Unicare Health Insurance Company
of the Midwest

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	February 20, 2007 through February 8, 2008
EXAMINATION OF:	Unicare Health Insurance Company of the Midwest
LOCATION:	233 S. Wacker Chicago, Illinois 60604
PERIOD COVERED BY EXAMINATION:	January 1, 2006 through December 31, 2006 – Claims January 1, 2005 through February 20, 2007 – Division of Insurance and Consumer Complaints
EXAMINERS:	Pat Hahn Mike Hager David Bradbury, Examiner-in-Charge

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I. SUMMARY

1. The Company was criticized under Section 919.50(a)(1) of the Illinois Administrative Code for failure to provide the insured "Notice of the Availability of the Division of Insurance" on denied claims. (See 50 Ill. Adm. Code 919.50(a)(1))

2. The Company was criticized under Section 919.70(a)(2) of the Illinois Administrative Code for failure to provide the insured "Notice of the Availability of the Division of Insurance" on delayed claims. (50 Ill. Adm. Code 919.70(a)(2))

3. The Company was criticized under Section 919.70(a)(2) of the Illinois Administrative Code for failure to provide the insured with a reasonable explanation for delay beyond forty-five (45) days. (50 Ill. Adm. Code 919.70(a)(2))

4. The Company was criticized under Section 5/224(l) of the Illinois Insurance Code for failure to notify the insured's beneficiary of the availability of interest due to delayed claim processing. (See 215 ILCS 5/224(l))

5. The Company was criticized under Section 5/154.6(d) of the Illinois Insurance Code for failure to effect prompt, fair and equitable settlement of claims when liability has become reasonably clear. (See 215 ILCS 5/154.6(d))

6. The Company was criticized under Section 5/368a(c) of the Illinois Insurance Code for the underpayment of interest when a claim remains unpaid beyond thirty (30) days. (See 215 ILCS 5/368a(c))

7. The Company was criticized under Section 5/132(2) of the Illinois Insurance Code for failure to provide complete files needed to complete the examination. (215 ILCS 5/132(2))

8. The Company was criticized Section 5/154.6(i) of the Illinois Insurance Code for failing to affirm or deny coverage within thirty (30) days. (215 ILCS 5/154.6(i))

9. The Company was criticized under Section 2051.55(c)(1)(B) of the Illinois Administrative Code for improper denial and subsequent underpayment of claims. (See 50 Ill. Adm. Code 2051.55(c)(1)(B))

10. The Company was criticized under Section 5/356g of the Illinois Insurance Code for denying a breast reconstruction procedure post-mastectomy. (See 215 ILCS 5/356g)

11. The Company was criticized under Section 1407.20 for using an incorrect definition of "terminal illness" in policy forms. (50 Ill. Adm. Code 1407.20)

12. The Company was criticized under Section 5/143 of the Illinois Administrative code for using language falsely describing ambulances as part of a participating provider network in the terms and conditions of the issued policy forms. (See 215 ILCS 5/143)

13. The Company was criticized under Section 5/356x(b) of the Illinois Insurance Code for imposing a greater deductible, coinsurance, waiting period or other cost sharing limitation for colorectal cancer examinations. (See 215 ILCS 5/356x(b))

14. The Company was criticized under Section 5/356z.6 of the Illinois Insurance Code for not providing coverage for medically necessary bone mass measurement/osteoporosis screening. (215 ILCS 5/356z.6)

15. The Company was criticized under Section 2020.40 of the Illinois Administrative Code for failure to comply with the required reimbursement provision language. (50 Ill. Adm. Code 2020.40)

16. The Company was criticized under Section 5/370c of the Illinois Insurance Code for failure to list post-traumatic stress disorders as a serious mental illness in the filed policy forms. (See 215 ILCS 5/370c)

17. The Company was criticized under Section 5/500-80 of the Illinois Insurance Code for accepting business and payment of commissions to unlicensed producers. (215 ILCS 5/500-80)

II. BACKGROUND

Unicare Health Insurance Company of the Midwest (UHICM) was incorporated in Illinois in March 2000 as Rush Prudential Health Plans. The name was changed to Unicare Health Insurance Company of the Midwest Inc. by Restated Articles of Incorporation dated April 12, 2000.

The company is a wholly owned subsidiary of Unicare Illinois Services, Inc., which in turn is a wholly owned subsidiary of Unicare National Services, Inc. Unicare National Services, Inc. is a wholly owned subsidiary of Anthem Holding Corp., which is a wholly owned subsidiary of WellPoint, Inc.

III. METHODOLOGY

The Market Conduct Examination places emphasis on evaluating an insurer's system and procedures used in dealing with insureds and claimants. The following categories are the general areas examined:

1. Producer Licensing and Production Analysis
2. Policy Forms and Advertising Material Analysis
3. Nonforfeiture Analysis
4. Medicare Supplement Analysis
5. Claims
6. Insurance Division Complaints

The review of these categories is accomplished through examination of producer files, Medicare supplement application files, cash surrendered policy files, extended term and reduced paid-up policy files, claim files, Insurance Division complaint files, policy forms and advertising material. Each of these categories is examined for compliance with Division regulations and applicable state laws.

The report concerns itself with improper practices performed with such frequency as to indicate general business practices. Individual criticisms are identified and communicated to the insurer, but not cited in the report if not indicative of a general trend, except to the extent that there were underpayments in claim surveys or undercharges and/or overcharges in underwriting surveys. The following methods were used to obtain the required samples and to assure a methodical selection.

Producer Licensing and Production Analysis

Populations for the producer file reviews were determined by whether or not the producers were licensed by the State of Illinois. New business listings were retrieved from Company records selecting newly solicited insurance applications which reflected Illinois addresses for the applicants.

Policy Forms and Advertising Material Analysis

The Company was requested to provide specimen copies of all policy forms and samples of all advertising material in use during the survey period.

Nonforfeiture Analysis

Listings were requested of all policies cash surrendered, placed on extended term insurance status, or converted to reduced paid-up insurance during the period covered by the examination. These listings were retrieved by a search of Illinois life policies which either lapsed for nonpayment of premium or were requested non-forfeiture option conversions made by the policyholders.

Medicare Supplement Analysis

Survey size for issued Medicare supplement policy review was obtained from the Company's system by requesting a listing of all Illinois residents who had been issued a Medicare supplement policy during the examination period. In addition, a listing of all Illinois residents having a Medicare supplement policy in force as of the start date of the examination was requested.

Claims

Claim surveys were selected using the following criteria:

1. Paid Claims - Payment for coverage made during the examination period.
2. Denied Claims - Denial of benefits for losses not covered by policy provisions.
3. Individual or Franchise Claims - Determine whether the contracts were issued on an individual or franchise basis.

All claims were reviewed for compliance with policy contracts and endorsements, applicable sections of the Illinois Insurance Code (215 ILCS 5/*et seq.*) and Illinois Administrative Code (50 Ill. Adm. Code).

All median payment periods were measured from the date necessary proofs of loss were received to the date of payment or denial to the insured or the beneficiary.

Division of Insurance Complaints

The Company was requested to provide all files relating to complaints that had been received via the Division of Insurance as well as those received directly by the Company from the insureds of his/her representative. A copy of the Company's complaint register was also reviewed. Median periods were measured from the date of notification of the complaint to the date of response to the Division of Insurance.

The examination period for Division of Insurance and consumer complaints was January 1, 2005 through February 20, 2007.

SELECTION OF SAMPLE

SURVEY

CLAIMS ANALYSIS	Population	Reviewed	% Reviewed
Paid Group Life	24	24	100.00
Denied Group Life	2	2	100.00
Paid Individual Life	3	3	100.00
Paid AD & D	5	5	100.00
Denied AD & D	1	1	100.00
Paid Whole Life	3	3	100.00
Paid Group Health	1199462	120	.01
Denied Group Health	262450	119	.05
Paid Student Health	9287	118	1.27
Denied Student Health	13019	42	.32
Paid Medicare Supplement	153293	120	.08
Denied Medicare Supplement	18221	119	.65
UNDERWRITING			
Medicare Duplications	102	102	100.00
Medicare Supplement Declined Apps	12	12	100.00
COMPLAINTS			
Division of Insurance Complaints	433	433	100.00
Consumer Complaints	3440	116	3.37
ADVERTISING & POLICY FORMS			
Policy Forms	90	90	100.00
PRODUCERS ANALYSIS			
Producer Licenses	2551	2551	100.00

IV. FINDINGS

A. Claims Analysis

1. Paid Group Life

A review of twenty-four (24) paid group life claims produced no criticisms.

The median for payment was six (6) days.

2. Denied Group Life

A review of two (2) denied group life policies produced one (1) general criticism. A general criticism was written under Section 919.50(a)(1) of the Illinois Administrative Code for failure to provide insured's "Notice of Availability of the Division of Insurance" on denied claims. (See 50 Ill. Adm. Code 919.50(a)(1))

The median for denial could not be established.

3. Paid Individual Life

A review of three (3) paid individual life claims produced no criticisms.

The median for payment could not be established.

4. Paid Accidental Death & Dismemberment

A review of five (5) paid group accidental death and dismemberment files produced one criticism. A general criticism was written under Section 919.70(a)(2) of the Illinois Administrative Code for failure to provide the insured with a "Notice of Availability of the Division of Insurance" on the forty-five (45) day delay letter. (See 50 Ill. Adm. Code 919.70(a)(2))

The median for payment was five (5) days.

5. Denied Accidental Death & Disability

A review of one (1) denied accidental death and dismemberment file produced one criticism. A criticism was written under Section 919.50(a)(1) of the Illinois Administrative Code for failure to provide the insured with a "Notice of Availability of the Division of Insurance" on denied claims. (See 50 Ill. Adm. Code 919.50(a)(1))

A median could not be established.

6. Paid Whole Life

A review of three (3) whole life claim files produced one (1) criticism. A general criticism was written under Section 5/224(1) of the Illinois Insurance Code for failure to notify the insured's beneficiary of the availability of interest due to delayed claim processing. (See 215 ILCS 5/224(l))

A median could not be established.

7. Paid Group Health

A review of 120 paid group health files produced no criticisms.

The median for payment was one (1) day.

8. Denied Group Health

A review of 119 denied group health claims produced 17 criticisms. Nine (9) individual criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for a claim underpayment in the amount is $1057.01. These include subsequent interest due to late payment. Eight (8) of the nine (9) criticisms were written because UHICM stated in error that the insured was not eligible on the date of service. Eight (8) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for the underpayment of interest when a claim remains unpaid for thirty (30) days. The underpayment amounts totaled $62.23.

The median for denial was three (3) days.

9. Paid Student Health

A review of 118 paid student health claims produced 3 general and 2 individual criticisms. A general criticism was written under Section 5/132(2) of the Illinois Insurance Code (215 ILCS 5/132(2)) for failure to provide files needed to complete the examination. Claim forms were not provided for fourteen (14) files and received dates could not be determined for five (5) claim files. A second general criticism was written under Section 5/154.6(i) for failing to affirm or deny coverage within thirty (30) days. A third general criticism was written under Section 919.70(a)(2) for failure to provide the insured with a delay letter when a claim is delayed beyond forty-five (45) days. Individual criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for two (2) claim underpayments in the amount is $363.85. This includes subsequent interest due to late payment.

The median for payment was thirty-nine (39) days.

10. Denied Student Health

A review of forty-two (42) denied student health claims produced three (3) general criticisms and one (1) individual criticism. A general criticism was written under Section 919.50(a)(1) of the Illinois Administrative Code (50 Ill. Adm. Code 919.50(a)(1)) for failure to provide the insured's "Notice of Availability of the Division of Insurance" on denied claims. A second general criticism was written under Section 919.70(a)(2) of the Illinois Administrative Code (50 Ill. Adm. Code 919.70(a)(2)) for failure to provide the insured with a reasonable explanation for delay beyond forty-five (45) days. A third general criticism was written under Section 5/154.6(i) of the Illinois Insurance Code (215 ILCS 5/154.6(i)) for failing to deny coverage within thirty (30) days. An individual criticism was written Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)) for a claim underpayment in the amount is $684.31.

The median for denial was eighteen (18) days.

11. Paid Medicare Supplement

A review of 120 paid Medicare supplement files produced no criticisms.

A median for payment was one (1) day.

12. Denied Medicare Supplement

A review of 119 denied Medicare supplement files produced no criticisms.

A median for denial was one (1) day.

B. Underwriting

1. Medicare Supplement Duplication Review

Examiners reviewed 102 Medicare supplement new issues to ensure duplications did not exist with current policies in force. No exceptions were noted.

2. Declined Medicare Supplement Applications

Examiners reviewed twelve (12) declined Medicare supplement applications. No exceptions were noted.

C. Complaints

1. Division of Insurance Complaints

A review of 433 Division of Insurance Complaint files produced 129 criticisms.

Ninety-four (94) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for the underpayment interest when a claim remained unpaid for thirty (30) days. The underpayment amounts totaled $10,981.14. The company agreed and paid sixty-two (62) of the criticisms totaling $7704.90. Thirty-three (33) criticisms remain unpaid totaling $3276.20.

Eleven (11) individual criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)). The company agreed and paid seven (7) of the criticisms totaling $161,351.44. This includes interest due to late payment. Four (4) criticisms totaling $373.38 remain unpaid. The company should also calculate subsequent interest due to late payment.

Twenty-three (23) individual criticisms were written under Section 2051.55(c)(1)(B) of the Illinois Administrative Code (50 Ill. Adm. Code 2051.55(c)(1)(B)) for improper denial and subsequent underpayment of a claim. The insurer is prohibited from placing liability for a claim with the insured when the insured has not willfully chosen to access non-participating providers. All claims involved participating provider directed care. The claim underpayments are in the amount of $18,975.54. The company should also calculate subsequent interest due to late payment.

An individual criticism was written under Section 5/356g of the Illinois Insurance Code (215 ILCS 5/356g) because UHICM denied a breast reconstruction procedure due to a mastectomy. The procedure was denied as cosmetic. The company agreed with the criticism and paid the claim for a total of $13,352.13 which included subsequent interest due to late payment.

The median for response to the Division was twenty (20) days.

2. Consumer Complaints

A review of 116 consumer complaint claim files produced 29 criticisms.

Twenty-one (21) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for the underpayment of interest when a claim remained unpaid for thirty (30) days. The underpayment amounts totaled $238.40. The company agreed to sixteen (16) criticisms and paid $204.48 prior to completion of the Exam. Five (5) underpayments remain unpaid totaling $33.92.

Four (4) individual criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)). The company agreed and paid $1693.19. This included subsequent interest due to late payment. Three (3) criticisms totaling $420.00 remain unpaid. The company should also calculate subsequent interest due to late payment.

Four (4) individual criticisms were written under Section 2051.55(c)(1)(B) of the Illinois Administrative Code (50 Ill. Adm. Code 2051.55(c)(1)(B)) for improper denial and subsequent underpayment of a claim. The insurer is prohibited from placing liability for a claim with the insured when the insured has not willfully chosen to access non-participating providers. All involved claimants had claims incurred due to participating provider directed care and the claimant did not make a willful choice to access non-participating providers. The claim underpayments are in the amount of $2771.83. The company should also calculate subsequent interest due to late payment.

A median for response to the consumer was eighteen (18) days.

D. Policy Form Review

A review of the ninety (90) policy forms, endorsements and addendums in use resulted in fifty (50) individual criticisms. Each criticism applies to multiple policy forms.

One (1) criticism was written under Section 1407.20 of the Illinois Administrative Code (50 Ill. Adm. Code 1407.20) for using an incorrect definition of terminal illness. This section of the Administrative Code defines terminal illness as life expectancy of twenty-four (24) months.

Sixteen (16) criticisms were written under Section 5/143 of the Illinois Insurance Code (215 ILCS 5/143) for using language describing ambulances as participating providers. Ambulances do not participate in any network of providers and this language places additional liabilities on the insureds that are not truthfully described in the terms and conditions of the filed and issued policy forms. The coinsurance levels are greater for non-participating providers and any excess over the "covered expense" as determined at UHICM's sole discretion is denied.

Three (3) criticisms were written under Section 5/356z.4 of the Illinois Insurance Code (215 ILCS 5/356z.4 – as enacted by 93-102) for failure to provide coverage for outpatient contraceptive services.

Three (3) criticisms were written under Section 5/356x(b) (215 ILCS 5/356x(b)) of the Illinois Insurance Code for imposing a greater deductible, co-insurance, waiting period, or other cost sharing limitation for colorectal cancer examinations.

Five (5) criticisms were written under Section 5/356z.6 of the Illinois Insurance Code (215 ILCS 5/356z.6) for not providing coverage for medically necessary bone mass measurement/osteoporosis.

Five (5) criticisms were written under Section 2020.40 of the Illinois Administrative Code (50 Ill. Adm. Code 2020.40) for failure to comply with the required reimbursement provision language.

Four (4) criticisms were written under Section 5/370c of the Illinois Insurance Code (215 ILCS 5/370c) for failure to list post-traumatic stress disorder as a serious mental illness.

E. Producer Analysis

A review of 2551 producer licenses and first year commissions produced two (2) general criticisms.

A general criticism was written under Section 5/500-80 of the Illinois Insurance Code (215 ILCS 5/500-80) for $5,631.49 in commissions paid to nine (9) unlicensed producers on thirty-five (35) applications.

A second general criticism was written under Section 5/132(2) of the Illinois Insurance Code (215 ILCS 5/132(2)) for failure to provide files needed to complete the examination.

V. INTERRELATED FINDINGS

A. Ambulance Claim Underpayments

For the ground ambulance claims criticized, UHICM denied a portion of the billed claims as exceeds reasonable and customary, usual and customary, exceeds covered expense, and exceeds a contractual benefit and/or not a participating provider. Though UHICM describes a participating provider network of ambulances in all filed and issued forms in use, a participating provider ambulance network does not exist and separate benefit levels cannot be applied. The benefit level can never be attained as described. Eighteen (18) criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)). UHICM agreed that four (4) claims were underpaid in the amount of $2517.80. UHICM disagreed with fourteen (14) criticisms and all remain unpaid with a total of $1309.32. Additional interest should also be calculated and paid.

For the air ambulance claims criticized, four (4) underpayment criticisms were written under Section 5/154.6(d) of the Illinois Insurance Code (215 ILCS 5/154.6(d)). UHICM agreed that two (2) claims were underpaid and paid $5,989.87. This included subsequent interest due to late payment. UHICM disagreed with two (2) criticisms totaling $2007.30. The insuring document clearly states a $5,000 per trip limitation with an 80/20 co-insurance level. UHICM states the meaning as a $4,000 limitation. The risk purported to be assumed has a $5,000 limitation according to the terms and conditions of the filed policy form. The company should reopen and adjudicate the claims correctly according to the filed and issued terms and conditions.

B. Eligibility Underpayments

Examiners noted during the review of the health claims that many claims were denied as ineligible when in fact, according to all of the information examiners reviewed, the insured was eligible. This resulted in 606 individual criticisms.

UHICM agreed with 405 of the criticisms resulting in $75,528.53 in claim underpayments with subsequent interest due to late payment. For the 405 claims that were denied prior review, the insured's claim liability was $145,991.46. After the criticism was given to UHICM, UHICM made $58,722.61 in claim payments, $16805.92 in prompt pay interest payments, and $69,805.26 in contractual discounts were applied with only $17,463.59 of co-insurance, co-payment, and/or deductible liabilities of the insured.

UHICM disagreed with three (3) of the criticisms in the amount of $416.73. All should be paid with interest due to late payment.

178 criticisms resulted in an insured's claim savings of $5,847.39 of $45,452.44 in claims originally denied by UHICM. UHICM misinformed the participating providers that the claimants were not insured and told the provider to pursue the insured for 100% of the gross medical service billing by releasing them from any hold-harmless contractual provisions. Examiners found the claimants were insured and the claims should have been processed with applicable deductibles, co-insurance, and co-payments less contractual discounts with the participating providers.

Three (3) explanation-of-benefit denial codes were used to deny claims as described above. R11250, R01030, and R11010 were identified. Examiners reviewed all claims for the January 1, 2006 through December 31, 2006 period and for only the R11250 code. UHICM shall reopen and adjudicate correctly all claims with the three (3) explanation of benefit codes processed June 1, 2004 to date and provide a report to our Division.

Twenty (20) individual criticisms were written under Section 5/368a(c) of the Illinois Insurance Code (215 ILCS 5/368a(c)) for the underpayment interest when a claim remains unpaid for thirty (30) days and totaled $163.06. All were paid by UHICM before the completion of the Exam.

C. Network Inadequacy Underpayments

Examiners found that UHICM health claims were consistently underpaid. UHICM used the explanation of benefit code R15650 to deny non-participating ancillary provider claims associated with a participating provider facility charge. We have criticized about 1/5 of the claims with this code for the period January 1, 2006 through December 31, 2006 amounting to $33,579.43. UHICM should reopen all such claims with this code and adjudicate properly from June 1, 2004 through present and provide a report to our Division.

D. Company Cooperation

During the examination, while the Company made efforts to facilitate the examination process, it was inadequate. The data, information, files, and responses to citations were not received in a timely manner. The median number of days to respond to the 1179 criticisms and requests for information was 33 days. Unicare has not offered a response to several criticisms and they remain in the report as written.

Populations requested were not provided, initially. Populations for all lines were requested. After I reviewed the financials, it was discovered that Unicare failed to provide whole life, travel and student health claim populations.

VI. APPENDICES