Illinois Department of Insurance

JB Pritzker
Governor

Robert H. Muriel
Director

VIA ELECTRONIC MAIL
VIA USPS CERTIFIED MAIL

July 14, 2020

Ms. Deborah M. Johnson
Vice President, Compliance
Celtic Insurance Company
77 West Wacker Drive, Suite 1500
Chicago, IL 60601

Re: Celtic Insurance Company, NAIC 80799
Market Conduct Examination Report Closing Letter

Dear Ms. Johnson:

The Department has received your Company's proof of compliance. 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
Chief Market Conduct Examiner
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 REPORT OF

CELTIC INSURANCE COMPANY

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	February 5, 2018 through July 28, 2018
EXAMINATION OF:	Celtic Insurance Company NAIC #80799
LOCATION:	77 West Wacker Drive Chicago, IL 60601
PERIOD COVERED BY EXAMINATION:	December 1, 2016 through November 30, 2017
EXAMINERS:	Lucinda Woods Linda Miller Art Kusserow Bithia Anderson André J. Mumper-Ham, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner

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I. SUMMARY

A targeted mental health parity market conduct examination of Celtic Insurance Company (hereinafter referred to as the "Company" or "Celtic") was performed to determine compliance with Illinois statutes and the Illinois Administrative Code. The line of business reviewed was individual health.

The following table represents general findings, with specific details in each section of the report.

Table of Total Violations

Criticism Number	Statute/Rule	Description of Violations	Files Reviewed	No. of Violations	Error %
01 – Mental Health Parity	215 ILCS 5/370c.1(a)(1) and (e), 45 CFR 146.136(c)(2)(i), 29 CFR 2590.712(c)(2)(i) and ACA § 1563/PHSA § 2726	Failure to be compliant with MHPAEA by failing to perform substantially all / predominant cost-sharing tests before plans were issued in 2016 and 2017.	N/A	N/A	
02-Mental Health Parity	215 ILCS 5/370c.1(a)(1), 45 CFR 146.136(c)(2)(i), 29 CFR 2590.712(c)(2)(i) and ACA § 1563/PHSA § 2726	Failed to be compliant with MHPAEA. The Company was non-compliant with cost sharing for one (1) plan in 2017.	N/A	N/A	
03-Utilization Review	215 ILCS 5/154.6(b)	Failed to notify the insured of the utilization review determination. The Company failed to acknowledge with reasonable promptness pertinent communications.	113	15	13.3%
04-Individual Health Denied Claims	215 ILCS 5/368a(c)	Failed to pay interest on health claims paid beyond 30 days of receipt of written proof of the loss.	108	13	12.0%
05-Individual Health Paid Claims	215 ILCS 5/368a(c)	Failed to pay interest on health claims paid beyond 30 days of receipt of written proof of the loss.	108	20	18.5%

II. BACKGROUND

Celtic Insurance Company - NAIC #80799

In 1980, Celtic Group, Inc. (CGI) formed a 50/50 partnership named Celtic Investment Group (CIG) with Celtic Associates to purchase an 80% stake in Resolute Investment Corp (RIC), which included America Reserve Life Insurance Company (ARLIC). ARLIC was renamed as Celtic Life Insurance Company.

Then, in 1990, Celtic Life Insurance Company changed its domicile state from Rhode Island to Illinois. In 1999, Celtic Life Insurance Company changed its name to Celtic Insurance Company. On July 1, 2008, Centene Corporation purchased Celtic Group, Inc., the parent company of Celtic Insurance Company.

Celtic currently sells health insurance on the Illinois marketplace exchange under the name Ambetter Insured by Celtic. Centene Corporation also provides Medicare-Medicaid services in Illinois under the name IlliniCare Health.

The Company's 2017 NAIC Annual Statement, Page 24 (Illinois), reflects the following information for accident and health:

Line	Direct Premiums Written	Direct Premiums Earned	Direct Losses Incurred
24. Accident and Health	$82,506,623	$82,513,612	$60,671,224

III. METHODOLOGY

The market conduct examination process places emphasis on an insurer's systems and procedures used in dealing with insureds and claimants. The individual health business was reviewed in this examination.

The scope of this examination focused on a review of mental health and substance use disorder operations including the following areas:

A. Company Operations and Management
B. Complaints
C. Appeals
D. Grievances
E. Underwriting
F. Utilization Reviews
G. Claims
H. Mental Health Parity

The review of these categories was accomplished through examination of material related to the Company's operations and management, complaint files, appeals, grievances and claim files, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, interrogatories, and criticisms. Each of the categories listed above was examined for compliance with Illinois statutes and the Illinois Administrative Code, as well as federal statutes and rules related to the Mental Health Parity and Addiction Equity Act of 2008.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third party vendors, internal audits, certificate of authority, previous market conduct examinations, and annual statements. There were no exceptions noted.

Complaints

The Company was requested to identify mental health and substance use disorder consumer and Illinois Department of Insurance complaints received during the examination period and to provide copies of the complaint logs. There were no exceptions noted.

Appeals

The Company was requested to identify and provide all mental health and substance use disorder appeals for the examination period.

Grievances

The Company was requested to identify and provide all mental health and substance use disorder grievances for the examination period. There were no exceptions noted.

Underwriting

The Company was requested to provide a sample individual accident and health policy including all disclosures for a policy written in Illinois. There were no exceptions noted.

Utilization Reviews

The Company was requested to identify all utilization reviews for the period of June 1, 2016 through November 30, 2017. The Company identified the universe of mental health and substance use disorder utilization reviews. Random samples of the files were made by the examiners and submitted to the Company.

Claims

The Company was requested to provide a list of all claims during the examination period, to include paid and denied. The Company identified the universe of mental health and substance use disorder claims. Random samples of the files were made by the examiners and submitted to the Company. The files and responses to information requests and interrogatories were reviewed to ensure the claims were processed in compliance with the policy, Illinois statutes, the Illinois Administrative Code, and the Mental Health Parity and Addiction Equity Act of 2008 and related regulations.

Mental Health Parity

The Company was requested to provide the mental health parity testing of its health plans and the benefit classifications for medical/surgical and mental health and substance use disorder categories. The benefits, as classified accordingly, were evaluated for Quantitative Treatment Limits (QTL) or Non-Quantitative Treatment Limits (NQTL) compliance. Also, the Company was requested to identify and provide all pharmacy policies and procedures used during the experience period for mental health and substance use disorder (MHSUD) requirements. In accordance with the requirements of the examination, the data and responses to follow up information requests were reviewed. The parity analyses, pharmacy documentation, and responses to follow up information requests and interrogatories were reviewed for compliance with Illinois statutes, the Illinois Administrative Code, as well as the Mental Health Parity Addiction Equity Act (MHPAEA) and Affordable Care Act (ACA) statutes and regulations.

IV. SELECTION OF SAMPLES

Survey	Population	Number Reviewed	Percentage Reviewed
Complaints			
Consumer Complaint – ILDOI	0	0	0%
Consumer Complaints – Received by the Company	16	16	100%
Appeals			
Appeals – Consumer	8	8	100%
Grievance Reviews			
Grievance Consumer	12	12	100%
Utilization Reviews			
Individual Health	526	113	21%
Claims			
Individual Health – Paid	2,539	108	4%
Individual Health – Denied	2,820	108	3.8%
Pharmacy – Paid	29,951	109	<1%
Pharmacy – Denied	7,906	109	1.3%

V. FINDINGS

A. COMPLAINTS

1. Department of Insurance Consumer Complaints

There were no criticisms in the Department of Insurance consumer complaints survey.

2. Consumer Complaints Received Directly by the Company

There were no criticisms in the consumer complaints survey.

B. APPEALS

There were no criticisms in the appeals survey.

C. GRIEVANCES

There were no criticisms in the grievance survey.

D. UNDERWRITING

There were no criticisms in the underwriting survey.

E. UTILIZATION REVIEWS

In 15 instances of the 113 mental health utilization review files reviewed, for an error percentage of 13.27%, the Company failed to notify the insured of the Company decision to approve or not approve the service for which a claim was made. The Company failed to provide the decision with reasonable promptness in response to pertinent communications with respect to claims arising under its policies. This is in violation of 215 ILCS 5/154.6(b).

F. CLAIMS

1. Individual Mental Health/Substance Use Disorder – Paid

In 20 instances of the 108 mental health paid claims review files reviewed, for an error percentage of 18.5%, the Company failed to address coding issues that resulted in an inaccurate denial and failed to pay interest on health claims paid beyond 30 days of receipt of written proof of loss. This is in violation of 215 ILCS 5/368a(c).

2. Individual Mental Health/Substance Use Disorder – Denied

In 13 instances of the 108 mental health denied claims review files reviewed, for an error percentage of 12%, the Company failed to address coding issues that resulted in an inaccurate denial and failed to pay interest on health claims paid beyond 30 days of receipt of written proof of loss. This is in violation of 215 ILCS 5/368a(c).

3. Pharmacy – Paid

There were no criticisms in the pharmacy paid survey.

4. Pharmacy – Denied

There were no criticisms in the pharmacy denied survey.

G. MENTAL HEALTH PARITY

1. Substantially All/Predominant Cost-Sharing Testing

The Mental Health Parity and Equity Addiction Act generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits are no more restrictive than those for medical or surgical benefits. This is commonly referred to as providing mental health/substance use disorder benefits in parity with medical/surgical benefits. Companies assess compliance by utilizing predominant and substantially all tests to determine if they are in parity. During the examination, the Company was requested to provide the parity testing for the nine (9) health plans issued in 2016 and ten (10) health plans issued in 2017. Prior to our request for the substantially all/predominant cost-sharing test, the Company had never performed testing. It was determined during the examination review that they were not in compliance with one plan.

For Ambetter Balanced Care 3, the plan inpatient stays are subject to copay, but professional services provided during the stay are subject to coinsurance. The coinsurance applied to professional services during the stay did not satisfy the "substantially all" test for using coinsurance in the inpatient classification and is not allowed for any patient behavioral care (including professional, facility, or other fees).

Additionally, ambulance services are subject to coinsurance, while emergency room services are subject to copay. Ambulance services could either be classified as part of the inpatient benefit classification, or as part of the emergency benefit classification,

but in either case the coinsurance does not pass the "substantially all" test and is not allowed for behavioral use of ambulance services.

The Company failed to be compliant with cost sharing for one (1) plan in 2017. This is in violation of 215 ILCS 5/370c.1(a)(1), 45 CFR 146.136(c)(2)(i), 29 CFR 2590.712(c)(2)(i) and ACA § 1563/PHSA § 2726.

2. Review of Associated Mental Health and Substance Use Disorder Files

A listing was compiled from the universes of claimants with multiple health and pharmacy claims, utilization reviews, appeals and complaints. From this listing, three (3) top claimants were selected for a high-level review of the process and procedures involved in adjudicating the various submissions for each of these subscribers in order to receive the benefits of the health plan.

An adult dependent of the subscriber was diagnosed with chronic post-traumatic stress disorder and opioid dependence. The dependent's 35 claims were reviewed. Of those claims, 32 were submitted for in-network therapy office visits and 32 claims were appropriately paid in a timely manner with no restrictions. Three (3) claims submitted for out-of-network office visits were appropriately denied. One (1) utilization review file was reviewed and approved outpatient. All these associated mental health claims were treated in parity and were no more restrictive than the handling of medical claims.

A child dependent (17 years old) of the subscriber was diagnosed with major depression. The dependent's 39 out-of-network claims were reviewed for office therapy visits and counseling. All claims were appropriately denied due to the provider not included as participating with the HMO/EPO policy. All these associated mental health claims were handled no more restrictively than the handling of medical claims.

An adult subscriber was diagnosed with anxiety disorder with major depression. The subscriber's 42 claims were reviewed. All were submitted for in-network 60 minute therapy visits and all 42 claims were appropriately paid in a timely manner with no restrictions. All these associated mental health claims were treated in parity and were handled no more restrictively than the handling of medical claims.

VI. INTERRELATED FINDINGS

Interrelated Finding #1

In two (2) instances of the 180 associated claim files, the Company applied an incorrect copay amount. The Company applied a $1.00 copay amount to both claims instead of the correct copay amount of $20.00. This error was to the members' benefit and no further action on the part of the Company is required.

Interrelated Finding #2

The Company was requested to provide a reason why the claims amount eligible for coverage was different for claims reviewed for the same procedure code of 90837. Each of these files contains eligible coverage amounts in excess of the amount required by the Company's filed rating plan. The Company stated "After research it has been determined that the claims that paid the higher rate paid incorrectly from the Medicaid fee schedule. Current claims are paying the correct rate which is the lower rate". This error resulted in an over payment to the member and no further action by the Company is required.

Interrelated Finding #3

The Company had claims that contained a denial reason of "Claim was not submitted within the required time frame." However, it was determined that all of these claims were submitted within a one-year time frame. In the Evidence of Coverage Contract under the claims section, on page 54 it states for Proof of Loss "you or your covered dependent member must give us written proof of loss within 90 days of the loss or as soon as is reasonably possible. Proof of loss furnished more than one year late will not be accepted, unless you or your covered dependent member had no legal capacity in that year."

The Company was requested to provide an explanation as to how the Company determined that the claims were subject to a denial based on the Company notice of claim and proof of loss statement. The Company stated, "Provider timely is determined by provider status and state, for IL it is 180 days for par and 90 days for no-par when considering 1st timely. Provider Status includes: IP-par provider, NP-non par provider and CF-credentialing accepting fees provider (this is a non-par provider who is in the process of becoming a par provider). A date of service (DOS) and the received date are entered into a calculator to see if the provider has met our timely guidelines. Please refer to the attached Timely Filing Guideline for reference.

The Evidence of Coverage or any other document does not have filed and approved language that defines "as soon as reasonably possible". The Proof of Loss language expands the notice of claim timeframe to 1 year 90 days from date of loss or unlimited timeframe for member or dependents that had no legal capacity. The member has the right to submit an appeal for claims

denied as untimely. A determination of as soon as reasonably possible should be determined during the appeal review."

Based on the Company's response it is clear that specific timeframes are used in determining if a claim is paid or denied. The Company maintains that the member has the right to submit an appeal to dispute the denial. This is not stated in the Evidence of Coverage Contract. The term "as soon as is reasonably possible" can mean as many as 365 days depending on each individual's interpretation. The Company needs to revise the proof of loss timeframes in the contract to be more specific.

The Company's response to Interrelated Finding #3 is as follows, "The Company acknowledges the concerns of Interrelated Finding #003. The language in the 2019 Evidence of Coverage will be revised to state the proof of loss timeframes of 180 days for in network providers and 90 days for non-network providers. This language will be submitted to the state for approval."

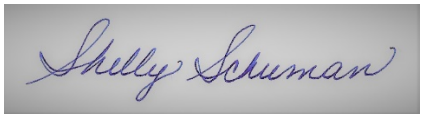
EXAMINATION DRAFT REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Lucinda Woods
Linda Miller
Art Kusserow
Bithia Anderson
André J. Mumper-Ham, Examiner-in-Charge
Shelly Schuman, Supervising Examiner

Respectfully submitted,

André J. Mumper-Ham
ANDRÉ J. MUMPER-HAM
EXAMINER-IN-CHARGE



SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF PENNSYLVANIA)
) ss
COUNTY OF YORK)

André J. Mumper-Ham, 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 Celtic Insurance Company NAIC 80799.

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

That neither the Examiner-In-Charge nor any other persons so designated nor any members of their immediate families is an officer of, connected with, or financially interested in the Companies nor any of the Companies' affiliates other than as a policyholder or claimant under a policy or as an owner of shares in a regulated diversified investment 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 Companies 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 Companies for the period covered by the Report as determined by the examiners;

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

André J. Mumper-Ham
Examiner-In-Charge

Subscribed and sworn to before me
this 17 day of August, 2018

Andrea Samples
Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
ANDREA SAMPLES, Notary Public
York, York County
My Commission Expires September 17, 2018

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

CELTIC INSURANCE COMPANY
77 WEST WACKER DRIVE
CHICAGO, IL 60601

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, Celtic Insurance Company ("the Company"), NAIC 80799, 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 policies and procedures whereby the Company shall perform substantially all / predominant cost-sharing tests before plans are issued as required by 215 ILCS 5/370c.1(a)(1) and (e), 45 CFR 146.136(c)(2)(i), 29 CFR 2590.712(c)(2)(i) and ACA § 1563/PHSA § 2726.

2. Institute and maintain policies and procedures whereby the Company shall not issue plans that are not compliant with cost sharing as required by 215 ILCS 5/370c.1(a)(1), 45 CFR 146.136(c)(2)(i), 29 CFR 2590.712(c)(2)(i) and ACA § 1563/PHSA § 2726.

3. Institute and maintain policies and procedures whereby the Company shall acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies as required by 215 ILCS 5/154.6(b).

4. 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).

5. Submit to the Director of Insurance, State of Illinois, proof of compliance with the above five (5) orders within 30 days of execution of this Order.

6. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $207,750.00 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 CELTIC INSURANCE COMPANY

Signature

Anand Shukla
Name

Chief Executive Officer
Title

Subscribed and sworn to before me this
17th day of January ~~2018~~. 2019

Pedro Galvan
Notary Public

OFFICIAL SEAL
PEDRO GALVAN
NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES:12/23/19

DEPARTMENT OF INSURANCE of the
State of Illinois:

DATE 01/28/19

~~Karin Tilly Zosel~~
Acting Director