

**STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
COMPLIANCE EXAMINATION  
STATUTORY DEPENDENT COVERAGE AND  
AUTISM SPECTRUM DISORDERS LEGISLATION  
OF  
HEALTH ALLIANCE MEDICAL PLANS, INC.  
MARKET CONDUCT EXAMINATION REPORT**

**MARKET CONDUCT EXAMINATION REPORT**

**DATE OF EXAMINATION:** July 20, 2009 through August 28, 2009

**EXAMINATION OF:** Health Alliance Medical Plans, Inc.

**LOCATION OF EXAMINATION:** INS Offices in Philadelphia, PA and  
Kansas City, MO

**PERIOD COVERED BY EXAMINATION:** December 12, 2008 through June 11, 2009

**EXAMINERS:** Shelly Schuman  
Dennis Shoop

## INDEX

|   | <u>Page</u> |
|---|-------------|
| <b>I. SUMMARY</b>                                       | <b>1</b>    |
| <b>II. BACKGROUND</b>                                   | <b>2</b>    |
| <b>III. COMPANY HISTORY AND ILLINOIS PREMIUM VOLUME</b> | <b>3</b>    |
| <b>IV. METHODOLOGY</b>                                  | <b>4</b>    |
| <b>V. DATA ANALYSIS</b>                                 | <b>7</b>    |
| <b>VI. FINDINGS/RECOMMENDATIONS</b>                     | <b>8</b>    |

## I. SUMMARY

1. Health Alliance Medical Plans, Inc. (the "Company") was subject to a limited scope Market Conduct Examination designed to assess compliance with two (2) pieces of legislation 215 ILCS 5/356z.14, Autism Spectrum Disorders, and 215 ILCS 5/356z.12, Dependent Coverage. The Autism Spectrum Disorder legislation was effective December 12, 2008. Its text is attached as Appendix A. The Dependent Coverage legislation was effective June 1, 2009. Its text is attached as Appendix B.

The Company was required to submit information on its underwriting practices to assess compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders.

The Company was required to submit claims information data for all group insurance and individual insurance claims received between December 12, 2008 and June 11, 2009 if an insured had at least one (1) claim for autism submitted during the examination period. Standard industry diagnostic codes commonly referred to as ICD-9 Codes (*International Classification of Diseases, ninth revision*) were used to determine what qualified as an autism claim. Claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. Submitted data was analyzed to review basic statistical information and trends related to claim payment, claim denials, additional information requests and other dispositions.

The Company was required to submit information on the steps the company had taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.12, Dependent Coverage.

It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the Company's, or any of its affiliates' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

## II. BACKGROUND

This examination reflects the Illinois insurance activities of the Company, specifically as it relates to the Company's implementation of legislation regarding coverage for individuals with autism and coverage for adult dependent children. The examination was conducted on behalf of the Illinois Department of Insurance by INS Regulatory Insurance Services, Inc. It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the Company's, or any of its affiliates,' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

### **Project Description**

A review of autism related claim information was selected from the Company utilizing ACL<sup>®</sup> software which provides a general evaluation of the payment, denial, pending and other claims handling practices related to claims under review.

### **Fields to be Collected**

The fields selected for inclusion in the data request were extracted from the NAIC *Market Regulation Handbook* Standardized Data Calls. The fields include information designed to provide a snapshot of the numbers of claims received, paid and denied during the examination period.

### **Specific Information Collected**

The Company was sent a letter with two (2) attachments requests along with an examination warrant. The first attachment to this letter was a request for data that included the fields identified for submission in the Company's data file. The second attachment was a series of interrogatories designed to extract information from the Company about its compliance with the recently enacted legislation.

### III. COMPANY HISTORY AND ILLINOIS PREMIUM VOLUME

Health Alliance Medical Plans, Inc. (Company) is the corporate successor to Carle Clinic Association, P.C., an Illinois corporation that operates as a private multi-specialty group medical practice. The Company was established in 1979 as a for-profit managed care insurance company which operates as a licensed Health Maintenance Organization in the State of Illinois. The Company also owns Health Alliance – Midwest, Inc., which offers prepaid health care services in Illinois and Iowa and Healthcare Horizons of Illinois, Inc.; the parent for HCH Administration, Inc., a provider of administrative services for employees with self funded health benefits. The Company was initially founded by physicians. The Company provides coverage for more than 250,000 individuals in Illinois and Iowa.

The Company's primary office is located in Urbana, Illinois. The Company offers a full range of health insurance products for employer groups, individuals, and Medicare beneficiaries. The Company offers individual insurance coverage, "My Health Alliance," which provides individual coverage in 69 Illinois counties and offers short-term medical options, standard PPO, qualified high deductible, PPO and HMO products. In addition, the Company also has a contract with Medicare, "Health Alliance Medicare," which is a health plan offering Medicare Advantage coverage for HMO's, PPO's and also Medicare Supplement plans.

The Company's 2008 Annual Statement reflects \$703,102,358 in Illinois direct group health insurance policy premiums and \$27,995,789 in Illinois individual health insurance policy premiums. The Company's 2009 Annual Statement reflects \$765,919,424 in Illinois group health insurance policy direct premiums and \$32,239,464 in Illinois individual health insurance policy premiums.

The Company's Illinois Policy Count Report indicates that it had in force 88,360 Large Group Comprehensive Major Medical insurance policies with 169,215 certificate holders and 1,762 Associate Group insurance policies with 2,991 certificate holders in 2008, as well as 7,175 Individual Policies. The Company's Illinois Policy Count Report indicates that it had in force 76,974 Large Group Comprehensive Major Medical insurance policies with 151,849 certificate holders and 12,257 Small Group Comprehensive Major Medical insurance policies with 19,585 certificate holders in 2009. The Company also had 1,603 Associate Group insurance policies with 2,745 certificate holders and 8,383 Individual policies in 2009.

#### IV. METHODOLOGY

This limited scope Market Conduct Examination was designed to assess compliance with the Autism Spectrum Disorders law and the Dependent Coverage law. A two-fold approach to the examination included (1) interrogatories and (2) analysis of data submissions.

##### Interrogatories

There were a total of five (5) questions included in the interrogatories.

The first question related to the identification of the project coordinator.

The second and third questions were designed to determine whether autism was one of the criteria used when underwriting new individual health insurance applications. (Group health insurance policies are not allowed to refuse enrollment based on health status.) In addition, specific data regarding the numbers of applications that were denied coverage was collected.

The fourth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Autism Spectrum Disorders law.

The fifth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Dependent Coverage law. This law prohibits termination of individual or group health insurance coverage for dependents prior to their 26<sup>th</sup> birthday, regardless of the dependent's health status. (Note this legislation is not limited to dependents with autism).

Interrogatory questions are listed below along with the Company's response.

- 1. Please provide the name of the individual that is the company coordinator for this project along with telephone and email. This information should be submitted no later than June 25, 2009.**

The Company identified Scott McAdams as its coordinator.

- 2. Do the company's underwriting guidelines take into consideration autism?**

The Company indicated its guidelines do take conditions such as autism into account, but the condition does not result in an automatic decline.

- 3. Provide the number of applicants denied for each 2008 and 2009 due to autism.**

| Year | Number of Applicants Denied due to Autism |
|------|---|
| 2008 | 0   |
| 2009 | 0   |

**4. Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.14. Provide copies of procedures or bulletins issued to comply with this Statute.**

The Company provided a series of documents and materials to demonstrate that it has implemented processes and procedures in response to the Insurance Coverage for Autism requirements.

In addition, the Company indicated it has implemented a manual workaround process to identify autism related claims for special processing. The manual process identifies claims with autism code so it may be extracted from automated adjudication processes.

The documents submitted include:

1. A Group HMO Policy Amendment has been developed which will be inserted into new group and renewing group member materials packets.
2. An Individual HMO Policy Amendment has been developed which will be inserted into new individual plan member materials packets.
3. A Group Accident & Health Policies Amendment has been developed which will be inserted into new group and renewing group member materials packets.
4. An Individual Accident & Health Policies Amendment has been developed which will be inserted into the new individual member's material packets.
5. A Health Alliance Medical Policy – Autism Spectrum Disorders.
6. Health Alliance developed educational fact sheet distributed within various departments of the Company.
7. Health Alliance developed educational legislative analysis distributed within various departments of the Company.
8. An educational article highlighting the autism spectrum disorders benefit coverage is scheduled to be included in the third quarter edition of the *Health Alliance Review* newsletter distributed to employers and brokers.

**5. Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z. 12. Provide copies of procedures or bulletins issued to comply with this Statute.**

The Company provided a series of documents and materials to support its position that it has implemented processes and procedures in response to the Young Adult Dependent Coverage requirements. The Company provided 12 sets of supplemental materials supporting its documentation developed for compliance and a listing of a future article.

1. A Group HMO Policy Amendment has been developed which will be inserted new group and renewing group member materials packets.



2. An Individual HMO Policy Amendment has been developed which will be inserted into new individual plan member materials packets.
3. A Group Accident & Health Policies Amendment has been developed which will be inserted into new group and renewing group member materials packets.
4. An Individual Accident & Health Policies Amendment has been developed which will be inserted into new individuals member materials packets
5. A Notice included in group plans' member enrollment/application packet.
6. A Notice included in individual plans' member enrollment/application packet.
7. Educational communication was provided to Health Alliance brokers.
8. Notification Letter sent to Health Alliance employers.
9. Educational article included in the second quarter edition of the *Health Alliance Review* newsletter distributed to employers and brokers.
10. Summary of procedures implemented.
11. The Company developed an educational fact sheet distributed within various departments of the Company.
12. The Company developed educational legislative analysis distributed within various departments of the Company.
13. A semi-annual notification will appear in the fourth quarter edition of *For Your Health*, a quarterly publication distributed to all members, and twice every year thereafter.

## V. DATA ANALYSIS

### **Analysis of Company Data**

A summary of the Company data analysis is listed below. The analysis was conducted using ACL<sup>®</sup> software.

The Company submitted a total of 1,661 transactions involving 15 policyholders. These 15 policyholders had had at least one (1) claim for autism submitted during the examination period. However, the majority of the 1,661 transactions were not autism specific claims. The Autism Spectrum Disorders legislation mandates coverage for a number of different treatments and services which are not unique to individuals with autism, such as psychiatric care, psychological care, counseling and speech and behavioral therapies. Accordingly, claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. This broader set of claims was chosen to ensure that coverage was not being denied to any individual with autism for any mandated treatment or service.

The total amount billed on these 1,661 transactions was \$361,942. Of this amount, the Company paid in full \$200,766 transactions. There were 49 denied transactions, but only 10 of those were directly coded to autism related claims. The Company provided the reasons why billed amounts were not paid. The examiners selected and reviewed a sample of claim files for compliance with 215 ILCS 356z.14.

Additional information on the 1,661 claim transactions may be found in Appendix D.

## VI. FINDINGS/RECOMMENDATIONS

The Company provided the examiners with documentation, information and materials to support its position that it has developed processes and procedures designed to maintain compliance with 215 ILCS 5/356z.14, Autism Spectrum Disorders and 215 ILCS 5/356z.12, Dependent Coverage. The examiners reviewed this documentation, information and material. The Company also provided the examiners with data and information on all claims submitted by any individual who had had submitted at least one (1) claim with an autism related diagnosis during the examination period. The examiners analyzed this data and reviewed the information as well as a sample of claim files. The examination and sample files did not identify any instances in which the Company was in material non-compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders or 215 ILCS 5/356z.12, Dependent Coverage.

When asked to define what system modifications have been made to support the requirements, the Company responded that it had implemented a manual process. It is recommended that the Company complete the automation of requirements to comply with the Illinois autism mandate rather than continued reliance on manual processing of those claims.

The process in place prior to the examination with regard to autism related claim transactions was such that the extraction or identification of claims was limited to those claims specifically coded with an autism diagnosis code. The examiners would recommend that the Company's procedures be expanded to incorporate all claims for an individual with at least one (1) claim for autism or an autism related condition or treatment.

**Appendix A**  
**Insurance Code Section 356z.14**  
**Autism Spectrum Disorders**

(215 ILCS 5/356z.14)

(Text of Section from P.A. 95-1005)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of \$36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of the Division of Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(f) Upon request of the reimbursing insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical

treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Admin. Code 500 and any subsequent amendments thereto.

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

- (1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
- (2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
- (3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs,

including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-1005, eff. 12-12-08.)

**Appendix B**  
**Insurance Code Section 356z.12**  
**Dependent Coverage**

215 ILCS 5/356z.12)

Sec. 356z.12. Dependent coverage.

(a) A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday.

(b) A policy or plan subject to this Section shall, upon amendment, delivery, issuance, or renewal, establish an initial enrollment period of not less than 90 days during which an insured may make a written election for coverage of an unmarried person as a dependent under this Section. After the initial enrollment period, enrollment by a dependent pursuant to this Section shall be consistent with the enrollment terms of the plan or policy.

(c) A policy or plan subject to this Section shall allow for dependent coverage during the annual open enrollment date or the annual renewal date if the dependent, as of the date on which the insured elects dependent coverage under this subsection, has:

- (1) a period of continuous creditable coverage of 90 days or more; and
- (2) not been without creditable coverage for more than 63 days.

An insured may elect coverage for a dependent who does not meet the continuous creditable coverage requirements of this subsection (c) and that dependent shall not be denied coverage due to age.

For purposes of this subsection (c), "creditable coverage" shall have the meaning provided under subsection (C)(1) of Section 20 of the Illinois Health Insurance Portability and Accountability Act.

(d) Military personnel. A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible for coverage under this subsection (d), the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

(e) Calculation of the cost of coverage provided to an unmarried dependent under this Section shall be identical.

**(f) Nothing in this Section shall prohibit an employer from requiring an employee to pay all or part of the cost of coverage provided under this Section.**

**(g) No exclusions or limitations may be applied to coverage elected pursuant to this Section that do not apply to all dependents covered under the policy.**

**(h) A policy or plan subject to this Section shall not condition eligibility for dependent coverage provided pursuant to this Section on enrollment in any educational institution.**

**(i) Notice regarding coverage for a dependent as provided pursuant to this Section shall be provided to an insured by the insurer:**

- (1) upon application or enrollment;**
- (2) in the certificate of coverage or equivalent document prepared for an insured and delivered on or about the date on which the coverage commences; and**
- (3) in a notice delivered to an insured on a semi-annual basis.**

**(Source: P.A. 95-958, eff. 6-1-09.)**



**Appendix C**  
**Claims Data Analysis**  
**Definitions**

Prior to reviewing the analysis of the data submitted by the company, it may be useful to review the definitions of the terminology used in this report. The following information provides definitions for the headers used to explain the analysis of the data received by and from the Company.

**Claim** – a notification to an insurance company requesting payment of an amount due under the terms of the policy. One claim may contain multiple transactions or lines of payment requests.

**Transaction/Line** – A single electronic exchange to request payment for medical visit, product or service. Claims may contain more than one (1) transaction/line. (For example: one (1) claim may include separate bills for the medical visit, physical therapy and equipment. In this instance, the one (1) claim would be comprised of three (3) individual transactions or lines.) Transactions/Lines are often assigned distinct numbers.

**Claim Status** – The status of the transaction that is currently being processed. The various statuses for claims/transactions according to this Company include: denied, paid or partially paid.

**Amount Billed-** The fees or charges billed by the provider.

**Partial Denied Count** – A partially denied count is the number of transactions where a portion of the amount billed by the provider or insured was denied. This may include certain Transactions/Lines within a claim without denying the entire claim.

**Partial Denied Billed** – A partially denied billed transaction is a transaction where a portion of the amount billed by the provider or insured was denied. There may be contractual reasons for a partial denial such as copayments or coinsurance requirements or payments may be reduced as a result of contracted benefit payments arrangements made with the provider. Partial denials may also occur if the policy's maximum benefit for a period of time has been reached. One (1) example of a maximum benefit may be seen where a policy has limits on the number of outpatient visits for mental/nervous disorders in a calendar quarter.

**Uncategorized Claim Status** – A transaction that is unidentified in the electronic payment system as not being paid, pending, denied or closed without payment. Generally, the uncategorized transactions are identified as “informational lines” or “adjustment lines” which are inadvertently inserted in a claim. The “informational lines” can cause the sample to be skewed if they are not identified in a population to be studied. The inadvertent selection of these lines will dilute the sample as they contain no actual claim payment information. Examiners needed to review an entire “Claim Event” in order to determine if certain lines were informational only and could be disregarded or if the claim contained any “Lines” that contained treatment codes corresponding to autism treatment even where the event may not appear to be autism related. An example of an uncategorized claim would be for the use of general anesthesia related to simple dental procedures. Normally the procedure would be performed with local dental anesthesia but in the case of an autistic child, more extensive treatment may have been necessary.

**Closed Without Payment Transaction Status** – A transaction that is closed without any payment.

**Denied Transaction Status** – A transaction that has been denied for payment. Denial for transactions could be for a number of reasons, such as the policy doesn’t cover that type of transaction, the provider is not authorized to bill for that type of transaction or the coverage was terminated at the time this expense was incurred.

**Pending Transaction Status** – A transaction that has not been paid, denied or closed without payment. Examples of pending transactions may include those that are currently in process or where more information has been requested before payment is considered.

**Paid Amount** – Actual amount paid by an insurance company during a specified time interval.

**Amount Billed** – The amount billed to the insurance company for the claim or transaction.

**Patient’s Responsibility** – The amount of a claim or transaction which is to be paid by the insured. These amounts may apply to deductibles, coinsurance or other provisions in the insurance contract.

**Provider Discount** – A negotiated discount for services. These provider discounts are agreed to in contracts between the providers and insurance company or other affiliated network.

**Maximum Allowable** – The maximum amount payable per the contract.

**Co-Pay (Copayment)** – The copayment is an amount the insured pays in accordance with their insurance contract. This amount may be a flat dollar amount such as \$25 per office visit or may be a percentage of the billed amount such as 20% of the amount billed.

**Deductible** – A deductible is the amount of expenses that must be paid out of pocket before an insurer will cover certain benefits or expenses.

**COB (Coordination of Benefits)** – A group policy provision which helps determine the primary carrier when an insured is covered by more than one policy. This provision prevents claims overpayments.

**EOB (Explanation of Benefits)** – A document that explains the claim and its charges and discounts. The EOB identifies any copay or coinsurance owed, the amount have paid toward a deductible and any network discounts. A summary of the Company data analysis is listed below. The analysis was conducted using ACL<sup>®</sup> software.

**Appendix D  
Claims Payment Information**

Initially the Company provided data that did not fully meet the specifications of the data request made by the examiners.

The Company subsequently submitted corrected data. A summary of the revised data submission follows:

Of the paid claims, 95 were partially denied in the amount of \$12,714.60. The Company submitted information regarding a total of 1,661 claims in response to the data request. Claims information was reported for 102 different policies.

Of the paid claims, seven (7) were partially denied in the amount of \$598.50.

**Table 1 (Claim Status by Transaction)**

| <u>Claim Status</u> | <u>Claim Count</u>  | <u>Amount Billed</u>     | <u>Partial Denied Count</u> | <u>Partial Denied Billed</u> |
|---------------------|---------------------|--------------------------|-----------------------------|------------------------------|
| Denied              | 49                  | 7,561.59                 | 1                           | 216.00                       |
| Paid                | 1,612               | 354,380.41               | 7                           | 598.50                       |
|                     |                     |                          |                             |                              |
| <b>Totals</b>       | <b><u>1,661</u></b> | <b><u>361,942.00</u></b> | <b><u>8</u></b>             | <b><u>814.50</u></b>         |

**Summary of Table 1 (Claim Status by Transaction)**

According to the Company, during the time period under review there were a total 1,661 claim transactions of which 97% of all the claims submitted were paid in the amount of \$354,380.41. Seven (7) of those claims were partially denied in the amount of \$598.50. Claims denied totaled 49 or less than 3% of the total claim transactions for an amount totaling \$7,345.59. Of the 49 denied claims, there was one (1) claim partially denied in the amount of \$216.00.

**Table 2 (Claim Payment Breakdown)**

| <u>Claim Status</u> | <u>Count</u>        | <u>Paid Amount</u>       | <u>Amount Billed</u>     | <u>Patient's Responsibility</u> | <u>Provider Discount</u> | <u>Maximum Allowable</u> | <u>Co Pay</u>           | <u>Deductible</u>      | <u>Interest</u>    |
|---------------------|---------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|-------------------------|------------------------|--------------------|
| Denied              | 49                  | 194.00                   | 7,561.59                 | 7,229.00                        | 548.90                   | 7,012.69                 | 0.00                    | 0.00                   | 0.00               |
| Paid                | 1,612               | 200,766.00               | 354,380.41               | 24,099.00                       | 156,526.77               | 197,853.64               | 17,316.03               | 6,272.56               | 8.32               |
|                     |                     |                          |                          |                                 |                          |                          |                         |                        |                    |
| <b>Totals</b>       | <b><u>1,661</u></b> | <b><u>200,960.00</u></b> | <b><u>361,942.00</u></b> | <b><u>31,328.00</u></b>         | <b><u>157,075.67</u></b> | <b><u>204,866.33</u></b> | <b><u>17,316.03</u></b> | <b><u>6,272.56</u></b> | <b><u>8.32</u></b> |

**Summary of Table 2 (Claim Payment Breakdown)**

The total amount billed for all of these claims was \$361,942.00, with \$204,866.33, or 57% of that being the maximum allowable amount covered by the policy. The amount listed as patient's responsibility is \$31,328.00, plus a copayment amount of \$17,316.03 and a deductible amount of \$6,272.56 for a total of cost to the consumers of \$54,916.59 or 15% of the total amount billed.

The reason for the 49 transactions that were denied in full is included in the following table.

**Table 3 (Reason for the Denial)**

| <u>Explanation of Denial Reason</u>             | <u>Count</u> | <u>Amount Billed</u>     |
|---|--------------|--------------------------|
| Exceeds Limits Governed by Policy               | 5            | 925.00                   |
| Routine Eye Exams are not Covered by the Policy | 2            | 121.00                   |
| Services for Cosmetic Purposes are Excluded     | 1            | 290.00                   |
| Services Provided are not Covered by the Policy | 23           | 3,550.34                 |
| Services Obtained/Ordered from Non-Affiliation  | 18           | 2,675.25                 |
|   |              |                          |
| <b>Total</b>                                    | <b>49</b>    | <b><u>\$7,561.59</u></b> |

**Summary of Table 3 (Reason for Denial)**

Of the 49 transactions that were denied, the largest amount (23) of these denials occurred because the services provided were not covered by the policy, for an amount of \$3,550.34 or an average of \$154.36, per transaction. The second largest amount of denials (18) occurred because services were obtained or ordered from a non-affiliated provider, for a total amount of \$2,675.25, for an average amount of \$148.62. The highest amount per transaction denied was for the one (1) denial for services for cosmetic purposes which are excluded for an amount of \$290.00.

**Table 4 (Autism Only Claims)**

| <u>Claim Status</u> | <u>Record Count</u> | <u>Amount Billed</u> | <u>Partially Denied Count</u> | <u>Partial Denied Amount</u> |
|---------------------|---------------------|----------------------|-------------------------------|------------------------------|
| Denied              | 10                  | 1,335.67             | 0                             | 0.00                         |
| Paid                | 541                 | 109,182.49           | 1                             | 155.00                       |
|                     |                     |                      |                               |                              |
| <b>Totals</b>       | <b>551</b>          | <b>110,518.16</b>    | <b>1</b>                      | <b>155.00</b>                |

**Summary of Table 4 (Autism Only Claims)**

Of the original 1,661 claim transactions reported, 551 or 33% of those transactions were specifically coded with an autism related diagnostic code. Of the 551 autism specific claim transactions, 541 were paid in the amount of \$109,182.49 with 10 claim transactions being denied in the amount of \$1,335.67. There was one partially denied claim in the amount of \$155.00.

**Table 5 (Reason for the Denial-Autism Only)**

| <u>Explanation of Denial Reason</u>             | <u>Count</u> | <u>Amount Billed</u> |
|---|--------------|----------------------|
| Exceeds Limits Governed by Policy               | 1            | 220.00               |
| Services Provided are not Covered by the Policy | 9            | 1,115.67             |
|   |              |                      |
| <b>Total</b>                                    | <b>10</b>    | <b>1,335.67</b>      |

**Summary of Table 5 (Reason for Denial)**

The 10 autism specific claim transactions reported as having been denied, listed the following reasons – nine (9) transactions services not covered by the policy for an amount totaling \$1,115.67 – one (1) transaction for an amount totaling \$220.00 because it exceeded limits covered by the policy.