

Final Report -- Federal Targeted Market Conduct Examination of
Coventry Health and Life Insurance Company HIOS ID #44240

State of Missouri July 20, 2021

Examination Report: 44240– 2018 – FED – 1

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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 (West) (Issuer), HIOS ID #44240, 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 (CCIIO) 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; Essential Health Benefits: 42 U.S.C. § 300gg-6, 45 C.F.R. §§147.150 and 156.100, *et seq*; and Guaranteed Renewability of Coverage: 42 U.S.C. §300gg-2 and 45 C.F.R. §147.106. The period covered by the Examination was July 1, 2016 through June 30, 2017 (Examination Period).

A random sample of 1,557 Issuer-generated documents and claims were reviewed. Of the selected samples, CCIIO found 92 violations related to two areas reviewed. All 92 violations were found in plan certificates or related Summary of Benefits and Coverage (SBC). The violations included a failure to provide an accurate SBC for 42 plans and a failure to provide Essential Health Benefits (EHB) that are substantially equal to the Missouri EHB-benchmark plan in 50 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.

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

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations.

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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	5,989	213
MH/SUD denied claims – individual plans	1,184	201
MH/SUD paid Rx claims – individual plans	11,570	109
MH/SUD denied Rx claims – individual plans	39,944	108
Medical/Surgical paid claims – individual plans	50,386	184
Medical/Surgical denied claims – individual plans	3,829	108
Medical/Surgical paid Rx claims – individual plans	59,860	184
Medical/Surgical denied Rx claims – individual plans	216,181	184
Guaranteed Availability	4,878	115
Guaranteed Renewability	4,878	115**
Fair Health Insurance Premiums	4,878	115**
Terminations	35,035	116
Advertising	35	35

*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) and non-qualified health plans (non-QHPs) in the individual market.	42 U.S.C. §300gg-15 and 45 C.F.R. §147.200(a)(3) and the SBC Individual Market Instruction Guides	<p>For the identified SBCs:</p> <ul style="list-style-type: none"> a. For the 2017 plan year, no further action is required as the Issuer corrected the inaccurate “Plan Type,” and no claims were impacted by this error. b. For the 2016 plan year, <ul style="list-style-type: none"> i. <i>Revised SBCs</i>: No further action is required. as the Issuer presented updated SBCs correcting the error to show no 60-day limit for mental health / substance abuse disorder (MH/SUD) in-patient (IP) rehabilitation; and ii. <i>Claims Audit</i>: 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. <p>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.</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 QHPs and non-QHPs in the individual market.	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 of claims processed during the Examination Period to identify and re-adjudicate any claims that were improperly denied 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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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) and the Instruction Guide for Individual Coverage (SBC Instruction Guide)¹

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:

“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-

¹ What This Plan Covers and What It Costs, Instruction Guide for Individual Health Insurance Coverage (February 2012), available at: <https://www.cms.gov/CCIO/Resources/Files/Downloads/instructions-individual-final.pdf>

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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 Guide (page one (1)) states:

“PHS Act Section 2715 generally requires all health insurance issuers offering 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 individual market health plans included in the samples tested.

SBC Findings

During the review of the Issuer’s individual market QHPs and non-QHPs for compliance with MHPAEA and the provision of EHB, in the paid and denied claims samples, it was noted that 43 SBCs did not accurately reflect the type of coverage provided under the plan. The review of the SBCs during the examination identified the following findings:

Finding 1.a.

For three individual market health plan SBCs included in the samples tested, the SBCs did not accurately reflect the type of coverage provided under the plan. The “Plan Type” noted in the SBC header (e.g., EPO (Exclusive Provider Organization), PPO (Preferred Provider Organization), or HMO (Health Maintenance Organization)) did not accurately reflect the type of coverage provided under the plan.

The Issuer agreed, stating:

“While we agree with this criticism, it should be noted, as stated in our response to Request 22, this was a human error with the limitations of the SBC production tool, and has been corrected.”

Area Reviewed	Population	Sample Size
MH/SUD paid claims – individual market	5,989	213

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Medical/Surgical paid claims – individual market	50,386	184
Medical/Surgical denied claims – individual market	3,829	108
Medical/Surgical paid Rx claims – individual market	59,860	184
Medical/Surgical denied Rx claims – individual market	216,181	184

Required Action:

No further action is required because the Issuer provided CCIIO with the updated SBCs containing the correct plan type, and this error did not impact claims.

Finding 1.b.

For 40 individual market health plan SBCs, the SBC did not accurately reflect the coverage provided under the plan. The SBC listed a 60-day limit for MH/SUD inpatient (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 Mental Health/Substance Use. This issue was corrected for the 2017 plan year.”

Area Reviewed	Population	Sample Size
MH/SUD paid claims – individual market	5,989	213

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

CCIIO concurs with the Issuer’s position.

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:

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“(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
- (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:

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“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
 - (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 50 health plans in the individual 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 also did not submit evidence that an actuarially equivalent substitution was provided for the essential health benefit that is the basis for the finding.

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The Issuer disagreed with the finding, stating in responses to Criticism Nos 5, 12, 16, and 20:

“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 22 and 24, 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 parole. The attached COC [Certificates of Coverage] below highlights several sections indicating that medically necessary services are covered.”

For Criticism Nos 26 and 29, 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 also 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. The attached COC below highlights several sections indicating that medically necessary services are covered.”

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.”

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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. ...

In accordance with 45 C.F.R. §150.319, CMS may take into account 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.

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MH/SUD paid claims – individual market	5,989	213
MH/SUD denied claims – individual market	1,184	201
MH/SUD paid Rx claims – individual market	11,570	109
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Required Action:

The Issuer shall revise current 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.

In addition, the Issuer shall 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 of the Issuer’s proposed plan of correction, which will include any required modifications to plan documents should

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the Issuer re-enter the market. CCIIO accepts the Issuer's response regarding the claims self-audit.

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VI. Closing

A total of 1,557 randomly selected Issuer-generated documents and claims were reviewed. Of the samples selected, CCIIO found 92 violations related to two areas reviewed. All 92 violations were found in plan certificates or related SBCs.

Violations included:

- Failure to provide an accurate SBC in 42 health plans for the Issuer's individual market health plans; and
- Failure to provide EHB that are substantially equal to the Missouri EHB-Benchmark plan in 50 individual market health plans.

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Final as of July 20, 2021

CCIO/Oversight Group/Compliance and Enforcement

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.

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:

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