

Final Report -- Federal Targeted Market Conduct Examination of  
**Coventry Health and Life Insurance Company HIOS ID #44527**  
State of Missouri as of July 20, 2021

Examination Report: 44527– 2018 – FED – 1

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Final as of July 20, 2021

CClIO/Oversight Group/Compliance and Enforcement

July 20, 2021

In accordance with Title 45 of the Code of Federal Regulations (C.F.R.), section 150.313, the Center for Consumer Information and Insurance Oversight (CClIO) has completed a targeted Market Conduct Examination (Examination) of Coventry Health and Life Insurance Company (East) (Issuer), HIOS ID #44527, in the State of Missouri. The Examination review period was July 1, 2016 through June 30, 2017. The Examination was called to assess the Issuer's compliance with the requirements of the following:

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) - 42 U.S.C. §300gg-26, 45 C.F.R. §§146.136 and 147.160;
- Fair Health Insurance Premiums – 42 U.S.C. §300gg and 45 C.F.R. §147.102;
- Guaranteed Availability of Coverage – 42 U.S.C. §300gg-1 and 45 C.F.R. §147.104;
- Guaranteed Renewability of Coverage – 42 U.S.C. §300gg-2 and 45 C.F.R. §147.106; and
- Essential Health Benefits – 42 U.S.C. §300gg-6 and 45 C.F.R. §§147.150 and 156.100, *et seq.*

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## I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIO) has conducted a targeted Market Conduct Examination (Examination) of Coventry Health and Life Insurance Company (Issuer) to assess the Issuer's compliance with the requirements of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended, 42 U.S.C. §300gg-26, 45 C.F.R. §§146.136, and 147.160; Fair Health Insurance Premiums 42 U.S.C. §300gg and 45 C.F.R. §147.102; Guaranteed Availability of Coverage 42 U.S.C. §300gg-1 and 45 C.F.R. §147.104; Guaranteed Renewability of Coverage 42 U.S.C. §300gg-2 and 45 C.F.R. §147.106; and Essential Health Benefits 42 U.S.C. § 300gg-6 and 45 C.F.R. §§ 147.150 and 156.100, *et seq.* The period covered by the Examination was July 1, 2016, through June 30, 2017 (Examination Period).

A random sample of 2,277 of Issuer-generated documents and claims were reviewed. Of the selected samples, CCIO found 141 violations related to three areas reviewed. Of the violations, 140 were found in plan certificates or related Summary of Benefits and Coverages (SBCs), and one (1) claim violation was found during the Examination Period. The plan violations included a failure to provide an accurate SBC in 50 plans, and a failure to provide Essential Health Benefits (EHB) that are substantially equal to the Missouri EHB-benchmark plan in 90 plans. Through this Examination report, the Issuer is directed to modify certain policies and procedures to ensure future compliance, complete a self-audit to identify any inappropriately denied claims, and re-adjudicate the identified claims, as appropriate.

This report is by exception; therefore, the Examination Results section only indicates areas where findings were noted and includes criticism responses from the Issuer (when provided). In summary, findings were identified for the following Federal requirements:

- a. 42 U.S.C. §300gg-15 and 45 C.F.R. §147.200(a)(3): Accuracy of Summary of Benefits and Coverage (SBC) limitations and exceptions; and
- b. 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i) and (ii): Provision of Essential Health Benefits (EHB) - Providing EHB Substantially Equal to the Missouri EHB-benchmark plan; and
- c. 45 C.F.R. §147.138(b)(2)(iv) and (b)(3)(i) Patient Protections - Cost-Sharing for Out-of-Network (OON) Emergency Services.

Additional details regarding these findings are in the Examination Results section of this report.

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The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations. The Issuer is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. When applicable, corrective actions for other jurisdictions and/or affiliates should also be addressed.

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## II. Scope of Examination

CCIIO conducted an Examination pursuant to 45 C.F.R. §150.313. The Examination Period was July 1, 2016 through June 30, 2017. The purpose of the Examination was to assess the Issuer’s compliance with select applicable Federal requirements.

Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal requirements does not constitute acceptance of such practices.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners and procedures developed by CCIIO. All samples were selected using a computer-generated, random sample program unless otherwise stated.

Area	Population	Sample Size
MH/SUD* paid claims – individual plans	9,327	249
MH/SUD denied claims – individual plans	1,946	201
MH/SUD paid Rx claims – individual plans	19,631	109
MH/SUD denied Rx claims – individual plans	802	105
Medical/Surgical paid claims – individual plans	68,552	184
MH/SUD paid claims – small group plans	605	160
MH/SUD denied Rx claims – small group plans	2,086	108
Medical/Surgical paid claims – small group plans	7,112	109
Medical/Surgical denied claims – small group plans	8,625	109
Medical/Surgical paid Rx claims – individual plans	87,470	184
Medical/Surgical denied Rx claims – individual plans	242,831	184
Medical/Surgical paid Rx claims – small group plans	8,164	109
Medical/Surgical denied Rx claims – small group plans	10,041	109
Advertising	42	42
Terminations – individual plans	39,983	116
Issued - Guaranteed Availability – individual plans	5,062	116
Guaranteed Renewability – individual plans	5,062	116**
Fair Health Insurance Premiums – individual plans	5,062	116**
Terminations – small group plans	438	83

\*MH/SUD stands for mental health and substance use disorder.

\*\*The Guaranteed Availability sample was also used for these reviews.

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**III. Summary of Findings**

Finding #	Summary	Citation	Completed or Required Corrective Actions
1	Failure to provide an accurate SBC for qualified health plans (QHPs) in the individual market and non-qualified health plans (non-QHPs) in the small group market.	42 U.S.C. §300gg-15 and 45 C.F.R. §147.200(a)(3) and the SBC Group and Individual Market Instruction Guides	<p>For the identified SBCs:</p> <p>a. For the 2017 plan year, no further action is required with respect to this error and revising SBCs as the Issuer corrected this error beginning with the 2017 plan year.</p> <p>For the 2016 plan year, the Issuer is directed to conduct a self-audit to identify and re-adjudicate any claims for mental health and substance use disorder (MH/SUD) inpatient (IP) rehabilitation that were denied for exceeding the 60-day limit during the Examination Period.</p> <p>Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and</p>

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Finding #	Summary	Citation	Completed or Required Corrective Actions
			<p>amount paid on the date of re-adjudication;</p> <p>b. The Issuer is directed to add prior authorization limitations to applicable SBCs for outpatient surgery, outpatient MH/SUD services (if applicable) and all inpatient MH/SUD services. For two randomly selected plans identified with this error, provide the corrected plan year 2020 SBCs to CCIO for review to ensure the concerns have been addressed within 45 calendar days of the date of the final report. If the SBCs issued for plan year 2020 contain this error, send notices to existing policyholders to advise them of the prior authorization requirement; and</p> <p>c. The Issuer is directed to add the penalty for failure to pre-certify OON outpatient surgery and OON outpatient MH/SUD services to applicable SBCs. For two randomly selected plans identified with this error, provide the</p>

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Finding #	Summary	Citation	Completed or Required Corrective Actions
			<p>corrected plan year 2020 SBCs to CCIO for review to ensure the concerns have been addressed within 45 calendar days of the date of the final report. If any SBCs issued for plan year 2020 contain this error, the Issuer is directed to send notices to existing policyholders to advise them of this penalty.</p> <p>The Issuer is directed to also conduct a self-audit to identify and re-adjudicate any claims that applied a \$400 penalty for failure to pre-certify OON outpatient surgery and OON outpatient MH/SUD services during the Examination Period.</p> <p>Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.</p>

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Finding #	Summary	Citation	Completed or Required Corrective Actions
2	Failure to provide EHBs that are substantially equal to the Missouri EHB-benchmark plan for individual and small group plans.	42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i) and (ii), and (b)	<p>The Issuer is directed to revise the plan documents to clarify that coverage is provided for court-ordered services and services that are a condition of probation or parole, including psychiatric evaluation or therapy, if the services are medically necessary, to provide benefits that are substantially equal to the Missouri EHB-benchmark plan.</p> <p>In addition, the Issuer is directed to conduct a self-audit to identify and re-adjudicate any claims improperly denied during the Examination Period for medically necessary court-ordered services and/or psychiatric evaluation or therapy for court-ordered services.</p> <p>Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.</p>

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Finding #	Summary	Citation	Completed or Required Corrective Actions
3	Failure to ensure cost-sharing requirements on OON emergency services do not exceed those imposed on in-network emergency services.	45 C.F.R. §147.138 (b)(2)(iv) and (b)(3)(i)	<p>The Issuer is directed to conduct a self-audit of claims processed for OON emergency services during the Examination Period to confirm that the claims were adjudicated and paid applying a cost-sharing amount (expressed as a copayment amount or coinsurance rate) that does not exceed the one imposed for in-network emergency services.</p> <p>The Issuer shall re-adjudicate any claims for OON emergency services claims found to have been adjudicated with an incorrect cost-sharing amount during the Examination Period.</p> <p>Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.</p>

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#### **IV. Issuer Profile**

Coventry Health and Life Insurance Company originally incorporated in the State of Texas as American Service Life Insurance Company on April 15, 1968. Coventry Corporation (DE) acquired the Company in 1987. In 1995, American Service Life Insurance Company changed its name to Coventry Health and Life Insurance Company (CHL). On May 14, 1999, the Company re-domesticated from Texas to Delaware.

In 1997, Coventry Corporation formed Coventry Health Care, Inc., a wholly-owned subsidiary.

On May 7, 2013, CHL's prior parent, Coventry Health Care, Inc., completed a merger with Aetna, Inc. Coventry Health Care, Inc. survived the merger as a wholly-owned subsidiary of Aetna, Inc. On January 1, 2014, Coventry Health Care, Inc. merged into Aetna Health Holdings, LLC.

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## V. Examination Results

### A. Summary of Benefits and Coverage (SBC) – Limitations and Exceptions Information

Finding 1 – Violation of 42 U.S.C. §300gg-15, 45 C.F.R. §147.200(a)(3), the Instruction Guide for Individual Health Insurance Coverage and the Instruction Guide for Group Market Coverage (collectively referred to as the SBC Instruction Guides)<sup>1</sup>

Accuracy of SBCs – Limitations and exceptions

42 U.S.C. §300gg-15 states in the pertinent part:

“Development and utilization of uniform explanation of coverage documents; standardized definitions

(d) Requirement to provide

(1) In general Not later than 24 months after March 23, 2010, each entity described in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

(A) an applicant at the time of application;

(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.”

45 C.F.R. §147.200(a)(3) states in the pertinent part:

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What This Plan Covers and What It Costs, Instruction Guide for Individual Health Insurance Coverage (February 2012), available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-individual-final.pdf>; What This Plan Covers and What it Costs, Instruction Guide for Group Coverage (February 2012) available at: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-instructions-for-completing-the-group-health-plan-coverage.pdf>

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“A group health plan and a health insurance issuer must provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance. The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage must provide the SBC as a stand-alone document.”

The SBC Instruction Guides, (page one (1)) states:

“PHS Act Section 2715 generally requires all group health plans and health insurance issuers offering [group] [or] [individual] health insurance coverage to provide applicants, enrollees, and policyholders or certificate holders with an accurate summary of benefits and coverage.”

The Issuer failed to meet the cited requirements by failing to provide an accurate SBC for some of the small group and individual market health plans included in the samples tested.

### **SBC Findings**

During the review of the Issuer’s individual and small group market plans for compliance with MHPAEA and the provision of EHB, in the paid and denied claims samples, it was noted that 50 SBCs did not accurately reflect the coverage provided under the plan. The review of the SBCs during the examination identified the following findings:

#### **Finding 1.a.**

- a. For 31 plan SBCs included in the samples tested, the SBCs did not accurately reflect the type of coverage provided under the plan. The SBCs listed a 60-day limit for MH/SUD IP rehabilitation. The 60-day limit was not listed as a limitation applicable to MH/SUD IP rehabilitation in the plans’ Certificates of Coverage (COC).

The Issuer agreed stating:

“This language should've been removed from the Inpatient Mental Health/Substance Use on the SBC as there are no visit limits that apply to

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Mental Health/Substance Use. This issue was corrected for the 2017 plan year.”

Area Reviewed	Population	Sample Size
MH/SUD paid claims – individual plans	9,327	249
MH/SUD paid Rx claims – individual plans	19,631	109
MH/SUD Rx denied claims – individual plans	802	105
Medical/Surgical Rx paid claims – individual plans	87,470	184
Medical/Surgical Rx denied claims – individual plans	242,831	184

**Required Action:**

The Issuer presented updated SBCs correcting the error to show no 60-day limit for MH/SUD IP rehabilitation. Therefore, no further action is required for this issue regarding the SBCs.

However, for the 2016 plan year, the Issuer is directed to conduct a self-audit to identify and re-adjudicate any claims for MH/SUD IP rehabilitation that were improperly denied during the Examination Period for exceeding the 60-day limit. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

**Issuer Response:**

“The Company acknowledges the examiners’ recommendation.

The self-audit of our claims exceeding the 60-day limit for mental health and substance use disorder (MH/SUD) inpatient (IP) rehabilitation has been completed. As suspected, this was an SBC error only and our claim systems were coded correctly. Therefore, our claim audit verified that all claims were properly adjudicated, and no claims were denied for exceeding the 60-day

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limit for mental health and substance use disorder (MH/SUD) inpatient (IP) rehabilitation.”

**CCIIO concurs with the Issuer’s position.**

**Finding 1.b.**

- b. For 19 plan SBCs included in the samples tested, the SBCs failed to indicate prior authorization is required for outpatient surgery, certain outpatient MH/SUD services, and all inpatient MH/SUD services, except emergency services, as outlined in the plans’ COCs.

The Issuer agreed stating “We agree that there was no notice of prior authorization for outpatient surgery or Mental Health/Substance Use on the SBCs. As the SBC is a high-level summary with limited space available per CMS guidelines, and prior authorizations are not required for in-network OP surgery (just out-of-network OP surgery), our SBC leads members to verify detailed benefits and other requirements on their Schedule of Benefits. It should also be noted that it states *may be required*; as prior authorizations are not required for emergency situations. It is always critical to refer to the detailed Schedule of Benefits.”

Area Reviewed	Population	Sample Size
Medical/Surgical Rx paid claims – Small Group plans	8,164	109

**Required Action:**

The Issuer is directed to ensure that the prior authorization requirements are included and accurately displayed in all applicable SBCs in accordance with the applicable SBC Instruction Guide. For two randomly selected plans identified with this error, to ensure the concerns have been addressed, the Issuer is directed to provide corrected plan year 2020 SBCs to CCIIO for review within 45 calendar days of receipt of the final report. If the SBCs issued for plan year 2020 contain this error, the Issuer is directed to send notices to existing policyholders to advise them of the prior authorization requirement.

**Issuer Response:**

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“The Company acknowledges the examiners’ recommendation.

The Company withdrew from the individual market effective 12/31/17. As a result of our market exit, there are no individual SBCs to be modified at this time. Should we re-enter the market, we will ensure all corrections are made to all applicable SBCs. For the small group market, we offered limited plans, and no longer offer any plans in 2020 for Coventry Health and Life Insurance Company, therefore there are no small group SBCs to be modified.”

**CCIIO conditionally approves the Issuer’s proposed plan of correction, which will include any required modifications to plan documents should the Issuer re-enter the market. CCIIO otherwise concurs with the Issuer’s position and accepts the Issuer’s response.**

**Finding 1.c.**

- c. During the review, it was noted that for the same 19 plan SBCs noted under Finding 1.b. above, the SBCs failed to outline a \$400 penalty for failure to pre-certify OON outpatient surgery and OON outpatient MH/SUD services as outlined in the plans’ COCs.

The Issuer was in partial agreement with the finding stating:

“We agree that there was no precertification penalty for outpatient surgery on the SBCs, however, for Mental Health/Substance Use it did state the following under the inpatient row: Prior authorization may be required. \$400 per occurrence for failure to pre-certify OON services. While this documentation is on the incorrect line, it did state the penalty. As the SBC is a high-level summary with limited space available per CMS guidelines, the SBC leads members to verify detailed benefits and other requirements on their Schedule of Benefits. It should also be noted the majority of members opt for in-network providers to obtain the best benefits possible, as well as the lowest cost share.”

Area Reviewed	Population	Sample Size
Medical/Surgical Rx paid claims – Small Group plans	8,164	109

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**Required Action:**

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The Issuer is directed to ensure that applicable SBCs for all plans correctly reflect the penalty for failure to pre-certify OON outpatient surgery and OON outpatient MH/SUD services. To ensure the concerns have been addressed, the Issuer is directed to provide corrected plan year 2020 SBCs to CCIIO for review within 45 calendar days of the date of the final report. If SBCs issued for plan year 2020 contain this error, the Issuer is directed to send notices to existing policyholders to advise them of the prior authorization requirement.

In addition, for the 2016 plan year, the Issuer is directed to conduct a self-audit to identify and re-adjudicate any claims that applied a \$400 penalty for failure to pre-certify OON outpatient surgery and OON outpatient MH/SUD services. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

**Issuer Response:**

“The Company continues to dispute this finding.

While there was no precertification penalty for outpatient surgery on the SBCs, the Mental Health / Substance Use inpatient did state: Prior authorization may be required. \$400 per occurrence for failure to pre-certify OON services. While this documentation is on the incorrect line, the required information (the existence and amount of penalty) is printed. As the SBC is a high-level summary with limited space available per CMS guidelines, the SBC leads members to verify detailed benefits and other requirements on their Schedule of Benefits.

Further, Company withdrew from the individual market effective 12/31/17. As a result of our market exit, there are no individual SBCs to be modified at this time. Should we re-enter the market, we will ensure all corrections are made to all applicable SBCs. For the small group market, we offered limited plans, and no longer offered any plans in 2020 for Coventry Health and Life Insurance Company, therefore there are no small group SBCs to be modified.

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The claims self-audit of this issue (whether a \$400 penalty was applied for failure to pre-certify OON outpatient surgery OON outpatient MH/SUD services) has been completed. As suspected, this was an SBC error only and our claim systems were coded correctly. Therefore, our claim audit verified that all claims were properly adjudicated, and no subscribers received a \$400 penalty for failure to pre-certify.”

**CCIIO conditionally approves the Issuer’s proposed plan of correction, which will include any required modifications to plan documents should the Issuer re-enter the market. CCIIO accepts the Issuer’s response regarding the claims self-audit.**

**B. Essential Health Benefits – Failure to Provide Benefits Substantially Equal to the Missouri EHB-Benchmark Plan**

Finding 2 – Violation of 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i) and (ii)

42 U.S.C. §300gg-6 states in the pertinent part:

“

(a) Coverage for essential health benefits package A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title.”

42 U.S.C. §18022 states in the pertinent part:

“Essential health benefits

(a) Essential Health Benefits Package—In this title, the term "essential health benefits package " means, with respect to any health plan, coverage that—

- (1) provides for the essential health benefits defined by the Secretary under subsection (b);
- (2) limits cost sharing for such coverage in accordance with subsection (c); and

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(3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) Essential Health Benefits

(4) In General Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

- (A) Ambulatory patient services.
- (B) Emergency services.
- (C) Hospitalization.
- (D) Maternity and newborn care.
- (E) Mental health and substance use disorder services, including behavioral health treatment.
- (F) Prescription drugs.
- (G) Rehabilitative and habilitative services and devices.
- (H) Laboratory services.
- (I) Preventive and wellness services and chronic disease management.
- (J) Pediatric services, including oral and vision care.”

45 C.F.R. §156.115 states in the pertinent part:

“Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

- (i) Covered benefits; and
- (ii) Limitations on coverage including coverage of benefit amount, duration, and scope: and...”

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:

- (i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;
- (ii) Is made only within the same essential health benefit category; and

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- (iii) Is not a prescription drug benefit.
- (2) Submits evidence of actuarial equivalence that is:
  - (i) Certified by a member of the American Academy of Actuaries;
  - (ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
  - (iii) Based on a standardized plan population; and
  - (iv) Determined regardless of cost-sharing.”

The Issuer failed to meet the above requirements because it failed to provide EHBs that are substantially equal to the Missouri EHB-benchmark plan.

### **EHB Findings – Not Substantially Equal**

For 90 health plans in the individual and small group market, the corresponding certificates did not provide EHBs that were substantially equal to the Missouri EHB-benchmark plan. Page 54 of the Missouri EHB-benchmark plan provides coverage for medically necessary court-ordered services. The Issuer’s certificates excluded court-ordered services and specifically excluded psychiatric evaluation or therapy for court-ordered services without making an exception for services that are medically necessary as is provided by the Missouri EHB-benchmark plan. The Issuer did not submit evidence that an actuarially equivalent substitution was provided for the essential health benefits that are the basis for the finding.

The Issuer disagreed with the finding, stating in responses to Criticism Nos. 2, 4 and 6:

“We have filed our QHPs for five years now, and received no deficiencies from CMS or objections from the state of Missouri regarding the Coventry plan coverage.”

For Criticism Nos 10, 11, 12, 15, 17 and 18, the Issuer disagreed with the finding stating:

“After further review, and to provide clarification, while court-ordered services or services that are a condition of probation or parole are excluded, we do cover services that are medically necessary, regardless of probation or parole. While the choice of language is different from the benchmark plan, medically necessary services are covered and this language only excludes non-medically necessary services in connection with probation or

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parole. The attached COC below highlights several sections indicating that medically necessary services are covered.”

For Criticism Nos 19, 20, 21, and 22, the Issuer disagreed with the finding stating:

“We do cover all services that are medically necessary, including court-ordered services, however, only when medically necessary. This would include Psychiatric Evaluation or Therapy. While the choice of language is different from the benchmark plan, medically necessary services are covered and this language only excludes non-medically necessary court-ordered services. In the event of a conflict, the claim is reviewed to determine the medical necessity. The attached COC below highlights several sections indicating that medically necessary services are covered.”

Please see Exhibit 2 - COC for the relevant excerpts from the COCs referenced in the Issuer’s responses above.

**CCIIO Response:**

While the Issuer is correct that the COCs state medically necessary services are covered, the COCs cited in the response and the reviewed COCs (in the pertinent part) at the start of the “SCHEDULE OF COVERED SERVICES” and the “EXCLUSIONS AND LIMITATIONS” sections, state the following:

“In the event of any conflict between the list of exclusions and limitations set forth in Section 6 and the Covered Services list below, the list of exclusions and limitations shall govern.”

The exclusions and limitations section of the COCs for the identified plans do not provide an exception to the exclusion for court-ordered services and psychiatric evaluation or therapy when the services are medically necessary.

In addition, the issuer has submitted plan documents for review and this language has not been flagged during those reviews. This was an oversight and as our acknowledgement states, in pertinent parts,

“...This email will serve as your record of our preliminary review of the forms submitted to CMS and that there are no outstanding substantive issues identified at this time.

Additionally, CMS reserves the right to raise any issues that it becomes aware of in the future. ...

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In accordance with 45 C.F.R. §150.319, CMS may consider the issuer’s previous record of compliance with respect to situations which may arise where the imposition of a Civil Monetary Penalty is warranted. This notification of our preliminary review of the submissions stated above, the review reflecting that there are no outstanding issues at this time, and your company’s cooperation in this process will become part of the record that will be maintained as evidence of your effort to comply with the market reforms of the Affordable Care Act.”

Therefore, the finding will remain in the report.

Area Reviewed	Population	Sample Size
MH/SUD paid claims – individual plans	9,327	249
MH/SUD denied claims – individual plans	1,946	201
MH/SUD paid Rx claims – individual plans	19,631	109
MH/SUD denied Rx claims – individual plans	802	184
Medical/Surgical paid claims – individual plans	68,552	184
MH/SUD paid claims – small group plans	605	160
MH/SUD denied Rx claims – small group plans	2,086	108
Medical/Surgical paid claims – small group plans	7,112	109
Medical/Surgical denied claims – small group plans	8,625	109
Medical/Surgical paid Rx claims – individual plans	87,470	184
Medical/Surgical denied Rx claims – individual plans	242,831	184
Medical/Surgical paid Rx claims – small group plans	8,164	109
Medical/Surgical denied Rx claims – small group plans	10,041	109

**Required Action:**

The Issuer is directed to revise plan documents to clarify that coverage is provided for court-ordered services and services that are a condition of probation or parole,

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including psychiatric evaluation or therapy, if the services are medically necessary, to provide benefits that are substantially equal to the Missouri EHB-benchmark plan.

In addition, the Issuer is directed to conduct a self-audit of claims processed during the Examination Period to identify and re-adjudicate all claims improperly denied involving medically necessary court-ordered services and/or psychiatric evaluation or therapy for court-ordered services.

Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

**Issuer Response:**

“The Company continues to dispute this finding.

We maintain our position that we pay all medically necessary claims, regardless if court ordered due to probation or parole. As a result of our market exit, there are no individual documents to be modified at this time. To clarify any confusion, should we re-enter the market we will modify our exclusion language in the plan documents to match the Missouri EHB-benchmark plan as follows: Court Ordered Testing – Court ordered testing or care unless Medically Necessary.

The self-audit of our claims has been completed. As there are no ICD or disposition codes for “court ordered”, “probation” or “parole”, we pulled all claims that were denied and reviewed by the Medical Director. On the respective results, claims were then reviewed for any reference to a court order, probation or parole. There was no reference at all to any of these terms in the claims submitted. All claims are reviewed for medical necessity, whether or not they have been court ordered.”

**CCIIO conditionally approves the Issuer’s proposed plan of correction, which will include any required modifications to plan documents should the Issuer re-enter the market. CCIIO accepts the Issuer’s response regarding the claims self-audit.**

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**C. Patient Protections, Emergency Services – Failure to Ensure Cost-Sharing Requirements on OON Emergency Services Do Not Exceed those Imposed on In-Network Emergency Services**

Finding 3 – Violation of 45 C.F.R. §147.138(b)(2)(iv) and (b)(3)(i)

45 C.F.R. §147.138 states in the pertinent parts:

“(b) Coverage of emergency services— (1) Scope. If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b).

(2) General rules. A plan or issuer subject to the requirements of this paragraph (b) must provide coverage for emergency services in the following manner—

...

(iv) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section...”

(3) Cost-sharing requirements—

(i) Copayments and coinsurance. Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant, beneficiary, or enrollee for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant, beneficiary, or enrollee if the services were provided in-network. However, a participant, beneficiary, or enrollee may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits

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with respect to an emergency service in an amount equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (b)(3)(i)(B), and (b)(3)(i)(C) of this section (which are adjusted for in-network cost-sharing requirements).

The Issuer failed to meet the above requirements because it imposed a higher cost-sharing requirement on OON emergency services than applied to in-network emergency services.

**Cost Sharing Finding**

For one OON emergency claim in the documents tested, the Issuer imposed a higher cost-sharing requirement for the OON emergency service than applied to in-network emergency services. The relevant plan documents state that for an emergency room visit, members would pay “\$350 Copay per visit after Deductible (waived if patient admitted).” However, the Issuer only paid \$175.19 (the allowed amount for OON services) of the \$835 bill for emergency services and the member’s responsibility was stated as \$659.81 on the explanation of benefits (EOB). The EOB showed that no amounts were applied to the deductible, or imposed as a copay or coinsurance. The Issuer failed to comply with the requirement that cost-sharing for OON emergency services cannot exceed the amount for in-network emergency services.

The Issuer agreed with the finding, stating in response to Criticism #16:

“After further investigation, it has been determined that this claim was processed incorrectly. It has been reprocessed and payment will be made minus any copayment, coinsurance or deductible applicable. Copies of records will be provided when full processing has been completed.”

The Issuer provided documents demonstrating that the claim was reprocessed and an additional \$659.81 was paid (to provide 100% of the billed amount).

**Required Action:**

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The Issuer is directed to conduct a self-audit of claims processed during the Examination Period to identify and re-adjudicate OON emergency services claims that were processed with an incorrect cost-sharing amount. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

**Issuer Response:**

“The Company acknowledges the examiners’ recommendation.

The self-audit of our claims for OON emergency services has been completed. During the Examination Period there were a total of 7,615 claims. Detailed analysis, as outlined in the attached Excel spreadsheet, demonstrates that five claims were not paid correctly. These claims were not auto adjudicated and were manually processed. Human error occurred and we have processed a refund to the respective members as indicated.”

The Issuer provided proof of the completed self-audit. As a result of the self-audit, the Issuer paid \$1640.78 for five claims that were denied incorrectly due to human error.

**CCIIO concurs with the Issuer’s position.**

**VI. Closing**

A total of 2,277 randomly selected Issuer-generated documents and claims were reviewed. Of the samples selected, CCIIO found 141 violations related to three areas reviewed. There were 140 violations found in plan certificates or related SBCs, and one violation was found in claims samples reviewed.

Violations included:

- Failure to provide an accurate SBC in 50 health plans for the Issuer’s individual and small group market health plans;
- Failure to provide EHBs that are substantially equal to the Missouri EHB-Benchmark Plan in 90 health plans; and

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- Failure to comply with the requirement that cost-sharing on OON emergency services cannot exceed the amount imposed on in-network emergency services.

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## **VII. Examination Report Submission**

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Examination are hereby acknowledged.

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Mary Nugent, Director, CIE, FLMI, AIRC, MCM, ACS  
Compliance and Enforcement Division  
Oversight Group  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services

In addition, the following individuals participated in this Examination and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Mary Nugent, CIE, FLMI, AIRC, MCM, ACS - Compliance and Enforcement Division Director
- Darshell Sheppard, MCM
- Judah Katz, Esq., MCM

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