as required by 215 ILCS 134/45(c).

F. Utilization Review

No violations were noted.

G. External Review

No violations were noted.

H. Pharmacy Review

1. MH/SUD Pharmacy Paid Claims

   No violations were noted.

2. Medical/Surgical Pharmacy Paid Claims

   No violations were noted.

3. MH/SUD Pharmacy Denied Claims

   No violations were noted.

4. Medical/Surgical Pharmacy Paid Claims

   No violations were noted.

5. Pharmacy Parity Review

   No violations were noted.

I. Mental Health Parity Review

No violations were found.

STATE OF FLORIDA)
) ss
COUNTY OF MARION)

Victor M. Negron, 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 Health Alliance Medical Plans, Inc. (the "Company"), NAIC #77950.

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 28 day of June, 2018.

Notary Public

Marcie Sanders
State of Florida
My Commission Expires 02/26/2021
Commission No. GG 159223

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HEALTH ALLIANCE MEDICAL PLANS, INC.
301 SOUTH VINE STREET
URBANA, IL 61801-3347

STIPULATION AND CONSENT ORDER

WHEREAS, the 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. ("the Company"), NAIC 77950, 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 a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

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

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and related rules and statutes; 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 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 understands and agrees 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. 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 shall render a decision on appeals within 15 business days and notify all parties involved in the appeal of its decision as required by 215 ILCS 134/45(c).

2. Institute and maintain policies and procedures whereby the Company shall provide a "Notice of Availability of the Department of Insurance" on denied claims as required by 50 Ill. Adm. Code 919.50(a)(1).

3. Institute and maintain policies and procedures whereby the Company shall pay interest on health claims paid beyond 30 days of receipt of written proof of the loss as required by 215 ILCS 5/368a(c).

4. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above three (3) orders within 30 days of execution of this Order.

5. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $2,000.00 to be paid within 30 days of execution of this 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 HEALTH ALLIANCE MEDICAL PLANS, INC.

Signature

John M. Snyder

Name

CEO

Title

Subscribed and sworn to before me this
14 day of January 2019.

Notary Public

OFFICIAL SEAL
AMANDA BRYAN
Notary Public - State of Illinois
My Commission Expires 9/08/2021

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 1/22/19

Karin Zosel
Acting Director