

**MARKET CONDUCT EXAMINATION REPORT  
OF THE  
LIFE AND HEALTH BUSINESS OF**

**COVENTRY HEALTH CARE OF DELAWARE, INC.**

**2751 Centerville Road, Suite 400  
Wilmington, DE 19808  
NAIC Company Code 96460**

**REPORT NUMBER 4867-03**



**STATE OF MARYLAND  
MARYLAND INSURANCE ADMINISTRATION**

**ALFRED W. REDMER, JR., COMMISSIONER  
DECEMBER 9, 2004**

ROBERT L. EHRLICH, JR.  
GOVERNOR

ALFRED W. REDMER, JR.  
COMMISSIONER

MICHAEL S. STEELE  
LIEUTENANT GOVERNOR

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DEPUTY COMMISSIONER

**STATE OF MARYLAND**  
**MARYLAND INSURANCE ADMINISTRATION**  
525 St. Paul Place, Baltimore, Maryland 21202-2272

P. TODD CIONI  
ASSOCIATE COMMISSIONER  
COMPLIANCE & ENFORCEMENT

December 9, 2004

The Honorable Alfred W. Redmer, Jr.  
State Insurance Commissioner of Maryland  
Maryland Insurance Administration  
525 Saint Paul Place  
Baltimore, Maryland 21202

Dear Commissioner:

Pursuant to your instructions and authorization, a target market conduct examination of the claims processing practices of

**COVENTRY HEALTH CARE OF DELAWARE, INC.**

a Foreign Insurer, whose executive offices are located at 2751 Centerville Road, Suite 400, Wilmington, DE 19808, has been completed.

The report of the examination is respectfully submitted herein.

Sincerely,

*Signature on file with original*

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P. Todd Cioni, Associate Commissioner  
Compliance and Enforcement

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## I. Executive Summary

The Maryland Insurance Administration (hereinafter referred to as “MIA”) conducted a targeted prompt payment examination of Coventry Health Care of Delaware, Inc. (hereinafter referred to as the “Company” or “CHCD”) regarding its timeliness of claim processing. This examination focused on health claims processed by “CHCD” and pharmacy claims processed by Caremark, Inc. (“Caremark”), for Maryland business during the period January 1, 2002 through June 30, 2003 (“survey period”).

The report documents significant and substantial noncompliance issues. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct insurance business in compliance with Maryland laws and regulations.

Section XIII of the report contains a Summary of Violations and the frequency by which they occurred. In general, the following Maryland laws and regulations were found to have been violated by the Company during the survey period:

- Insurance Article 15-1005(c) Failure to process claims within 30 days of receipt
- Insurance Article 15-1005 (f) Failure to consistently pay interest on claims processed in excess of 30 days of receipt
- Insurance Article 15-1005(c)(2)(i) Failure to give the proper reason for denial
- Insurance Article 15-1207(b)(1) and COMAR 31.11.06.03A(22) and COMAR 31.11.06.03E(3) Failure to provide coverage for prescribed contraceptives
- Insurance Article 15-10A-02(b) Failure to render a final decision in writing to a member or a health care provider acting on behalf of the member, within 45 working days after the grievance was filed.
- Insurance Article 15-10D-02(e)(1) Failure to send a copy of the written notice of the coverage decision to the treating health care provider.
- Insurance Article 15-10D-02(e)(2) Failure to send a notice of the coverage decision.

## **II. Scope of Examination**

The primary purpose of the examination was to assess the Company's compliance with the requirements of Claims and Utilization Review, Title 15, Subtitle 10 of the Insurance Article of the Annotated Code of Maryland ("Insurance Article") and Code of Maryland Regulations ("COMAR") Title 31, Subtitle 15, Chapter 08 "Payment of Claims Under Life and Health Policies and Annuity Contracts". Additionally, the examination was to determine if operations were consistent with the public interest.

The report is by test and indicates all tests applied during the examination as well as pertinent findings and directives for Company action. The examination planning and testing methodologies follow the standards established by the National Association of Insurance Commissioners ("NAIC") and procedures developed by the MIA.

All unacceptable or non-compliant practices may not have been discovered or noted in the report. Failure to identify or criticize improper or non-compliant business practices does not constitute acceptance of such practices. Examination report recommendations that do not reference specific insurance laws, regulations or bulletins are presented to improve the Company's practices and ensure consumer protection.

### **III. Company Profile**

Physicians Health Plan of Delaware, Ltd., a Delaware corporation, was incorporated on May 29, 1985, by Delaware physicians in order to establish and operate an IPA model HMO. On October 14, 1986, the company changed its name to Health Plan of Delaware, Ltd. The company's Certificate of Authority was granted by the State of Delaware on November 17, 1986.

In 1988, Principal Health Care, Inc. ("PHC") acquired Health Plan of Delaware, Ltd. and, on December 15, 1988, changed that company's name to Principal Health Care of Delaware, Inc. ("CHCD"). PHC was a wholly owned subsidiary of Principal Holding Company ("Principal Holding"), which was wholly owned by Principal Life Insurance Company, formally Principal Mutual Life Insurance Company ("Principal Life"). The State of Maryland granted CHCD a Certificate of Authority on December 1, 1996.

On April 1, 1998, the Delaware Department of Insurance approved the acquisition of Principal Health Care of Delaware, Inc. by Coventry Health Care, Inc. (CHC), as the result of a business combination among Principal Life, Principal Holding, PHC and the publicly held Coventry Corporation. Under the combination, Coventry Health Care, Inc. was formed on December 17, 1997 by Coventry Corporation (60% shareholder) and Principal Health Care, Inc. (40% shareholder).

Also effective April 1, 1998, Coventry Corporation was merged into a newly formed subsidiary of Coventry Health Care, Inc. CHC became the publicly held company. PHC contributed all of the outstanding stock of Principal Health Care of Delaware, Inc. (along with other HMOs it owned) to CHC in exchange for 40% of the outstanding stock of CHC.

Principal Health Care of Delaware, Inc. changed its name to Coventry Health Care of Delaware, Inc. ("CHCD") on October 4, 1999. CHCD is a for-profit, wholly owned subsidiary of Coventry Health Care, Inc. of Bethesda, Maryland.

The Company reported a total premium volume of \$ 127,644,195 for accident and health insurance on Schedule T of the 2002 annual report submitted to the NAIC. The

Company is only licensed in Delaware and Maryland with the following premiums collected in these states:

<b>State</b>	<b>Premium</b>	<b>Percent of Total Premium</b>
Delaware	\$ 82,483,790	64.6%
Maryland	\$ 45,160,405	35.4%

#### **IV. Business Practices**

##### **A. Internal Audits**

**Standard - The Company has an up-to-date, valid, internal or external audit program.**

The examiners requested copies of any internal audits conducted by the Company during the survey period.

The Company performs periodic internal claims audits. These audits focus on accuracy and consist of targeted audits, claim processor audits, random audits, and auto-adjudicated audits.

The examiners did not find any problems with the Company's claim audit procedures.

##### **B. Market Conduct Examinations Done By Other Jurisdictions**

**Standard - The Company has responded to the findings and directives of previous examinations.**

The Company provided the examiners with a final copy of a limited scope market conduct report from the State of Delaware as of August 15, 2003. The survey period was not indicated in the report. The examination targeted claims processing by CHCD through the use of its vendor, APS Healthcare Bethesda, Inc. ("APS").

The examiners reviewed this report and found no concerns or violations that would affect their examination or require special consideration because claims processed by APS were excluded from this MIA examination.

## V. Claims Reviewed

**Standard – The Company is processing all claims appropriately within 30 days and paying the required interest if payment is made after 30 days of receipt.**

### A. Health Claims Selection

The purpose of this portion of the examination was to investigate the timeliness and claims handling practices of the Company in order to verify compliance with Section 15-1005 of the Insurance Article and COMAR 31.15.08.03B(12).

The initial data requirements were set forth in a letter dated October 15, 2003 from the MIA to the Company. In addition, the examiners discussed in detail, by telephone with the Company, the particular requirements necessary to complete the examination.

The examiners requested and the Company provided a data file that included all health claims received during the survey period. This file included 73,141 claims denied during the survey period. The examiners selected a random sample of 150 denied health claims to review for timeliness of processing.

The data file also included 214,797 health claims paid during the survey period. The examiners selected a random sample of 300 paid health claims to review for timeliness of payment.

#### 1. Health Denied Claims

The examiners reviewed the 150 health denied claims and found the following 5 claims (3%) were not processed within 30 days of Company receipt:

Claim #	Date Received	Date Denied	Total # of Days
2861582	9/24/02	11/5/02	42
3109875	5/14/02	3/26/03	317
3366448	5/16/03	7/1/03	46
2980657	11/16/02	1/15/03	50
3444544	6/23/03	9/22/03	91

**The Company is in violation of Section 15-1005(c) of the Insurance Article and COMAR 31.15.08.03B(12) for failure to process 5 claims within 30 days.**

## 2. Health Claims Paid

The examiners reviewed 300 paid health claims. No violations were noted.

## 3. Interest

The examiners reviewed the Company claim system to determine that interest is automatically calculated on late paid claims. The examiners found the Company was not paying interest on all claims processed in excess of 30 days.

The examiners found the following adjusted claims where interest was not paid:

Claim #	Date Received	Date Paid	Amount of Claim Payment	Days to Process	Total Interest Due
3109875	05/14/02	03/26/03	\$326.31	317	\$70.27
3444544	06/23/03	09/22/03	\$60.09	91	\$2.11

**The Company is in violation of Section 15-1005(f) for failure to pay interest on the above two claims processed in excess of 30 days.**

## 4. Improperly Denied Contraceptive Claims

Included in the original samples was claim 2203703327, MIA sample number 24, a small group claim denied as not being covered under the plan. This claim was for contraceptives. Section 15-1207(b) of the Insurance Article, COMAR 31.11.06.03A(22) and COMAR 31.11.06.03E(3) require payment of family planning services and associated prescription drugs.

The examiners then requested all denied claims for contraceptives. The Company provided data on 228 claims. The examiners selected 68 claims for review. The following 5 claims were improperly denied:

Claim #	Reason for Denial	Violation
1203101586	not covered under benefit plan	Insurance Article 15-1207(b), COMAR 31.11.06.03A(22) and COMAR 31.11.06.03E(3)
1204202681	not covered under benefit plan	Insurance Article 15-1207(b) and COMAR 31.11.06.03A(22)
1206500514	not covered under benefit plan	Insurance Article 15-1207(b) and COMAR 31.11.06.03A(22)

Claim #	Reason for Denial	Violation
1213302847	not covered under benefit plan	Insurance Article 15-1207(b) and COMAR 31.11.06.03A(22)
1218203285	not covered under benefit plan	Insurance Article 15-1207(b) and COMAR 31.11.06.03A(22)

**The Company is in violation of Section 15-1207(b) of the Insurance Article, COMAR 31.11.06.03A(22) and COMAR 31.11.06.03E(3) for not providing coverage for prescribed contraceptives.**

The Company is directed to pay these claims with interest.

**Company Response:**

The Company agrees that the contraceptive claims were not paid as required by Maryland law. The Company corrected the mandated benefit in the claim processing system on October 11, 2003.

**5. Improper Denial Reason on Explanation of Benefits**

Claim 1310401548, MIA sample number 26, was denied in its entirety and the reason on the Explanation of Benefits was “payment represents allowed amount member may not be balanced billed”. The correct reason for denial was for using a non-participating assistant surgeon.

**The Company is in violation of Section 15-1005(c)(2)(i) for failure to give the proper reason for the denial.**

**B. Pharmacy Claims Selection**

The Company contracts with Caremark as the Pharmacy Benefit Manager. When an insured goes to a pharmacy with a prescription and presents a valid prescription drug card, Caremark processes the charge at the point of sale and calculates the copayment amount due from the insured member.

The examiners requested and the Company provided a data file that included all pharmacy claims received during the survey period. This file included 1,967 denied pharmacy claims during the survey period. The examiners selected a random sample of 15 denied pharmacy claims to review for timeliness of processing. All of these claims were denied within 30 days of receipt.

The data file also included 284,098 pharmacy claims paid during the survey period. The examiners selected a random sample of 240 pharmacy claims paid, to review for timeliness of payment.

No violations of timeliness were found.

## VI. Adverse Decisions

**Standard - The Company makes all adverse decisions and/or utilization review determinations in compliance with all applicable statutes and rules and regulations.**

An adverse decision means a utilization review determination made by a private review agent that a proposed or delivered health care service is or was not medically necessary, appropriate, or efficient and may result in non-coverage of the health care service. An adverse decision may be made in the following manner:

- Prospective – A request for authorization care prior to the receipt of health care services;
- Concurrent- During an inpatient stay, or retrospectively, reviewed after the services were rendered (“adverse decision type”); and
- Retrospective – Review of a delivered health care service is normally associated with a claim submitted for payment by a provider who delivered the health care service.

Claim # 3246370 was a retrospective adverse decision for an in-patient hospital stay in which the last 2 days were denied as “not meeting in-patient stay criteria”. The claim was appealed on June 21, 2002 which was within 180 days of receipt of the denial. The Company did not send a decision letter until over 1 year later, on June 27, 2003. The reason for the overturning of the Company’s decision was noted in the claim file as “administrative overturn due to delay in clinical appeals processing”.

**The Company is in violation of Section 15-10A-02(b) of the Insurance Article for not rendering a final decision in writing to the member or a health care provider acting on behalf of the member, within 45 working days after the date the grievance was filed.**

## VII. Coverage Decisions

**Standard - The Company makes all coverage decisions in compliance with all applicable statutes and rules and regulations.**

A “coverage decision” means an initial determination by a carrier or a representative of a carrier that results in noncoverage of a health care service.

The examiners requested and reviewed the Company’s policies and procedures for coverage/benefit determinations. These policies and procedures state, “Members, facilities, PCPs, and physicians are notified, in writing, of the reason for the denial and the appeals process...”

The examiners found 4 claims denied for coverage decisions. None of the 4 claims notified the treating health care provider as required by a health maintenance organization. These 4 claims are as follows:

Claim 2995727 was a re-denial of claim 12226000184. The examiners requested all background information on this claim including the original claim and any other correspondence. This material was not provided to the examiners. The Company provided the examiners with a denial letter dated January 15, 2003 addressed to the member; however, no copy was sent to the treating health care provider. The notice required by Section 15-10D-02(e)(2) of the Insurance Article was not included in the file and was not referenced as an attachment to the January 15<sup>th</sup> letter.

**The Company is in violation of Section 2-207(b)(1) of the Insurance Article for failure to provide the examiners with the original claim and any other correspondence.**

**The Company is in violation of Section 15-10D-02(e)(1) for failure to send a copy of the written notice of the coverage decision to the treating health care provider.**

**The Company is in violation of Section 15-10D-02(e)(2) for failure to send a notice of the coverage decision.**

Claim 1316501115 was denied as a coverage decision. The Company provided the examiners with a denial letter dated June 30, 2003 addressed to the member; however, a copy was not sent to the treating health care provider. A notice was included in the file

but was not in compliance with Section 15-10D-02(e)(2) of the Insurance Article and it was not referenced as an attachment to the June 30<sup>th</sup> letter.

**The Company is in violation of Section 15-10D-02(e)(1) for failure to send a copy of the written notice of the coverage decision to the treating health care provider.**

**The Company is in violation of Section 15-10D-02(e)(2) for sending out a non-compliant notice.**

Claim number 1222601097 was denied as a coverage decision. The Company provided the examiners with a denial letter dated September 4, 2002 addressed to the member; however, a copy was not sent to the treating health care provider. The notice required by Section 15-10D-02(e)(2) of the Insurance Article was not in the file and was not referenced as an attachment to the September 4<sup>th</sup> letter.

**The Company is in violation of Section 15-10D-02(e)(1) for failure to send a copy of the written notice of the coverage decision to the treating health care provider.**

**The Company is in violation of Section 15-10D-02(e)(2) for failure to send a notice of the coverage decision.**

Claim 2217005708 was denied as a coverage decision. The Company provided the examiners with a denial letter dated October 12, 2002 addressed to the member; however, a copy was not sent to the treating health care provider. A notice was included in the file but was not in compliance with Section 15-10D-02(e)(2) of the Insurance Article and it was not referenced as an attachment to the October 11<sup>th</sup> letter.

**The Company is in violation of Section 15-10D-02(e)(1) for failure to send a copy of the written notice of the coverage decision to the treating health care provider.**

**The Company is in violation of Section 15-10D-02(e)(2) for sending out a non-compliant notice.**

**Company Response:**

Insurance Article §15-10D-02(e)(1): For ER claims that are reviewed by the Medical Director and then denied, the Company's practice has been to batch letters sent to the member by provider. The batch of letters were then submitted to each provider once each month, or as often as needed to meet the 30 day notification requirement. There is no indication in the letter to indicate the provider was copied nor is there a cover letter in the file to indicate that the copies were sent to the provider.

Beginning immediately, each member letter will include a cc to the applicable provider. Rather than batch the letters for a later mailing the Company will send a copy of the member letter to the provider, along with the applicable appeals information, concurrently with the letter to the member. While it is evident the insert is available, it is not clear if this insert was provided to the auditor.

### **VIII. Summary of Violations**

#### **Claims Reviewed – Pages 9-11**

The Company is in violation of Section 15-1005(c) of the Insurance Article for processing 5 claims in excess of 30 days.

The Company is in violation of Section 15-1005(f) of the Insurance Article for not paying interest on 2 claims processed over 30 days from receipt.

The Company is in violation of Section 15-1207(b)(1) of the Insurance Article, COMAR 31.11.06.03A(22) and COMAR 31.11.06.03E(3) for not providing coverage for prescribed contraceptives.

The Company is in violation of Section 15-1005(c)(2)(i) of the Insurance Article for failure to give the proper reason for denial.

#### **Adverse Decisions – Page 13**

The Company is in violation of Section 15-10A-02(b) of the Insurance Article for not rendering a final decision in writing to the member or a health care provider acting on behalf of the member, within 45 working days after the date the grievance was filed.

#### **Coverage Decisions – Pages 14-15**

The Company is in violation of Section 15-10D-02(e)(1) for failure to send a copy of the written notice of the coverage decision to the treating health care provider on 4 claims.

The Company is in violation of Section 15-10D-02(e)(2) for failure to send a notice of a coverage decision on 2 claims.

The Company is in violation of Section 15-10D-02(e)(2) for sending out a non-compliant notice of a coverage decision on 2 claims.

**Examination Report Submission**

The courteous cooperation extended to the examiners by the Company's officers and employees during the course of the examination is gratefully acknowledged.

In addition to the undersigned, Dottie Cordwell, HIA, ASF, MHP, CSF, AIRC and Angie Bartlett participated in this examination and in the preparation of this report.

Respectfully submitted,

*Signature on file with original*

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Leighton Tabron  
Chief Market Conduct Examiner  
Compliance and Enforcement