

**MARKET CONDUCT EXAMINATION REPORT  
PROMPT PAY**

**of**

**COVENTRY HEALTH AND LIFE INSURANCE COMPANY**

**as of**

**June 30, 2006**

I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

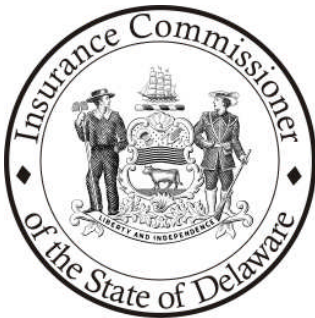
**COVENTRY HEALTH AND LIFE INSURANCE COMPANY**

is a true and correct copy of the document filed with this Department.

ATTEST BY:

*Annette Handy*

DATE: 15 MAY 2008



*In Witness Whereof,* I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 15TH DAY OF MAY 2008.

*Matthew Denn*

*Insurance Commissioner*

**REPORT ON MARKET CONDUCT EXAMINATION**  
OF THE  
**COVENTRY HEALTH AND LIFE INSURANCE COMPANY**  
AS OF  
**JUNE 30, 2006**

The above captioned Report was completed by examiners of the Delaware Insurance Department.

Consideration has duly been given to the comments, conclusions, and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted, and filed as an official record of this Department.

A handwritten signature in black ink, appearing to read "Matt Denn", written over a horizontal line.

MATTHEW DENN  
INSURANCE COMMISSIONER

DATED this 15TH day of MAY, 2008.

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May 8, 2007

Honorable Matthew Denn  
Insurance Commissioner  
State of Delaware  
841 Silver Lake Boulevard  
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.724, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

**Coventry Health and Life Insurance Company**

hereinafter referred to as the “Company.” The Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

This report is as of June 30, 2006. It covers the period from January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

## **EXECUTIVE SUMMARY**

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the seven (7) examination standards authorized by Certificate of Examination Authority Number 06.724. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair, and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80].

The principal focus for this examination was compliance with the Delaware insurance laws related to prompt, fair and equitable settlement of claims for health care services. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310, the timely, fair, and equitable payment of clean claims. The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

**Prompt Payment Standards 1-7:** The examiners found eight (8) areas of concern resulting in failure of the Company to comply with Standards 1, 2, 3, 4 and 6. The issues identified were:

- The Company definition of a clean claim does not comply with the definition of a clean claim as defined in 18 Del. Admin. Code 1310 § 4.

- In some instances the Company is denying claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7.
- In some instances, clean claims were not adjudicated within 30 calendar days of receipt, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.
- In some instances in network claims were incorrectly denied on the original submission as being out of network, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.
- In some instances properly submitted claims were incorrectly denied as being submitted to the wrong claims processor, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.
- In one instance a claim was incorrectly denied as member ineligible, when the member was actually eligible, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.
- In one instance a claim was incorrectly denied for no authorization, when an authorization was on file, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

- In some instances, claims were not adjudicated timely following the receipt of requested information, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.2.

### **HISTORY AND PROFILE**

The Company, formerly known as American Service Life Insurance Company, was acquired by the Coventry Corporation on October 1, 1987, and re-domesticated from Texas to Delaware on May 14, 1999. The Company is licensed in 34 states and the District of Columbia.

The Company does not have employees. Instead, it has administrative service agreements (ASA) with affiliate companies. Under these ASAs the affiliate health plan provides the management of Company products in a given state. In return, The Company pays a per member per month fee to the affiliate company for such services. The Company's parent is Coventry Health Care (CHC).

### **METHODOLOGY**

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC methodology.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic.



A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were measured using tests designed to adequately measure how the examinee met each standard. Each standard tested is described and the result of testing is provided under the appropriate standard. Only standards tested are shown in this report.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

The following sections are covered in a full scope market conduct examination. They are listed here to clarify that this exam was limited to the claims area only.

- A. COMPANY OPERATIONS/MANAGEMENT- not addressed on this exam**
- B. COMPLAINTS/GRIEVANCES-not addressed on this exam**
- C. MARKETING AND SALES- not addressed on this exam**
- D. NETWORK ADEQUACY- not addressed on this exam**
- E. PRODUCER LICENSING-not addressed on this exam**
- F. POLICYHOLDER SERVICE-not addressed on this exam**
- G. UNDERWRITING AND RATING-not addressed on this exam**
- H. CLAIMS**

*Comments:* The examiners reviewed six separate claims samples. Five (5) of the samples selected were random samples of specific populations and the sixth sample consisted of the entire population of claims. The six samples selected for review were as follows.

- Sample 1. One-hundred-fifteen claims from a population of 6,986 paid claims adjudicated by the Company within the examination period.
- Sample 2. One hundred-fifteen claims from a population of 1,890 denied claims adjudicated by the Company.
- Sample 3. Fifty behavioral health claims from a population of 1,619 paid claims adjudicated by United Behavioral Health (UBH) within the examination period.
- Sample 4. Fifty behavioral health claims from a population of 826 denied claims adjudicated by UBH within the examination period.
- Sample 5. Fifty radiology claims from a population of 144 paid claims adjudicated by MedSolutions (MSI) within the examination period.
- Sample 6. The entire population of Forty-eight denied radiology claims adjudicated by MSI within the examination period.

The evaluation of standards in this business area is based on Company responses to information requested by the examiners, discussions with the Company's staff, and the sample review of claim files. This portion of the examination is designed to provide a view of how the company

treats claimants and whether that treatment complies with applicable statutes, rules, and regulations.

Services provided to the insureds of the Company do not typically result in a claim by the recipient of care as is usually seen in an indemnity scenario. Claims to the Company usually arise from the provider who delivers services to an insured of the Company.

The following Standards were developed to test compliance with Delaware statutes, rules, and regulations.

#### **Prompt Payment Standard 1**

**The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.**

18 Del. Admin. Code 1310 § 4.0

*Comments:* This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" complies with 18 Del. Admin. Code 1310 § 4.0. Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, and internal communications of the Company, UBH, and MSI. The examiners also interviewed claims personnel.

*Results:* FAIL

*Observation:* The Company defines a clean claim as "A clean claim shall mean a claim that has no defect or impropriety (including lack of any required substantiating documentation) or

particular circumstance requiring special treatment that substantially prevents timely payments from being made on the claim. This means that any claim requiring information that must be obtained from an external source for correct processing makes the claim incomplete.”

The Company’s definition does not comply with the definition of a clean claim contained in 18 Del. Admin. Code 1310 § 4.0.

***Recommendations:*** It is recommended that the Company identify clean claims in a manner that complies with the definition contained in 18 Del. Admin. Code 1310 § 4.0.

## **Prompt Payment Standard 2**

**The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included.**

18 Del. Admin. Code 1310 § 4.7

*Comments:* This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7. Review methodology for this standard is generic and sample. The examiners reviewed the procedures, training manuals, internal communications, and selected claims samples of the Company, UBH, and MSI. The examiners also interviewed claims personnel.

*Results:* FAIL

*Observation:* Review of all selected samples indicated that two (2) claims out of 50 tested from Sample 4, that met the state’s definition of a clean claim, were denied with reason code 638 (Mental Health/Substance Abuse not covered. Your plan does not cover Mental Health and/ or substance abuse services when they are provided in connection with conditions not classified in the Diagnostic and Statistical Manual of the American Psychiatric Association.) However, the diagnoses listed on the claim forms were recognized and listed in the manual referenced by the Company. The claims were not processed in accordance with the requirements of 18 Del. Admin. Code 1310. No errors were revealed in Samples 1, 2, 3, 5, or 6.

***Recommendations:* It is recommended that the Company process clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.7.**

### **Prompt Payment Standard 3**

**The Company’s clean claim processing is timely and in compliance with applicable statutes, rules and regulations.**

18 Del. C. § 2304, 18 Del. Admin. Code 1310 § 6.0 and 7.0

*Comments:* This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0 et al which requires adjudication within 30 days and 18 Del. Admin. Code 1310 § 7.0, which states “Within a 36 month period, three instances of a carrier’s failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304.”

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

*Results:* FAIL

*Observation:* Review of all selected samples indicated that there were 37 errors, in which claims meeting the state's definition of a clean claim were adjudicated in an untimely manner. Those errors are outlined below:

1. Eight (8) of the 115 claims from Sample 1;
2. Twenty (20) of the 115 claims from Sample 2;
3. One (1) of the 50 claims from Sample 3;
4. Two (2) of the 50 claims from Sample 4;
5. Three (3) of the 50 claims from Sample 5; and
6. Three (3) of the 48 claims from Sample 6.

The number of non-compliant instances exceeds the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304

***Recommendations:*** It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department.

#### Prompt Payment Standard 4

**Proper payment is made on clean claims.**

18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2

*Comments:* This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

Review methodology for this standard is generic and sample.

The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

*Results:* FAIL

*Observation:* Review of the selected samples indicated seven (7) errors.

Five (5) claims out of 115 tested from Sample 1 were clean claims as defined by the state and the Company did not make proper payment.

- In one (1) instance, a claim was incorrectly denied on original submission as out of network provider when the provider was an in network provider.

- In two (2) instances, claims were incorrectly denied when submitted to the Company with directions to resubmit to MSI. These claims were out of network claims which the Company has responsibility for processing.
- In one (1) instance, a claim was denied for no authorization when an authorization was on file.
- In one (1) instance, a claim was denied as member not eligible. The Company had entered the member information in the wrong plan and the member was eligible for the services provided.

In addition, review of Sample 5 indicated that two (2) claims out of the 50 tested were clean claims as defined by the state and the Company did not make proper payment. The claims were incorrectly denied on original submission as out of network provider when the provider was an in network provider.

The above practices appear to constitute non-compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

The review of Samples 2, 3, 4, and 6 revealed no errors.



**Recommendations:** It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated accurately and according to the requirements of 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2. The Company should report to the Department its findings and any modifications to its systems and procedures implemented to assure ongoing compliance.

### Prompt Payment Standard 5

**The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.**

18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3

*Comments:* This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3.

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

*Results:* PASS

*Observation:* Review of the sample of claims indicate the Company, UBH and MSI are sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

## Prompt Payment Standard 6

**The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules.**

18 Del. Admin. Code 1310 § 6.1.4, 6.2 and 6.3

*Comments:* This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 § 6.1.4 states “if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.” 18 Del. Admin. Code 1310 § 6.2 states in part, “A carrier who requests information under this subsection shall take action... within 15 days of receiving properly requested information.” 18 Del. Admin. Code 1310 § 6.3 limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic and sample. The examiners reviewed Company, UBH, and MSI procedures and training manuals and interviewed claims personnel.

*Results:* FAIL

*Observation:* Review of all selected samples indicated 15 errors in which claims were not processed within 15 days of receipt of the information requested by the Company, resulting in

non-compliance with the requirement of 18 Del. Admin. Code 1310 § 6.2. Those 15 errors are outlined below.

1. Five (5) of the 115 claims from Sample 2;
2. Two (2) of the 50 claims from Sample 3;
3. Five (5) of the 50 claims from Sample 4;
4. One (1) of the 50 claims from Sample 5; and
5. Two (2) of the 50 claims from Sample 6

Review of Sample 1 revealed no errors.

The number of non-compliant instances exceeds the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304.

When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. If the Company receives additional information, the claim is given a new claim number and re-adjudicated based on the information received. This is considered a “soft denial.”

***Recommendations:*** It is recommended that the Company adjudicate claims timely following the receipt of requested information according to the requirements of 18 Del. Admin. Code 1310 § 6.2.

## Prompt Payment Standard 7

**The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations.**

18 Del. Admin. Code 1310 § 8.0

*Comments:* This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

*Results:* PASS

*Observation:* No interest payments on claims have been ordered to date.

### **SUMMARY**

The Company is a Delaware domiciled health insurer that provides health care coverage in the commercial market.

This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

Recommendations have been made to address the areas of concern noted during the examination.

These are summarized below.

### **LIST OF RECOMMENDATIONS**

It is recommended that the Company identify clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.0. (p.8)

It is recommended that the Company process clean claims in a manner that complies with the requirements of 18 Del. Admin. Code 1310 § 4.7. (p.9)

It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al. The Company should report its findings and modifications to its systems and procedures to assure ongoing compliance to the Department. (p.10)

It is recommended that the Company review its claims systems and procedures to ensure all claims are adjudicated accurately and according to the requirements of 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2. The Company should report to the Department its findings and any modifications to its systems and procedures implemented to assure ongoing compliance.(p.12)

It is recommended that the Company adjudicate claims timely following the receipt of requested information according to the requirements of 18 Del. Admin. Code 1310 § 6.2. (p.15)

**CONCLUSION**

The examination was conducted by the undersigned and respectfully submitted,

A handwritten signature in black ink, appearing to read "Fred R. Pappas". The signature is fluid and cursive, with a long horizontal stroke at the end.

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Market Conduct Examiner-in-Charge  
Delaware Insurance Department