STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
COMPLIANCE EXAMINATION
STATUTORY DEPENDENT COVERAGE AND AUTISM SPECTRUM DISORDERS LEGISLATION

OF

HEALTH CARE SERVICE CORPORATION
A Mutual Legal Reserve Company (HCSC)

MARKET CONDUCT EXAMINATION REPORT

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	July 20, 2009 through August 28, 2009
EXAMINATION OF:	Health Care Service Corporation, A Mutual Legal Reserve Company
LOCATION OF EXAMINATION:	INS Offices in Philadelphia, PA and Kansas City, MO
PERIOD COVERED BY EXAMINATION:	December 12, 2008 thru June 11, 2009
EXAMINERS:	Shelly Schuman Dennis Shoop

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I. SUMMARY

1. Health Care Service Corporation (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 recently enacted 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® 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 Care Service Corporation, A Mutual Legal Reserve Company (Company) is a life and health insurance company domiciled in Illinois. The Company offers indemnity and preferred provider organization (PPO) through Blue Cross and Blue Shield of Illinois/Texas/New Mexico/Oklahoma. The organization also offers health maintenance organization (HMO) and point-of-service (POS) products through several subsidiaries and divisions. The Company offers Blue Cross and Blue Shield branded Medicare Advantage and Medicare Part D coverage.

The Company writes the majority of its business in the health line of business in the states of Illinois, Texas, New Mexico and Oklahoma. The Company is also growing its business to expand into the business of life insurance products through its subsidiaries, which are licensed in life insurance in all 50 states and the District of Columbia. The Company serves Large Groups, Small Groups, Consumer Markets, Medicare Supplement and Government Programs.

The Company's 2008 Annual Statement reflects $10,085,129,146 in Illinois single employer direct Group Comprehensive Major Medical Health insurance policy premiums and $1,475,712,147 in Illinois Individual Comprehensive Major Medical Health insurance policy premiums. The Company's 2009 Annual Statement reflects $10,932,887,172 in Illinois single employer Group Comprehensive Major Medical Health insurance policy direct premiums and $1,618,587,600 in Illinois Comprehensive Major Medical Individual Health insurance policy premiums.

The Company's Illinois Policy Count Report indicates that it had in force 1,470,611 single employer Group Comprehensive Major Medical Health insurance policies with 2,730,073 certificate holders and 407,152 Individual Comprehensive Major Medical Health insurance policies in 2008. The Company's Illinois Policy Count Report indicates that it had in force 1,521,853 single employer Comprehensive Major Medical insurance policies with 1,989,556 certificate holders, and 474,788 Individual Comprehensive Major Medical Health insurance 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 26th 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 David Reid as the coordinator.

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

   Autism is considered in the Company's underwriting guidelines for insured group and individual business.

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

   The Company indicated it does not track the number of applicants denied for individual insured business. The Company indicated there were no applicants denied for autism in the group insured business line for either 2008 or 2009.

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 reported that it has implemented procedures to implement processes and procedures for Insurance Coverage for Autism requirements. The Company provided bulletins and materials which support its position that it has implemented policies and procedures for compliance with the Insurance Coverage for Autism requirements.

   1. A bulletin was distributed by the sales and marketing department announcing the implementation of the legislative changes in December of 2008.
   2. A project plan was finalized and work plan was created and implemented with two (2) specially appointed teams to review the mandates and implement new procedures. The first is a Health Care Management (HCM) subteam that determined eligibility, maintenance and procedures for the newly enacted legislation. The second is a specialized customer service team that reviewed the processes for implementing these changes.
   3. The Company did determine that implementation of the claim processing system would be updated once more claims data was available and once the federal mental health parity statute and this statute requirements have been fully evaluated. Until that point, the manual evaluation process would be implemented.
   4. The Company also provided a project definition document that detailed the Company's review of the statute's requirements and its impact on the Company's computer systems.

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 bulletins and materials which support its position that it has implemented policies and procedures for compliance with the Young Adult Dependent Coverage requirements.

   1. A project plan was finalized and work plan was created and implemented to expand the dependant age in accordance with the Young Dependent Coverage requirements.
   2. The Company evaluated the eligibility requirements, determined which the Company's policies were affected by the changes, edited/created process flows, evaluated military applications, modified student medical leave certification forms, evaluated certificate language and determined system impacts and changes necessary to fully implement. (System changes were to be completed prior to 06/01/2009.)

3. The Company also provided communication documentations for implementing the changes including: notification to members, employer communication, producer communication, Sales and Marketing news articles for account executives, web content for "What's New" section and development of a strategy for bi-annual member notification.

V. DATA ANALYSIS

Analysis of Company Data

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

The Company submitted a total of 3,412 transactions for 704 policyholders. These 704 policyholders had had at least one (1) claim for autism submitted during the examination period. However, the majority of the 3,412 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 3,412 transactions was $7,675,401.71. Of this amount, the Company paid in full $2,882,163.61 transactions and paid after coordination of benefits investigation $14,569.49 for a total of $2,896,733.10. The remaining amounts fell into three categories: No Payment Issued, Disapproved After Service and one uncategorized field. Questions were raised by the examiners about the uncategorized claim denials. The examiners did review a sample of those uncategorized claim denials. The uncategorized field is explained in more detail in Appendix C and Appendix D. The Company provided the reasons why these remaining 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 3,412 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 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.

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.

A sample of files were selected and reviewed for compliance with 215 ILCS 356z.14. The examiners reviewed 254 claim lines and found no material issues of concern. The 254 claim lines represented 160 insured/dependents. The examiners found that 41 claims were disqualified from the sample based on the over age requirement and the dates of service fell outside of the effective date of the statute. The examiners found no instances among the 254 selected claims where autism spectrum related claims with dates of service after December 12, 2008 and relating to claimants age 21 or younger were inappropriately denied. The examiners reviewed 51 of the uncategorized denials.

The Company indicated it does not track the number of individual applicants denied coverage. The examiners recommend exploration of the Company's underwriting management and record keeping practices to ensure it is maintaining appropriate information and data regarding applications submitted for consideration.

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 transaction/line. (For example: one claim may include separate bills for the medical visit, physical therapy and equipment. In this instance, the one claim would be comprised of three 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 co-payments 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 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. The 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.

Issued No Payment Transaction Status – A transaction that is closed without any payment.

Disapproved After Service 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.

Paid Post-Payment COB Investigation – Actual amount paid by an insurance company during a specified interval after a coordination of benefits (COB) review was conducted.

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 (1) policy. This provision prevents claims overpayments.

EOB (Explanation of Benefits) – A document that is 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® software.

Appendix D
Claims Payment Information

The Company submitted information regarding a total of 13,412 claims in response to the data request. Claims information was reported for 704 different policies.

Of the paid claims, 5,250 were partially denied in the amount of $2,163,360.98.

Table 1 (Claim Status by Transaction)

Claim Status	Claim Count	Amount Billed	Partial Denied Count	Partial Denied Billed
Paid	7,317	4,230,163.61	5,250	2,163,360.98
Issued - No Payment	1,392	333,210.50	36	17,693.40
Paid - Post-payment COB investigation	44	769,343.31	12	123,604.10
Disapproved - After Service	2,172	1,102,950.40	0	0.00
Uncategorized	2,487	1,239,733.89	1,091	495,376.19
Totals	13,412	7,675,401.71	6,389	2,800,034.67

Summary of Table 1 (Claim Status)
According to the Company during the time period under review there were a total of 13,412 claim transactions. Of all the claims submitted, 55% were paid in the amount of $4,230,163.61 and an additional 44 were paid after a coordination of benefits investigation occurred for an amount of $769,343.31. Five thousand two hundred and fifty of those claims were partially denied in the amount of $2,163,360.98. Claims disapproved after service totaled 2,172 for an amount of $1,239,733.89. There were a total of 6,389 transactions or 48% of all transactions that were partial denied for a total amount of $2,800,034.67. Of all the claims, 18.5% were uncategorized for a total amount of $1,239,733.89. The uncategorized field represents those claims that were not paid, issued or disapproved. For an explanation of the uncategorized claims, please see the summary information for Table 3.

Table 2 (Claim Payment Breakdown)

Claim Status	Claim Count	Paid Amount	Amount Billed	Patient's Responsibility	Provider Discount	Maximum Allowable	Co Pay	Deductible
Paid	7,317	2,882,018.90	4,230,163.61	327,544.94	914,834.61	937,892.43	48,682.67	135,235.73
Issued - No Payment	1,392	14,569.49	333,210.50	188,587.89	8,532.01	128,941.58	1,343.74	119,378.11
Paid - Post-payment COB investigation	44	642,149.68	769,343.31	34.80	265,618.32	882.26	1,350.00	3,871.88
Disapproved – After Service	2,172	0.00	1,102,950.40	202,825.31	0.00	0.00	0.00	0.00
Uncategorized	2,487	581,497.87	1,239,733.89	172,655.94	147,008.45	284,179.07	10,529.28	73,287.82
Totals	13,412	4,120,235.94	7,675,401.71	891,648.88	1,335,993.39	1,351,895.34	61,905.69	331,773.54

Summary of Table 2 (Claim Payment Breakdown)
The total amount billed for all of these claims was $7,675,401.71, with $1,351,895.34, or 17.6% being the maximum allowable amount covered by the policy. The amount listed as patient's responsibility is $891,648.88, plus the copayment amount of $61,905.69 and the deductible amount of $331,773.54 for a total of cost to the consumers of $1,285,328.11 or 16.7% of the total amount billed. An additional 44 claims were paid after a Coordination of Benefit (COB) investigation was completed with 12 of those claims partially denied in the amount of $123,604.10.

The denial reasons for the 2,172 denied transactions are below:

Table 3 (Reasons for Denial)

Denied Reason	Count	Amount Billed
Uncategorized	1,975	1,085,956.63
053-COB Investigation: No Response CSQ	158	7,025.97
058-COB Investigation: Requesting Other Carrier EOB from our sub	20	12,651.80
CAN-ITS CLAIMS ADJUSTMENT WITH NO ADJUSTED SF	1	(2,772.00)
CAS-ITS CLAIMS ADJUSTMENT WITH ADJUSTED SF	7	(1,289.00)
ESR-INVESTIGATED FOR ESRD	1	225.00
N/A - Claim Paid	5	852.00
NDA-NO HSA DOLLARS AVAILABLE	4	0.00
PDC-PAST DUE CLAIM PROCEDURE IN PROCESS - TO BE USED FOR HMO ADJ	1	300.00
Totals	2,172	1,102,950.40

Summary of Table 3 (Reasons for Denial)
Of the 2,172 denied claims, 1,975 or 91% were listed in the category of uncategorized according to the Company system. An additional 158 or 7% of the denials were listed under the denial reason of COB Investigation: No Response CSQ and 20, or less than 1% of the denials were listed under the denial reason of COB Investigation: Requesting Other Carrier EOB (Explanation of Benefits) from our sub.

A request was made with the Company to help explain the reason for the 1,975 denied claims that were uncategorized. The Company responded that the specific denial reasons are not included on the original denied claim submission because the denial reasons are maintained at the service level (transaction/line) for each claim. The Company provided additional information to further categorize these 1,975 claim denials at the transaction/line level, please see Table 5.

The total number of claims reported represents 704 different policies; however, autism related claims were reported for only 499 policies.

Table 4 (Claim Status -Autism Only Claims)

Claim Status	Record Count	Amount Billed	Partial Denied Count	Partial Denied Billed
Paid	4,518	2,123,149.47	3,386	1,271,477.68
Issued - No Payment	891	198,910.97	26	12,825.40
Paid - Post-payment COB investigation	22	202,277.24	10	96,144.10
Disapproved - After Service	1,183	561,751.18	0	0.00
Uncategorized	1,581	682,970.87	745	288,368.26
Totals	8,195	3,769,059.73	4,167	1,668,815.44

Summary of Table 4 (Claim Status - Autism Only Claims)
Of the original 13,412 claim transactions reported, 8,195 or 61% of those transactions were specifically coded with an autism related diagnostic code. Of the 8,195 autism specific claim transactions, 4,512 were paid in the amount of $2,123,149.47, another 22 were paid after a Coordination of Benefits (COB) review was conducted for an amount of $202,277.24 and a total 1,183 were disapproved after service in the amount of $561,751.18. There were 4,167 partially denied claims in the amount of $1,668,815.44. There were 1,581 uncategorized claims for an amount of $682,970.87 with 745 of those being partially denied in an amount of $288,368.26.

Table 5 (Reason for the Denial-Autism Only)

Denied Reason	Count	Billed
039 -CLAIM IS HMO/MCN MEDICAL GROUP RESPONSIBILITY	238	48,278.16
129 -THIS CHARGE IS A DUPLICATE OF A PREVIOUS PROCESSED CLAIM	202	66,626.47
273 - SERVICES ARE NOT COVERED BY CONTRACT FOR THIS TYPE OF PROVIDER	201	17,360.06
UNCATEGORIZED	191	17,384.25
503 - CHARGES EXCEED PPO ALLOWANCE	142	29,186.00
299 - THIS SERVICE IS NOT A BENEFIT OF THE CONTRACT	132	17,688.25
Denied Reason	Count	Billed
400 - THE MAXIMUM BENEFIT AVAILABLE FOR THIS SERVICE HAS BEEN PAID	112	28,669.16
420 - ADDITIONAL PRICING INFORMATION REQUESTED	61	8,266.17
507 - SERVICE NOT ELIGIBLE - FAILED TO MEET GROUP GUIDELINES	48	5,491.23
021 - NAME AND ADDRESS OF PHYSICIAN REQUIRED	36	4,289.80
510 - MEDICAL GROUP DID NOT APPROVE (ALL OTHER)	30	7,236.68
475 - CHARGES EXCEED HIAA SCHEDULE OF ALLOWANCES. SERVICES WERE P	21	6,858.58
686 - CPT/HCPCS E USED TO DETERMINE BENEFIT	20	2,719.88
113 - DATE OF ACCIDENT,INJURY, MEDICAL CONDITION, OR TREATMENT	12	2,471.70
749 - HIPAA COMPLIANT ACCOUNT - PRE-EXISTING CONDITION	11	1,940.55
284 - PROCEDURE NOT A CORPORATELY COVERED PROCEDURE	9	1,881.21
411 - CHARGE EXCEEDS USUAL AND CUSTOMARY	6	30,930.00
747 - HIPAA COMPLIANT ACCOUNT - PRE-EXISTING CONDITION	6	432.00
745 - MEDICAL POLICY REVIEW DETERMINED THAT THE SERVICES PROVIDED	5	1,594.00
LCD - LATE CHARGE DENIAL (NO EOB CREATED FOR THIS CLAIM)	5	381.00
269 - THIS SERVICE IS NOT COVERED FOR THIS DIAGNOSIS	4	740.00
360 - MEDICAL RECORDS REQUIRED	4	2,568.75
011 - ON OR AFTER TERMINATION DATE	3	654.80
999 - UNCODED DAP DEFAULT	3	2,061.00
025 - TIME LIMIT FOR FILING CLAIMS	2	164.00
516 - OUT OF AREA NON-EMERGENCY ACCIDENT/MEDICAL CARE	2	325.50
328 - MD CERTIFICATION FOR DURABLE MEDICAL EQUIPMENT REQUIRED	1	211.00
566 - RENTAL CHARGE EXCEEDS PURCHASE PRICE OF THE DURABLE MEDICAL	1	211.00
740 - APPROVAL/CERTIFICATION FROM MENTAL HEALTH ADVISOR NOT OBTAINED	1	89.00
Totals	1,509	306,710.20

Summary of Table 5 (Reason for the Denial-Autism Only)
Of the total 2,172 denied (or disapproved after service) claims, there were 1,509 or 69% were categorized to denied autism claims. Two hundred thirty eight (238) or 16% of those denied autism related claims transactions listed the reason as the claim is the HMO/MCN medical group's responsibility. Two hundred and two (202) or 13% of the denied autism claims were considered a duplicate of a previously processed claim and another 201 or 13% of the denied autism related claims were denied because the services are not covered by the contract for this type of provider. Of those denied autism claims, 191 or 13% were listed in the category of uncategorized according to the Company system. The highest amount per transaction denied for autism related claims was for the denial (202) for duplicate or previously processed claims for an average amount of $329.83.

The following table provides further detail for the total 2,487 uncategorized claim transactions.

Table 6 (Uncategorized Claim Denials)

Denied Reason	Count	Amount Billed
039 -CLAIM IS HMO/MCN MEDICAL GROUP RESPONSIBILITY	776	218,599.75
129 -THIS CHARGE IS A DUPLICATE OF A PREVIOUS PROCESSED CLAIM	762	295,915.21
UNCATEGORIZED	421	119,190.48
507 -SERVICE NOT ELIGIBLE - FAILED TO MEET GROUP GUIDELINES	403	53,025.61
400 -THE MAXIMUM BENEFIT AVAILABLE FOR THIS SERVICE HAS BEEN PAI	345	71,683.88
503 -CHARGES EXCEED PPO ALLOWANCE	294	51,647.00
273 -SERVICES ARE NOT COVERED BY CONTRACT FOR THIS TYPE OF PROVI	248	23,533.94
299 -THIS SERVICE IS NOT A BENEFIT OF THE CONTRACT (PROVISION IS	185	21,893.71
510 -MEDICAL GROUP DID NOT APPROVE (ALL OTHER)	162	216,668.50
420 -ADDITIONAL PRICING INFORMATION REQUESTED (E.G. OPERATIVE RE	161	43,984.37
475 -CHARGES EXCEED HIAA SCHEDULE OF ALLOWANCES. SERVICES WERE P	98	12,652.08
269 -THIS SERVICE IS NOT COVERED FOR THIS DIAGNOSIS	97	11,831.08
284 -PROCEDURE NOT A CORPORATELY COVERED PROCEDURE	83	11,985.69
745 -MEDICAL POLICY REVIEW DETERMINED THAT THE SERVICES PROVIDED	62	58,421.35
LCD -LATE CHARGE DENIAL (NO EOB CREATED FOR THIS CLAIM)	59	23,766.12
600 -DENTAL: PROCEDURE NOT COVERED PER CONTRACT	55	41,475.30
021 -NAME AND ADDRESS OF PHYSICIAN REQUIRED	36	4,289.80
686 -CPT/HCPCS code submitted can not be used to determine benefit	30	3,489.29
516 -OUT OF AREA NON-EMERGENCY ACCIDENT/MEDICAL CARE	25	2,370.69
360 -MEDICAL RECORDS REQUIRED	23	25,967.75
056 -OUTPATIENT PROFESSIONAL SERVICES RELATEDTO THE IN-AREA TREA	19	4,199.00
113 -DATE OF ACCIDENT,INJURY, MEDICAL CONDITION, OR TREATMENT DA	17	3,999.70
411 -CHARGE EXCEEDS USUAL AND CUSTOMARY	16	72,566.00
749 -HIPAA COMPLIANT ACCOUNT - PRE-EXISTING CONDITION WAITING PE	13	2,255.55
295 -SERVICES ARE NOT COVERED BY THE CONTRACT FOR THIS PLACE OF	13	235.90
011 -ON OR AFTER TERMINATION DATE	10	1,365.80
C33 -Subscriber has not responded to request for other coverage	6	8,335.00
500 -CONTINUOUS STAY DATES OVERLAPPING. OUT OF SEQUENCE WITH CON	6	7,125.24
281 -THIS SERVICE NEEDS A EOMB TO PROCESS	6	1,415.00
747 -HIPAA COMPLIANT ACCOUNT - PRE-EXISTING CONDITION WAITING PE	6	432.00
268 -DENTAL SERVICES/SURGERY NOT DUE TO AN ACCIDENT	5	9,469.00
025 -TIME LIMIT FOR FILING CLAIMS - XX NUMBER OF MONTHS FROM SER	5	329.84
017 -STUDENT CERTIFICATION REQUIRED	3	3,600.00
999 -UNCODED DAP DEFAULT	3	2,061.00

574 -SERVICES FOR THE CONDITION OF MENTAL, DRUG/ALCOHOL ABUSE AR	3	1,766.00
328 -MD CERTIFICATION FOR DURABLE MEDICAL EQUIPMENT REQUIRED	3	283.10
119 -OVERAGE DEPENDENT	3	181.70
711 -BENEFITS ARE NOT PROVIDED FOR EXPENSES THAT THE INSURED HAS	3	158.00
061 -HMO ILLINOIS MEDICAL GROUP IS ASSUMING RESPONSIBILITY FOR A	1	435.00
585 -SERVICES NOT COVERED IF DIAGNOSIS/TREATMENT IS FOR THE FOLL	1	292.00
901 -OPERATOR ENTERED - NO RESPONSE FROM PROVIDER TO OUR REQUEST	1	280.00
137 -MEMBER NOT COVERED FOR THESE DATES OF SERVICE DUE TO LAPSE	1	248.00
566 -RENTAL CHARGE EXCEEDS PURCHASE PRICE OF THE DURABLE MEDICAL	1	211.00
700 -ADJUSTMENT: CREDIT ONLY - REASON UNKNOWN	1	150.00
408 -CHARGE EXCEEDS MEDICARE'S ALLOWED AMOUNT	1	100.00
564 -MEDICARE B DEDUCTIBLE NOT COVERED	1	100.00
394 -PRE-EXISTING WAITING PERIOD HAS NOT BEEN MET AND THE SERVIC	1	90.00
740 -APPROVAL/CERTIFICATION FROM MENTAL HEALTH ADVISOR NOT OBTAI	1	89.00
218 -PRIOR ADMISSION DID NOT HAVE SAME CONDITION REQUIRED FOR TH	1	43.00
Totals	4,476	1,434,207.43

Summary for Table 6 (Uncategorized Claim Denials)

Of the 1,975 uncategorized claims, 289 were adjusted, leaving 1,686 claims. Please note that although there were only 1,686 claims, many of those contained multiple transactions/lines for a total of 4,476 transactions. The top five (5) reasons for claim denials include:

- 776 or 17.34% Claim is HMO/MCN Medical group responsibility
- 762 or 17.02% Claim is a duplicate charge
- 421 or 9.41% Uncategorized
- 403 or 9% Service not eligible, failed to meet group guidelines
- 345 or 7.71% The maximum payment for this service has been paid

Further review was conducted on the 421 transaction/lines that were uncategorized as denied and of those 421 transactions, 393 or 93% were paid, three (3) or 0.71% were Issued-No Payment, 19 or 4.51% were Paid-Post-payment COB investigation and six (6) or 1.43% were Disapproved-After Service.