

**OHIO DEPARTMENT OF INSURANCE**

**A**

**MARKET CONDUCT EXAMINATION**

**OF**

**CONSECO HEALTH INSURANCE COMPANY**

**NAIC # 78174**

**As Of**

**September 30, 2006**



## Ohio Department of Insurance

2100 Stella Court, Columbus, OH 43215-1067  
(614) 644-2658 www.ohioinsurance.gov

**Ted Strickland, Governor**  
**Mary Jo Hudson, Director**

Honorable Mary Jo Hudson  
Director  
Ohio Department of Insurance  
2100 Stella Court  
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

Conseco Health Insurance Company Insurance Company NAIC# 78174

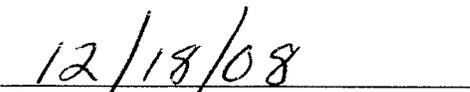
The examination was conducted at the Company's statutory home office at:

11825 North Pennsylvania Street  
Carmel, Indiana 46032

A report of the examination is enclosed.

Respectfully submitted,

  
Lynette Baker  
Chief, Market Conduct Division

  
Date

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## FOREWORD

This examination was conducted under authority provided under Ohio Revised Code (“O.R.C.”) 3901.011.

## SCOPE OF EXAMINATION

On June 6, 2006, the Market Conduct Division of the Ohio Department of Insurance (“Department”) opened an examination into the non-financial business practices of Conseco Health Insurance Company (“Company”) by sending the Company a call letter and initial request for information. On April 23, 2007 the on-site portion of the examination began at the Company’s statutory home office in Carmel, Indiana.

The examination was restricted to a review of Company activities for Ohio individual specified/named disease insurance policies for the period of August 1, 2005 through September 30, 2006. The examination report is reported by test and was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (“NAIC”) and the state of Ohio’s applicable statutes and rules.

Accordingly, the examination included the following areas of the Company’s operations:

- A. Company History
- B. Company Operations
- C. Certificate of Authority
- D. Compliance
- E. Claims
- F. Complaint Handling
- G. Policyholder Service

## METHODOLOGY

As part of the examination, the Department’s examiners reviewed the Company’s individual specified/named disease insurance policy and claim files and the Company’s corresponding procedure manuals. This information was supplemented by interviewing Company managers and with written inquiries requesting clarification and/or additional information.

Only Ohio policyholders’ files were reviewed. A series of tests were designed and applied to these files to determine the Company’s level of compliance with Ohio’s insurance statutes and rules. These tests are described and the results noted in this report.

The examiners used the NAIC’s standard of:

7% error ratio on claim files (93% compliance rate)

10% error ratio on all other files (90% compliance rate)

to determine whether an apparent pattern or practice of non-compliance existed for any given test. The results of each test applied to a sample are reported separately. Each test is expressed as a “yes/no” question. A “yes” response indicates compliance and a “no” response indicates a failure to comply.

In any instance where errors were noted, the examiners described the apparent error and asked the Company for an explanation. The Company responded to the examiners and either:

- Concurred with the findings,
- Had additional information for the examiners to consider, and/or

- Proposed remedial action(s) to correct the apparent deficiency.

If applicable, the examiners' recommendations are included in this report.

### SAMPLING

Upon request, the Company supplied reports of policy and claim data in file formats, which could be used on IBM compatible personal computers. Except as otherwise noted, all tests were conducted on a sample of files randomly selected from a given report. The samples were pulled from populations consisting of Ohio policies and were selected using a standard business database application that provides a true random sample given that it supplies a random starting point from which to select the sample.

### COMPANY HISTORY

Domiciled in the state of Arizona, Conseco Health Insurance Company was originally established and incorporated on October 1, 1970 as Capitol American Life Insurance Company. Conseco Incorporated acquired the Company in March 1997. In June 1997, administrative functions were transferred to Carmel, Indiana and the claims payment and processing areas were moved to Chicago, Illinois.

Capitol American Life Insurance Company and Capitol National Life Insurance Company, Ohio merged operations in April 1998 and changed the respective Company names to Conseco Health Insurance Company (CHIC). In June 1998, as a result of the direct acquisition of both companies by the Conseco Incorporated, Frontier National Life Insurance Company merged its operations into Conseco Health Insurance Company in July 2001.

### COMPANY OPERATIONS

Conseco Health Insurance Company ("Company") is a direct subsidiary of Conseco Life Insurance Company of Texas, as an indirect wholly subsidiary of Conseco Incorporated. The Company is domiciled in the state of Arizona and is licensed in every state except Connecticut, New York, and Massachusetts. The Company is also licensed in the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. The Company markets Medicare supplement products and specified/named disease insurance products through professional independent producers.

For calendar year 2006, the Company reported total premiums of \$301,824,844 and incurred losses of \$276,518,028. The Company's year-end 2006 premium and loss information from the Company's Financial Annual Statements is as follows:

<i>2006 Accident &amp; Health Insurance</i>	<b>Ohio</b>	<b>Ohio</b>
<u>Line of Business</u>	<u>Premiums</u>	<u>Incurred Losses</u>
Accident & Health Group	\$58,914,556	\$95,349,760
Accident & Health Other	\$242,910,288	\$181,168,268

As of September 30, 2006, the officers of the Company were:

Officer	Eugene Martin Bullis
Officer	Ronald Lee Jackson
Officer	Eric Ronald Johnson
Officer	Ronald Frank Ruhl
Officer	Steven Michael Stecher
Officer	Mark Edward Alberts

Officer	David Joseph Barra
Officer	Robert Eugene Burkett
Officer	Brad Jeffrey Corbin
Officer	David DeJong Humm
Officer	James Mark Crafton
Officer	Susan Carol Billman
Officer	Matthew Joseph Zimpfer
Officer	William Thomas Devanney
Director or Trustee	Christopher Joseph Nিকেle
Director or Trustee	Daniel Joseph Murphy
Director or Trustee	Michael John Dubes
Director or Trustee	Mark Edward Alberts
Director or Trustee	David Joseph Barra
Director or Trustee	Eugene Martin Bullis
Vice President	James Mark Crafton
Vice President	Mark Edward Alberts
Senior Vice President	Stephen W. Robertson
Vice President	Ronald Frank Ruhl
Vice President	Eugene Martin Bullis
Vice President	Eric Ronald Johnson
Vice President	Steven Michael Stecher
Vice President	Brad Jeffrey Corbin
Vice President	David Joseph Barra
First Person Responsible for Financial Statement	Michael John Dubes
Second Person Responsible for Financial Statement	Karl William Kindig
Third Person Responsible for Financial Statement	Daniel Joseph Murphy
Fourth Person Responsible for Financial Statement	Raymond Kent Ball

## **CERTIFICATE OF AUTHORITY**

The Company operates under a Certificate of Authority issued in accordance with the Ohio Revised Code, which permits it to transact appropriate business thereunder as defined by the Ohio Revised Code. In the course of the examination, the examiners determined that the Company's operations were in compliance with its Certificate of Authority.

## **COMPLIANCE**

### **Management Oversight**

The Company provided written documentation that it has established a Compliance Department for complying with Ohio laws and rule relating to market conduct activities. The Compliance Department reviews new laws, regulations and makes applicable assignments for procedure changes, which need to be implemented. The Compliance Department then posts all new laws, regulations and statutory surveys on the intranet as a reference for all associates (employees).

The Compliance Department reviews all advertising and agent training materials for compliance with state laws and regulations, and coordinates all market conduct examinations and makes any corrections in procedures necessary. The Compliance Department then audits all requirements contained within the market conduct examination reports. It additionally analyzes complaints, and reports any trends to the Chief Compliance Officer. The Compliance Department is in the Legal area of the Company and interacts with all other areas.

The Compliance Department stated in writing that it does have written compliance procedures. Other areas of the Company also have compliance procedures and quality audits written into their normal business procedures. All compliance issues discovered by the Compliance Department are communicated to the Chief Compliance Officer. The Chief Compliance Officer then reports the serious issues to senior management and/or the Board of Directors, and then works with Compliance Department management to correct the issues. In this manner, top management is kept informed of potential problems.

The management of the operating departments, in which compliance issues have been identified and/or audited, is ultimately responsible for the audit results/improvements.

All new employees of the Compliance Department view a presentation on Privacy-HIPPA/Graham-Leach-Bliley and Sarbanes-Oxley Acts. The new employees are then given an examination regarding the presentation. In addition, employees are trained within their respective departments regarding compliance issues. The compliance training program is reviewed as deemed necessary by the various departments, and the respective department monitors the employee's effectiveness on a daily basis.

On a quarterly basis, the Chief Compliance Officer reports any compliance issues to the Board of Directors' Audit Committee.

### **Monitoring of Laws and Rules**

The Company verified in writing that all applicable laws and rules governing operation units within the Company are audited. The Compliance Department monitors the Ohio Revised Code ("O.R.C.") and the Ohio Administrative Code ("O.A.C.") to identify applicable laws and rules, and implements any changes through new legislation review and market conduct examination results. Quality assurance audits performed by the operating units, and internal audits also monitor applicable laws and rules.

### **Auditing and Monitoring of Policy Files, Claims and Complaints**

The Company furnished documentation, which states that in addition to quality assurance audits that are performed by the operating units, the Internal Audit area may perform audit work within the Policy and Claims areas. The internal audit plan is developed using a risk-based approach utilizing the Committee of Sponsoring Organizations framework. One of the audit plan philosophies is to select a particular cycle each year for audit. Further auditing may be performed by the Sarbanes-Oxley team, who works with various key control owners to ensure that controls are designed and operating effectively.

In deciding which areas to audit, risk-based planning is performed to determine which areas, within a given timeframe (usually one year), will be subject to an internal audit. The Internal Audit Department conducts risk assessment in collaboration with management. Audit schedule recommendations are made to senior management and the Audit and Risk Management Committee of the Board of Directors (Audit Committee), who approves the audit plan. The Internal Audit Department then acts with management to determine the specific scope of a selected audit.

The internal audits are conducted by the enterprise based Conesco Internal Audit Team. On occasion the audit team may be augmented with outside resources who generally have in-depth audit and business experience.

Internal audits are part of the Company's overall compliance program. The audits provide additional assurance to management and the Audit Committee regarding adherence to policy, procedures, and Best practices. Internal audit findings and recommendations are formally reported and monitored until satisfactorily implemented by management.

Internal audits are conducted involving senior management as part of the audit planning and kick-off process through wrap-up and reporting.

Audit reports are distributed to senior management of the area under audit, along with several executive management members (i.e., the CEO, CFO, Business Unit President, Sarbanes-Oxley Leader, etc.).

Each audit finding includes a management response and action plan. Such action plans are considered along with other management priorities. Implementation is monitored and reported until completed and independently tested. The Internal Audit Department prepares quarterly scorecards, which include the status of any open audit recommendations, and these are shared with senior management and the Audit Committee.

The Internal Audit Department participates in regularly scheduled meetings with management, at which time audit results are discussed to consider changes within the organization (possible impact to the risk assessment) and the status of any audit recommendations. These are shared with senior management and the Audit Committee. Executive management and the Audit Committee also receive regular updates six or more times annually.

Various reports are generated by the Internal Audit Department, including a quarterly scorecard, which summarizes the audits completed, recommendations issued, and those that are currently outstanding. Also, ad hoc reports for segments of the business are produced. Each quarter, the Internal Audit Department dedicates time on the work schedule in order to follow-up on the status of recommendations and validate (via sampling, inquiry and observation) recommendations reported as implemented by management.

During the internal audit process, exceptions or issues are discussed in detail with management. Root causes are analyzed to allow recommendations and action plans to address the underlying issues. Management responses to internal audit findings are included in the "specific individuals responsible" and "target implementation dates" portion of the internal audit report. To assure further compliance, management is responsible for its implementation plans. Once the recommendations have been implemented by management, the Internal Audit Department is notified, which triggers the follow-up procedures. Follow-up procedures include sampling, where appropriate, to ensure that the findings have been addressed in an appropriate and lasting manner.

The Internal Audit Department is notified of any changes and improvements in the normal course of the Company's work and through the risk-assessment process. The Internal Audit Department often participates in major projects on a consultative basis, which allows control and procedural matters to be considered and addressed proactively.

In an effort to monitor and analyze complaints, to discover any potential market regulation problems, the Policyholder Compliance Department produces a weekly complaint trend report that includes inventory, types of complaints, departments affected by the complaints, and the types of policies involved. This report is published to 33 department supervisors and other responsible employees for their review and action. On a monthly basis, the Compliance Department analyses complaints and produces reports to the Chief Compliance Officer. This analysis shows complaint trends, types of complaints and departments affected. The Chief Compliance Officer discusses any issues with applicable department management. If necessary, Ad Hoc Committees are formed to work on specific problems discovered throughout the complaint analysis.

## GENERAL CLAIMS PRACTICES

### **File and Supporting Documentation**

It was extremely difficult to determine or verify the claim activity dates in the claims handling process. Inadequately documented claim files made it difficult for the examiners to reconstruct the Company's communications and claims activities.

The Company is not in compliance with O.A.C. 3901-1-60(G), which states that each third-party payer shall maintain complete documentation of every claim for a period of three years. The documentation shall be sufficient to permit complete reconstruction of the third-party payer's activities and communications with respect to each claim. Documentation shall include the date of each activity or communication. All documentation shall be reproducible to paper.

Additionally, instances were noted where the policyholder/ claimant and not the provider was required to obtain copies of additional information (i.e. attending physician statements, hospital records, other medical information, etc.) before the claim could be processed. This practice is not in compliance with O.R.C. § 3901.381(B)(2)(a), which states "*Not later than thirty days after receipt of the claim, the third-party payer shall **notify all relevant external sources** that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed.*"

When queried in a pre-examination interrogatory as to basis on which the Company justifies policyholders obtaining and submitting copies of additional information, the Company responded by declaring in writing that "*In the event we do not receive all of the needed records as identified on the claim form, we notify our policyholders of the specific missing information and request them to provide us with such information.*"

**Examiner Recommendation:** The Company should immediately implement procedures to ensure that all relevant external sources are notified when additional information is needed for the processing of a claim as required by O.R.C. § 3901.381(B)(2)(a).

**Comments:** The following issues are noted:

- The examiners were not allowed access to the Company's systems, nor did they receive proper instruction that would have allowed them entry.
- The Company provided the examiners "*hardcopies*" of claim system data. The examiners were not afforded the opportunity to view actual computer screens for the samples being examined/ reviewed.
- At the inception of the on-site portion of the examination, the Company gave assurance that it would provide all related information it possessed to the examiners, which related to the claims being reviewed. The Company further stated that all information necessary for the reconstruction of claim activity would be furnished. However, in responding to the initial Summary of Findings, the Company presented the examiners with additional data that was not initially supplied. The new information received influenced the Summary of Findings results.

## SPECIFIC CLAIMS PRACTICES

### Claims Paid Less Than 30 Days

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease claims that were closed during the exam period between August 1, 2005 and September 30, 2006. The examiners selected to review a random sample of 50 claim files from the total population of 3,093 CHIC Claims Paid Less Than 30 Days to test for compliance with the Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all Company procedure manuals as part of the exam process.
- Review also included tests to assure that the Company's claim practices and procedures were in compliance with the Ohio Revised Code and the Ohio Administrative Code.
- The claims files were reviewed to verify dates in the claims settlement process.
- A claim was considered to be an exception if it did not contain adequate documentation.
- A claim file was considered to be an exception if the documentation did not include the date of each activity or communication.
- A claim was considered to be an exception if the "clean" claim was not paid within 30 days from receipt of the claim.

**Standard:** Claim files are sufficiently documented to allow reconstruction of the third party payer's activities and are accessible and retrievable for examination.

**Test:** Are the Company's claim files documented in compliance with O.A.C. 3901-1-60(G)?

#### **Findings:**

Population	Sample	Yes	No	Standard	Compliance
3,093	50	46	4	93%	92%

The standard for compliance is 93%. The Company's claims practices were below this standard.

**Comments:** In four of the files within this sample, the Company failed to maintain complete documentation that was sufficient to allow for reconstruction of claim activities.

**Examiner Recommendation:** The Company must ensure that documentation is sufficient to permit complete reconstruction of the third-party payer's activities claim in compliance with O.A.C. 3901-1-60(G).

**Standard:** Claim file documentation shall include the date of each activity or communication and all documentation shall be reproducible to paper in its entirety.

**Test:** Does claim file documentation include the date of each claim activity or communication as required by O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
3,093	50	46	4	93%	92%

The standard for compliance is 93%. The Company's claims practices were below this standard.

**Comments:** Four files within this sample lacked complete documentation regarding the date of each claim activity or communication.

**Examiner Recommendation:** The Company must adopt procedures to ensure that all claim file documentation includes the date of each claim activity or communication as required by Ohio O.A.C. 3901-1-60(G).

**Standard:** Claims are settled and paid in a timely manner as required by Ohio statutes and rules.

**Test:** Are "clean" claims paid no later than 30 days from the receipt of the claim as required by O.R.C. § 3901.381(B)(1)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
3,093	50	29	2	19	93%	94%

The standard for compliance is 93%. The Company's claims practices were above to this standard.

**Comments:** This test did not apply to 19 of the claims within this sample as they were not considered to be "clean" claims – therefore reducing the sample size to 31 files.

**Claims Paid More Than 29 Days**

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease claims that were closed during the exam period between August 1, 2005 and September 30, 2006. The examiners selected to review a random sample of 50 claim files from the total population of 349 CHIC Claims Paid More Than 29 Days to test for compliance with the Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all Company procedure manuals as part of the exam process.
- Review also included tests to assure that the Company's claim practices and procedures were in compliance with the Ohio Revised Code and the Ohio Administrative Code.
- The claims files were reviewed to verify dates in the claims settlement process.
- A claim was considered to be an exception if it did not contain adequate documentation.
- A claim file was considered to be an exception if the documentation did not include the date of each activity or communication.
- A claim was considered to be an exception if the "clean" claim was not paid within 30 days from receipt of the claim.

**Standard:** Claim files are sufficiently documented to allow reconstruction of the third-party payer's activities and are accessible and retrievable for examination.

**Test:** Are the Company's claim files documented in compliance with O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
349	50	44	6	93%	88%

The standard for compliance is 93%. The Company's claims practices were below this standard.

**Comments:** Six files within this sample did not include complete documentation that was sufficient to allow for reconstruction of claim activities.

**Examiner Recommendation:** The Company must ensure that documentation is sufficient to permit complete reconstruction of the third-party payer's claim activities in compliance with O.A.C. 3901-1-60(G).

**Standard:** Claim file documentation shall include the date of each activity or communication and all documentation shall be reproducible to paper.

**Test:** Do the Company's claims documentation procedures conform to O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
349	50	44	6	93%	88%

The standard for compliance is 93%. The Company's claims practices were below this standard.

**Comments:** Complete documentation regarding the date of each claim activity or communication was missing in six of the files within this sample.

**Examiner Recommendation:** The Company must adopt procedures to ensure that all claim file documentation includes the date of each claim activity or communication as required by O.A.C. 3901-1-60(G).

**Standard:** When a claim is submitted, but the information provided is materially deficient, or it is determined that reasonable supporting documentation is needed to establish the third-party payer's responsibility, the Company shall notify the provider or beneficiary in a timely manner.

**Test 1:** If a standard claim form was used, but the information provided was materially deficient, was the provider or beneficiary notified within 15 days per O.R.C. § 3901.381(B)(3)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
349	50	0	0	50	93%	N/A

The standard for compliance is 93%.

**Comments:** None of the files reviewed were found to be applicable for this test as no information provided was found to be materially deficient, or no reasonable supporting documentation was needed to establish third-party payer responsibility.

**Test 2:** If standard claim form used, but reasonable supporting documentation is necessary, were all relevant external sources notified within 30 days in compliance with O.R.C. § 3901.381(B)(2)(a)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
349	50	35	6	9	93%	85%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** This test did not apply to nine of the claims within this sample as no reasonable supporting documentation was necessary – therefore reducing the sample size to 41 files. Necessary supporting documentation, including verification of employer and beneficiary coverage under the benefits contract, confirmation of premium payment, medical information regarding the beneficiary and services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider’s identification was missing in six files within this sample.

**Examiner Recommendation:** In situations where reasonable supporting documentation is necessary, the Company must notify all relevant external sources within 30 days of the supporting documentation needed as required by O.R.C. § 3901.381(B)(2)(a).

**Standard:** Claims are settled and paid in a timely manner as required by Ohio statutes and rules.

**Test:** Are “*clean*” claims paid or denied no later than 30 days from the receipt of the claim as required by O.R.C. § 3901.381(B)(1)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
349	50	0	9	41	93%	0%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** This test did not apply to 41 of the claims within this sample as they were not considered to be “*clean*” claims – therefore reducing the sample size to nine files. None of the nine “*clean*” claims reviewed were paid within 30 days from receipt of the claim as required.

**Examiner Recommendation:** The Company must implement procedures to ensure that all “*clean*” claims are paid or denied no later than 30 days from the receipt of the claim in compliance with O.R.C. § 3901.381(B)(1).

**Standard:** A third party payer shall make payment or deny the claim within 45 days of receipt of claim when supporting documentation is required.

**Test:** Is the Company in compliance with the provisions of O.R.C. § 3901.381(B)(2)(a)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
349	50	29	12	9	93%	71%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** This test did not apply to nine of the claims within this sample as no reasonable supporting documentation was necessary – therefore reducing the sample size to 41 files. Where supporting documentation was required, the Company failed to make payment within 45 days of receipt of claim in 12 of the claims reviewed within this sample.

**Examiner Recommendation:** The Company must develop a policy, which ensures that all claims are paid no later than 45 days from the receipt of the claim when supporting documentation is necessary as required by O.R.C. § 3901.381(B)(2)(a).

**Standard:** Any third party payer who does not make claim payments in compliance with Ohio statutes and rules shall be liable for claim interest payments.

**Test:** Does the Company comply with the provisions of O.R.C. § 3901.389 if applicable?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
349	50	0	21	29	93%	0%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** This test did not apply to 29 of the claims within this sample as no claim interest payments were required – therefore reducing the sample size to 21 files. No claim interest payments were made on any of the 21 applicable sample claim files reviewed where claim interest payment was required.

**Examiner Recommendation:** In instances where the Company has not made claim payments in compliance with Ohio statutes and rules, the Company must implement procedures, which ensure that interest payments are made on all such claims as required by O.R.C. § 3901.389.

**Claims Denied Less Than 30 Days**

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease claims that were closed during the exam period between August 1, 2005 and September 30, 2006. The examiners selected to review a random sample of 50 claim files from the total population of 2,884 CHIC Claims Denied Less Than 30 Days to test for compliance with the Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all company procedure manuals as part of the examination process.
- If the original claim failed to contain a legible receipt date stamp, the examiners considered the file to be an exception.
- If copies of letters requesting additional information were not provided, the examiners considered the file to be an exception.
- If subsequent submissions of supporting claim documentation failed to contain a legible receipt date stamp, the examiners considered the file to be an exception.
- If the letter of denial failed to contain language relating to complaint provisions in compliance with Ohio rules, the examiners considered the file to be an exception.

**Standard:** Claim files are sufficiently documented to allow reconstruction of the third party payer's activities and are accessible and retrievable for examination.

**Test:** Are the Company's claim files documented in compliance with O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	49	1	93%	98%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Standard:** Claim file documentation shall include the date of each activity or communication and all documentation shall be reproducible to paper in its entirety.

**Test:** Does claim file documentation include the date of each claim activity or communication as required by O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	50	0	93%	100%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Standard:** A third party payer shall notify the provider and beneficiary of denial of a claim and give reason(s) upon which the denial is based.

**Test 1:** Did the Company notify the provider and beneficiary that the claim was denied within 30 days from receipt of claim in compliance with O.R.C. § 3901.381(B)(1)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	48	2	93%	96%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Test 2:** Did the Company include the specific reason for the claim denial in its notice per O.R.C. § 3901.381(B)(2)(c)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	50	0	93%	100%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Standard:** Every third party payer shall include, in the claim denial, a complaint procedure statement in compliance with Ohio rules.

**Test:** Was a complaint procedure statement included in the claim denial notice as required by O.A.C. 3901-1-60(H)(4)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	50	0	93%	100%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Standard:** The third party payer shall provide the claimant with a reasonable notification of denial of a claim, including the specific reason(s) for a claim denial.

**Test:** Does the Company provide notification of claim denial in compliance with O.A.C. 3901-1-60(D)(1)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
2,884	50	49	1	93%	98%

The standard for compliance is 93%. The Company's claims practices were above this standard.

**Claims Denied More Than 29 Days**

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease claims that were closed during the exam period between August 1, 2005 and September 30, 2006. The examiners selected to review the entire population of 108 CHIC Claims Denied More Than 29 Days to test for compliance with the Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all company procedure manuals as part of the examination process.
- If the original claim failed to contain a legible receipt date stamp, the examiners considered the file to be an exception.
- If copies of letters requesting additional information were not provided, the examiners considered the file to be an exception.
- If subsequent submissions of supporting claim documentation failed to contain a legible receipt date stamp, the examiners considered the file to be an exception.
- If the letter of denial failed to contain language relating to complaint provisions in compliance with Ohio rules, the examiners considered the file to be an exception.

**Standard:** Claim files are sufficiently documented to allow reconstruction of the third-party payer's activities and are accessible and retrievable for examination.

**Test:** Are claim files adequately documented for reconstruction of Company's claim activities in compliance with O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	96	12	93%	89%

The standard for compliance is 93%. The Company's claims practices were below this standard.

**Comments:** 12 files within this sample did not include complete documentation that was sufficient to allow for reconstruction of claim activities.

**Examiner Recommendation:** The Company shall employ revised procedures to ensure that each claim file is documented to allow complete reconstruction of the third party payer’s activities in accordance with O.A.C. 3901-1-60(G).

**Standard:** Claim file documentation shall include the date of each activity or communication and all documentation shall be reproducible to paper in its entirety.

**Test:** Does claim file documentation include the date of each claim activity or communication as required by O.A.C. 3901-1-60(G)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	97	11	93%	90%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** Complete documentation regarding the date of each claim activity or communication was missing in 11 of the files within this sample.

**Examiner Recommendation:** The Company shall employ revised procedures to ensure that each claim file is documented to allow a complete chronological reconstruction of the third party payer’s activities in accordance with O.A.C. 3901-1-60(G).

**Standard:** When a claim is submitted, but the information provided is materially deficient, or it is determined that reasonable supporting documentation is needed to establish the third-party payer’s responsibility, the Company shall notify the provider or beneficiary in a timely manner.

**Test 1:** If claim information was materially deficient, was provider or beneficiary notified within 15 days from receipt of claim per O.R.C. § 3901.381(B)(3)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
108	108	0	0	108	93%	N/A

The standard for compliance is 93%

**Comments:** None of the files reviewed were found to be applicable for this test as no information provided was found to be materially deficient, or no reasonable supporting documentation was needed to establish third-party payer responsibility.

**Test 2:** If reasonable supporting documentation was needed, were all relevant external sources notified within 30 days from receipt of claim as required by O.R.C. § 3901.381(B)(2)(a)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
108	108	15	13	80	93%	54%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** This test did not apply to 80 of the claims within this sample as no reasonable supporting documentation was necessary – therefore reducing the population size to 28 files. Necessary supporting documentation, including verification of employer and beneficiary coverage under the benefits contract, confirmation of premium payment, medical information regarding the beneficiary and services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider’s identification was missing in 13 files within this sample.

**Examiner Recommendation:** The Company shall employ revised procedures to ensure that reasonable supporting documentation necessary to adjudicate each claim is requested from all relevant external sources within 30 days of receipt in accordance with O.R.C. § 3901.381(B)(2)(a).

**Standard:** A third party payer shall notify the provider and beneficiary of denial of a claim and give reason(s) upon which the denial is based.

**Test 1:** Did the Company notify the provider and beneficiary that the claim was denied within 30 days from receipt of claim in compliance with O.R.C. § 3901.381(B)(1)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	23	85	93%	21%

The standard for compliance is 93%. The Company’s claims practices were below this standard.

**Comments:** The provider and beneficiary were not notified that the claim was denied within 30 days from receipt of claim in 85 of the claim files reviewed within this sample.

**Examiner Recommendation:** The Company shall employ revised procedures to ensure that notification of the claim denial is sent to the provider and beneficiary within 30 days of receipt in accordance with O.R.C. § 3901.381(B)(1).

**Test 2:** Did the Company include the specific reason for the claim denial in its notice per O.R.C. § 3901.381(B)(2)(c)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	107	1	93%	99%

The standard for compliance is 93%. The Company’s claims practices were above this standard.

**Standard:** Every third party payer shall include, in the claim denial, a complaint procedure statement in compliance with Ohio rules.

**Test:** Was a complaint procedure statement included in the claim denial notice as required by O.A.C. 3901-1-60(H)(4)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	103	5	93%	95%

The standard for compliance is 93%. The Company’s claims practices were above this standard.

**Standard:** The third party payer shall provide the claimant with a reasonable notification of denial of a claim, including the specific reason(s) for a claim denial.

**Test:** Does the Company provide notification of claim denial in compliance with O.A.C. 3901-1-60(D)(1)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
108	108	103	5	93%	95%

The standard for compliance is 93%. The Company's claims practices were above this standard.

## GENERAL COMPLAINT HANDLING PRACTICES

### File Documentation

It was difficult to determine or verify the dates in the complaint handling process, particularly the initial contact date with the complainant. The Company is not in compliance with O.A.C. 3901-1-07(C)(15), which states that each third-party payer shall adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants.

Additionally, It was extremely difficult to determine or verify the dates in the claims handling process. The Company has failed to comply with O.A.C. 3901-1-60(G), which states that each third-party payer shall maintain complete documentation of every claim for a period of three years. The documentation shall be sufficient to permit complete reconstruction of the third-party payer's activities and communications with respect to each claim. Documentation shall include the date of each activity or communication.

## SPECIFIC COMPLAINT HANDLING PRACTICES

### Complaint Procedures

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease complaints that were opened or closed during the exam period between August 1, 2005 and September 30, 2006.

The examiners selected to review the entire population of 113 CHIC complaint files to test for compliance with the Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all company procedure manuals as part of the examination process.
- If the original complaint failed to contain a legible receipt date stamp, the examiners considered the file to be an exception.
- If copies of complaint correspondence were not provided, the examiners considered the file to be an exception.
- If the benefit plan or certificate did not include a complaint statement in every benefit plan or certificate, the examiners considered the file to be an exception.
- If the written notification of final adjudication of complaint did not contain a statement that the insured has a right to file a complaint with the Ohio Department of Insurance, the examiners considered the file to be an exception.

**Standard:** The Company shall acknowledge each pertinent communication with respect to claims it receives.

**Test:** Does the Company provide an acknowledgement within 15 working days of receipt of the communication in a manner that conforms with O.A.C. 3901-1-07(C)(2)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
113	113	81	32	90%	72%

The standard for compliance is 90%. The Company's complaint handling practices were below this standard.

**Comments:** No acknowledgement, within 15 working days of receipt of communication as required, was made in 32 of the complaint files within this sample.

**Examiner Recommendation:** The Company must revise and implement procedures to ensure an acknowledgement within 15 working days of receipt of the communication in a manner that conforms with O.A.C. 3901-1-07(C)(2).

**Standard:** The Company shall provide a timely response to each pertinent communication with respect to claims it receives.

**Test:** Does the Company provide a response within 15 working days of receipt of the communication in compliance with O.A.C. 3901-1-07(C)(3)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
113	113	59	54	90%	52%

The standard for compliance is 90%. The Company's complaint handling practices were below this standard.

**Comments:** The Company failed to provide a response, within 15 working days of receipt of communication, in 54 of the sample complaint files reviewed.

**Examiner Recommendation:** The Company shall develop a policy whereby a response is provided within 15 working days of receipt of the communication in compliance with O.A.C. 3901-1-07(C)(3).

**Standard:** Every third party payer shall include their complaint procedure in every benefit plan or certificate.

**Test:** Does the Company comply with O.A.C. 3901-1-60(H)(2)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
113	113	0	19	94	90%	0%

The standard for compliance is 90%. The Company's complaint handling practices were below this standard.

**Comments:** This test did not apply to 94 of the claims within this sample as the policy was issued before the October 1, 1994 effective date of O.A.C. 3901-1-60(H)(2) – therefore reducing the population size to 19 files. None of the 19 complaint files reviewed included a complaint procedure in the benefit plan or certificate as required.

**Examiner Recommendation:** The Company must adopt and implement procedures to ensure that its complaint procedure is included complaint procedure as required by O.A.C. 3901-1-60(H)(2).

**Standard:** Include a statement on written notification of final adjudication of complaint that the insured has a right to file a complaint with the Ohio Department of Insurance.

**Test:** Does the Company comply with O.A.C. 3901-1-60(H)(5)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
113	113	1	92	20	90%	1%

The standard for compliance is 90%. The Company’s complaint handling practices were below this standard.

**Comments:** This test did not apply to 20 of the claims within this sample as the Company’s correspondence did not relate to a final adjudication of the complaint – therefore reducing the population size to 93 files. A statement upon written notification of final adjudication of the complaint, that the insured has a right to file a complaint with the Ohio Department of Insurance, was missing in 92 of the sample complaint files reviewed.

**Examiner Recommendation:** The Company shall employ revised procedures to ensure that on written notification of final adjudication of complaint, a statement is included that states that the insured has a right to file a complaint with the Ohio Department of Insurance as described by O.A.C. 3901-1-60(H)(5).

**POLICYHOLDER SERVICE**

**Requested Cancellations**

**Test Methodology:** The examiners requested, and the Company supplied, a report of all Ohio health and specified disease policies that were cancelled at the policyholder’s request during the exam period between August 1, 2005 and September 30, 2006. The examiners selected to review a random sample of 50 policy files from the total population of 1,092 cancelled files to test for compliance. with Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all company procedure manuals as part of the examination process.
- If the policy file failed to contain documentation supporting the policy cancellation, the examiners considered the file to be an exception.
- If the Company failed to complete the requested policy cancellation upon receipt of the request or by the date referenced in the request, the examiners considered the file to be an exception.

**Standard:** All policy cancellations are processed and completed in a timely manner.

**Test:** Did the Company complete the requested policy cancellation upon receipt of the request or by the date referenced in the request in compliance with O.R.C. § 3923.04(M)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
1,092	50	45	5	90%	90%

The standard for compliance is 90%. The Company's policy cancellation practices were equal to this standard.

**Standard:** All policy transactions are processed accurately and completely.

**Test:** Did the Company non-renew or discontinue coverage of an individual or group policy for the proper reason as required by O.R.C. § 3923.57(C)(2)(a)-(e) or O.R.C. § 3924.03(B)(2)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
1,092	50	0	0	50	90%	N/A

The standard for compliance is 90%.

**Comments:** Testing indicated none of the 50 files involved a cancellation associated with O.R.C. § 3923.57(C)(2)(a)-(e) or O.R.C. § 3924.03(B)(2).

**Cancellations: Other**

**Test Methodology:**

The examiners requested, and the Company supplied, a report of all Ohio health and specified disease policies that were cancelled for a reason other than the policyholder's request during the exam period between August 1, 2005 and September 30, 2006.

The examiners selected to review a random sample of 50 policy files from the total population of 646 cancelled files to test for compliance with Sections of the Ohio Revised Code and the Ohio Administrative Code.

- The examiners reviewed all company procedure manuals as part of the examination process.
- If the policy file failed to contain documentation supporting the policy cancellation, the examiners considered the file to be an exception.
- If the Company failed to terminate the policy at the correct cancellation effective date, the examiners considered the file to be an exception.

**Standard:** All policy cancellations are processed and completed in a timely manner.

**Test:** Did the Company complete the policy cancellation in compliance with the provisions of O.R.C. § 3923.04(M)?

**Findings:**

Population	Sample	Yes	No	Standard	Compliance
646	50	50	0	90%	100%

The standard for compliance is 90%. The Company's policy cancellation practices were above this standard.

**Standard:** All policy transactions are processed accurately and completely.

**Test:** Did the Company non-renew or discontinue coverage of an individual or group policy for the proper reason as required by O.R.C. § 3923.57(C)(2)(a)-(e) or O.R.C. § 3924.03(B)(2)?

**Findings:**

Population	Sample	Yes	No	N/A	Standard	Compliance
646	50	0	0	50	90%	N/A

**Comments:** Testing indicated none of the 50 files involved a cancellation associated with O.R.C. § 3923.57(C)(2)(a)-(e) or O.R.C. § 3924.03(B)(2).

### COMPANY COOPERATION

Throughout the course of this examination, the level of cooperation offered by the Company has been polite, yet extremely restrained and indifferent. Each email and telephone exchange with the Company has been professional and timely. However, there were instances where the Company found our "*customary exam correspondence*" and response deadlines to be unacceptable.

From the onset of the exam, the examiners began to submit their summary of initial exam findings in a manner consistent with NAIC standards and Ohio's Market Conduct Examination Guidelines and Procedures Manual. The Company refused to respond to our findings until the format of the document had been changed. The examiners acceded to this request and reformatted the summaries.

Additionally, numerous requests made by the Department generated an immediate request for an extension by the Company and resulted in the fragmented and disorderly dissemination of requested information. In an effort to remain flexible and cooperative, the examiners have granted every requested extension in hopes of receiving a more complete and orderly response.

However, the end result has been the Company's submission of a delayed response requiring an overwhelming investment of time to piece together exam files - originally presented by the Company as "*complete*" in April.

The examiners understand that the Company's exam-support resources have been stretched fairly thin in recent months due to the number of simultaneous exams that are taking place. In light of this, the examination team has remained professional, patient, and flexible. However, this flexibility has come at the price of a dramatically skewed time and cost estimate and delayed completion dates.

## CONSECO HEALTH INSURANCE COMPANY SUMMARY

**The examination found the Company to be out of compliance in the following areas:**

<u>Areas of Review</u>	<u>Compliance Standard</u>	<u>Compliance Rate</u>
<b>CLAIMS PRACTICES</b>		
<b>Claims Paid Less Than 30 Days</b>		
Are the Company's claim files documented in compliance with O.A.C. 3901-1-60(G)?	93%	92%
Does claim file documentation include the date of each claim activity or communication as required by O.A.C. 3901-1-60(G)?	93%	92%
<b>Claims Paid More Than 29 Days</b>		
Are the Company's claim files documented in compliance with O.A.C. 3901-1-60(G)?	93%	88%
Do the Company's claims documentation procedures conform to O.A.C. 3901-1-60(G)?	93%	88%
If standard claim form used, but reasonable supporting documentation is necessary, were all relevant external sources notified within 30 days in compliance with O.R.C. § 3901.381(B)(2)(a)?	93%	85%
Are "clean" claims paid or denied no later than 30 days from the receipt of the claim as required by O.R.C. § 3901.381(B)(1)?	93%	0%
Does the Company make payment or deny the claim within 45 days of receipt of claim when supporting documentation is required in compliance with the provisions of O.R.C. § 3901.381(B)(2)(a)?	93%	71%
Does the Company comply with the provisions of O.R.C. § 3901.389, if applicable, which states that any third party payer who does not make claim payments in compliance with Ohio statutes and rules shall be liable for claim interest payments?	93%	0%
<b>Claims Denied More Than 29 Days</b>		
Are claim files adequately documented for reconstruction of Company's claim activities in compliance with O.A.C. 3901-1-60(G)?	93%	89%
Does claim file documentation include the date of each claim activity or communication as required by O.A.C. 3901-1-60(G)?	93%	90%
If reasonable supporting documentation was needed, were all relevant external sources notified within 30 days from receipt of claim as required by O.R.C. § 3901.381(B)(2)(a)?	93%	54%
Did the Company notify the provider and beneficiary that the claim was denied within 30 days from receipt of claim in compliance with O.R.C. § 3901.381(B)(1)?	93%	21%
<b>COMPLAINT HANDLING</b>		
<b>Complaint Procedures</b>		
Does the Company provide an acknowledgement within 15 working days of receipt of the communication in a manner that conforms with O.A.C. 3901-1-07(C)(2)?	90%	72%
Does the Company provide a response within 15 working days of receipt of the communication in compliance with O.A.C. 3901-1-07(C)(3)?	90%	52%
Does the Company comply with O.A.C. 3901-1-60(H)(2), which requires that a third party payer shall include their complaint procedure in every benefit plan or certificate?	90%	0%
Is the Company in compliance with O.A.C. 3901-1-60(H)(5), which states that a statement is to be included on written notification of final adjudication of a complaint that the insured has a right to file a complaint with the Ohio Department of Insurance?	90%	1%

## CONCLUSION

The impact of the compliance failures, as described on page (21) of this report, is to create an environment that effectively denies the policyholder claimant access to complain and/or challenge the Company's claims adjudication decisions. In addition, the failures to provide timely responses to policyholders throughout the course of the claims settlement process creates bureaucratic roadblocks which serve only to impede and wear down the policyholder's ability and will to continue pursuit of their policyholder benefits.

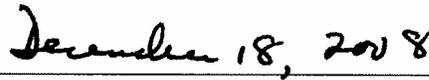
Overall, the Company exhibited a less than adequate commitment to Ohio policyholders and compliance to Ohio insurance laws and rules in those areas tested.

A plan of corrective action that involves strengthened oversight from the Company's senior management and board of directors is to be provided for regulatory review.

This concludes the report of the Market Conduct Examination of Conseco Health Insurance Company. The examiners, Larry C. Stovall, Rodney Beetch, Robert Baker, John Pollock, Angela Yoakum-Dingus and Julie Phillips would like to acknowledge the assistance provided by the management and the employees of the Company.



Larry C. Stovall  
Examiner-in-Charge



Date