

REPORT ON
TARGET MARKET CONDUCT EXAMINATION
OF
PRIORITY HEALTH CARE, INC.
AS OF JUNE 30, 2008

Conducted from March 23, 2009

Through

June 25, 2010

By

Market Conduct Section

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-1619755
NAIC: 96512

COMMONWEALTH OF VIRGINIA

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COMMISSIONER OF INSURANCE
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I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Market Conduct Examination of Priority Health Care, Inc., conducted at the company's office in Richmond, VA as of June 30, 2008, is a true copy of the original Report on file with this Bureau, and also includes a true copy of the Company's response to the findings set forth therein, the Bureau's review letter, the Company's offer of settlement, and the State Corporation Commission's Settlement Order in Case No. INS-2012-00139.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 11th day of September, 2012.

A handwritten signature in cursive script that reads "Jacqueline K. Cunningham".

Jacqueline K. Cunningham
Commissioner of Insurance

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I. SCOPE OF EXAMINATION

The Market Conduct Examination of Priority Health Care, Inc. (hereinafter referred to as Priority), a Health Maintenance Organization (HMO), was conducted at the company's office in Richmond, Virginia, under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code, including but not necessarily limited to the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1809, 38.2-3407.15 C, 38.2-4315 and 38.2-5808 of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

A previous Market Conduct Examination covering the period of January 1, 2003, through December 31, 2003, was concluded on August 3, 2004. As a result of that examination, Priority made a monetary settlement offer, which was accepted by the State Corporation Commission on June 30, 2005, in Case No. INS-2005-00114.

A previous Market Conduct Examination covering the period of January 1, 1998, through December 31, 1998, was concluded on August 31, 1999. As a result of that examination, Priority made a monetary settlement offer, which was accepted by the State Corporation Commission on February 24, 2000, in Case No. INS000034 in which Priority agreed to the entry by the Commission of an order to cease and desist from any conduct which constitutes a violation of certain sections of the Code and regulations.

A previous investigation was conducted to review emergency claims settlement practices. As a result of that investigation, Priority agreed to the entry by the Commission of a final settlement order in Case INS-2007-00225 on January 14, 2008.

In addition to the areas examined during the current examination period, Priority's practices were reviewed for compliance with the recommendations made to

Priority as a result of the examiners' findings during previous examinations and investigations.

Although Priority had agreed after these earlier regulatory actions to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where Priority had not done so. In the examiners' opinion, therefore, Priority in some instances knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2008, through June 30, 2008. The on-site examination was conducted at Priority's office in Richmond, Virginia from March 23, 2009, through December 4, 2009, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on June 25, 2010. The violations cited and the comments included in this Report are the opinions of the examiners.

The purpose of the examination was to determine whether Priority was in compliance with various provisions of the Code and the regulations found in the Virginia Administrative Code. Compliance with the following was considered in the examination process:

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance; and
14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices

- Advertising
- Premium Notices
- Cancellations/Non-renewals
- Complaints
- Claim Practices

Examples referred to in this Report are keyed to the number of the Review Sheet furnished to Priority during the examination.

COPY

II. COMPANY HISTORY

Priority Health Care, Inc. is licensed to furnish health maintenance care under Chapter 43, Title 38.2 of the Code. Priority Health Care, Inc. is a stock, for-profit health maintenance organization (HMO). On July 5, 1983, Health Plan of Virginia, Inc. was incorporated in the Commonwealth of Virginia as a for-profit HMO. On June 1, 1985, Health Plan of Virginia, Inc. was federally qualified as an HMO and effective January 19, 1988, Health Plan of Virginia, Inc.'s name was changed to Travelers Health Network of Virginia, Inc. (THN-VA).

On May 1, 1993, the State Corporation Commission's Bureau of Insurance approved the purchase of 100% of the issued and outstanding shares of common stock of THN-VA by Priority, Inc, a subsidiary of Tidewater Health Care, Inc. (Tidewater). On May 3, 1993, the Articles of Incorporation were amended and THN-VA's name was changed to Health First, Inc. On May 12, 1995, Blue Cross and Blue Shield of Virginia [subsequently renamed Trigon Insurance Company (Trigon)] purchased 80% of Priority, Inc. from Tidewater. Tidewater continued to own the remaining 20% of Priority, Inc. Effective July 15, 1997, Priority Health Care, Inc., an HMO formerly licensed in Virginia, merged into Health First, Inc., with Health First, Inc. being the surviving entity. On the same date, Health First, Inc. changed its name to Priority Health Care, Inc.

Effective July 1, 1998, Trigon contributed all of its stock in Priority, Inc. to Trigon Administrators, Inc. On September 29, 2000, Priority, Inc. purchased and retired the 20% of its outstanding shares held by Tidewater. Effective March 31, 2001, Trigon Administrators, Inc. was sold and the outstanding shares of Priority, Inc. were distributed to Trigon Healthcare, Inc. (Trigon Healthcare).

Effective July 31, 2002, Trigon Healthcare and Anthem, Inc. (Anthem), a publicly traded company incorporated in Indiana, completed a merger in which Trigon Healthcare was merged into a wholly owned subsidiary of Anthem that subsequently changed its name to Anthem Southeast, Inc. (Anthem Southeast). As a result, Priority Health Care, Inc. and its immediate parent, Priority, Inc., became wholly owned subsidiaries of Anthem Southeast.

On November 30, 2004, Anthem, Priority Health Care, Inc.'s ultimate parent, and WellPoint Health Networks, Inc. (WellPoint Health Networks) completed a merger in which WellPoint Health Networks and all WellPoint subsidiaries merged with and into Anthem Holding Corp., a direct and wholly owned subsidiary of Anthem, with Anthem Holding Corp. as the surviving entity in the merger. In connection with the merger, Anthem amended its Articles of Incorporation to change its name to WellPoint, Inc. (WellPoint). As of December 31, 2008, Priority Health Care, Inc. is a wholly owned subsidiary of Anthem Southeast.

Priority Health Care, Inc.'s service area includes the Virginia cities of Alexandria, Bedford, Buena Vista, Charlottesville, Chesapeake, Colonial Heights, Danville, Emporia, Fairfax, Falls Church, Franklin, Fredericksburg, Hampton, Hopewell, Lexington, Manassas, Manassas Park, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, South Boston, Suffolk, Virginia Beach, Williamsburg and Winchester; and the Virginia counties of Accomack, Albemarle, Amelia, Arlington, Bedford, Botetourt, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Clarke, Craig, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland,

Greene, Greenville, Halifax, Hanover, Henrico, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Shenandoah, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Westmoreland, Wythe, and York.

Marketing efforts are carried out by account representatives, agents, and brokers. Individual policies are issued only as conversions from group plans.

Total enrollment as of December 31, 2008, was 66,909 members, including Medicaid members.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 A of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

GENERAL PROVISIONS

Section 38.2-5801 C 2 requires that a request for an initial certificate of quality assurance be filed by HMOs which were licensed on or before July 1, 1998, by December 1, 1998. The review revealed that Priority was in substantial compliance.

Section 38.2-5802 D states that no MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier. The review revealed that Priority was in substantial compliance.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.
5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that Priority was in substantial compliance.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. 14 VAC 5-211-150 A requires an HMO to establish and maintain a grievance or complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The examiners reviewed a sample of 10 from the population of 118 written pre-service, post-service and contractual appeals; a sample of 2 from the population of 4 expedited appeals; a sample of 2 from the population of 4 executive inquiries; and a sample of 3 from the population of 8 written complaints received during the examination time frame.

Priority's approved complaint system provides mechanisms for reconsideration of adverse decisions and for pre-service, post-service, and expedited appeals. The procedures require written notification of the disposition of the pre-service or post-service appeals to the member within 30 calendar days from the receipt of the request

to appeal. Priority's goal is to provide written notification of the disposition within 14 working days from the receipt of all information regarding the request to appeal, but not more than 30 calendar days.

The review revealed that Priority was in substantial compliance.

PROVIDER CONTRACTS

The examiners reviewed a sample of 54 provider contracts from a total population of 26,004 provider contracts in force during the examination time frame. The examiners also reviewed Priority's contracts negotiated with intermediary organizations for the purpose of providing health care services pursuant to an MCHIP.

Section 38.2-5805 C 9 of the Code states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. An HMO may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to covered persons. The review revealed that 6 of Priority's contracts with vision providers were in violation of this section. An example is discussed in Review Sheet EF04-HMO, where the provider contract included the following supplemental language to the hold harmless clause prescribed by § 38.2-5805 C 9 of the Code:

...that no change is effective until fifteen (15) days after the relevant Commissioner of Insurance or other government agency has been notified of the proposed change.

Priority disagreed with the examiners and stated, "The hold harmless clause in Section 15 of the contract has been reviewed by our legal team in reference to 38.2-5805 C 9." The examiners would respond that by amending the hold harmless

clause it no longer reads as essentially set forth in § 38.2-5805 C 9 of the Code, placing Priority in violation of this section.

COPY

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services. Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section.

PROVIDER CONTRACTS

Professional, Facility, and Chiropractic

The examiners reviewed a sample of 26 professional, 10 facility, and 2 chiropractic provider contracts from a total population of 22,643 professional, 482 facility, and 274 chiropractic provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

Section 38.2-3407.15 B 9 of the Code states that no amendment to any provider contract shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. The review revealed that each of the 38 sample provider contracts contained language that was inconsistent with the notification requirements set forth in § 38.2-3407.15 B 9 of the

Code. The Standard Terms and Conditions of Priority's contract stated that the provider has 40 calendar days from the postmark date of the amendment to notify Priority of termination, while the Code specifically allows the provider a time frame of 30 calendar days from the *receipt* date to notify Priority of intent to terminate the contract.

Priority responded in part that:

...In order to comply with the law, give providers their required notice of an amendment and allow the Company to implement systems changes, the Company has included in its provider contract a period of ten days to allow for the mail to be delivered ("If you are unwilling to accept the amendment, you may terminate this Agreement by giving us written notice of termination within **forty (40) calendar days after the post mark date of the amendment...**"). Ten days is more than enough time for all mail to be delivered to providers in Virginia and, in fact, probably gives the vast majority of providers (if not all of them) more notice than is required by law...

While there may be instances in which the mail is not delivered within 10 days (i.e. late, lost, or stolen) of the postmark date, the examiners acknowledge that this would be an infrequent occurrence. However, in order to ensure future compliance with § 38.2-3407.15 B 9 of the Code in all instances, Priority must establish and implement written procedures to ensure that a provider would be permitted the full 30 days from receipt of the amendment to notify Priority of termination of the contract in the event that there is a delay in receiving notification.

Vision and Pharmacy

In addition to the contracts reviewed above, the examiners also reviewed a sample of 6 vision and 10 pharmacy provider contracts from a total population of 1,051 vision and 1,554 pharmacy provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed 122 instances in which all 16 sampled provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 2	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 3	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 4	16	EF03-HMO, EF04-HMO, EF05-HMO
§ 38.2-3407.15 B 5	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 6	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 7	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 8	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 9	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 10	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 11	16	EF03-HMO, EF04-HMO, EF05-HMO

SUMMARY

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 B of the Code. Priority's failure to amend all of its provider contracts to comply with § 38.2-3407.15 B of the Code occurred with such frequency as to indicate a general business practice, placing Priority in violation of § 38.2-510 A 15 of the Code. In the prior Report, it was recommended that Priority establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code. Due to the fact that violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 8 (formerly § 38.2-3407.15 B 7), and

38.2-3407.15 B 10 (formerly § 38.2-3407.15 B 9) of the Code were discussed in the prior Report, the current violations of these sections could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

PROVIDER CLAIMS

Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The following samples were reviewed for compliance with the minimum fair business standards in the processing and payment of claims: a sample of 54 out of a total population of 1,403 in-network claims under the professional, facility and chiropractic provider contracts; a sample of 20 from a population of 202 in-network claims processed under the 6 sample vision provider contracts; and a sample of 10 from an unknown population of in-network claims processed under the 10 sample pharmacy provider contracts. Of the 10 sampled pharmacy claims, 4 were determined to be Medicaid claims and were not reviewed. Therefore, the 6 remaining claims in the pharmacy claims sample were reviewed.

Section 38.2-3407.15 B 4 (ii) (c) of the Code requires every carrier to establish and implement reasonable policies to permit any provider with which there is a provider contract to confirm provider-specific payment and reimbursement methodology. Section 38.2-3407.15 B 4 (ii) (d) of the Code requires every carrier to establish and

implement reasonable policies to permit any provider with which there is a provider contract to confirm other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract. Section 38.2-3407.15 B 8 of the Code requires the provider contract to include the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid.

The review revealed 11 instances where Priority failed to allow the contracted amount, in violation of §§ 38.2-3407.15 B 4 (ii) (c), 38.2-3407.15 B 4 (ii) (d), and 38.2-3407.15 B 8. In each instance, Priority underpaid the provider by an amount that ranged between \$5 and \$15. An example is discussed in Review Sheet EFCL04-PR in which Priority underpaid the contractual allowance by \$5. Priority disagreed with the examiners' observations and stated, "The schedule used for audit reflected incorrect reimbursement. Proper fee schedules were supplied in response to the examiner." The examiners would note that, during April 8, 2010, through April 20, 2010, Priority provided the examiners with fee schedules from EyeMed that it indicated were included with the vision provider contracts. On April 20, 2010, the examiners requested clarification regarding how information contained in the claim files corresponded to the information in the fee schedules. Priority provided additional clarifying information to the examiners on April 21, 2010. However, on May 25, 2010, the examiners received a different set of fee schedules attached to Priority's response to Review Sheet EFCL04-PR. The examiners sent Memo EFCLMEM01BW-PR on June 7, 2010, requesting that Priority provide documentation confirming the delivery date of these fee schedules to the providers, as well as documentation of each provider's acceptance of the fee

schedule, as outlined in the terms and provisions of the provider's contract. Priority responded on June 21, 2010, stating:

Attached are the schedules that were communicated to the VA Blue View Vision providers in April 2006. Also attached is a Screen-shot from the EyeMed System, the [sic] EyeMed advised shows the date the communications were posted to the system. They were posted the evening of 4/12/2006 – which schedules them for transmission the following day 4/13/2006.

The examiners would comment that Priority's response failed to provide documentation that would verify the date that the fee schedules were mailed to the providers in accordance with the amendment provisions of the contracts. Priority's response documenting the date that the documents "...were posted into the system," and a description of what is scheduled to happen once a document is posted, is not sufficient. Therefore, Priority underpaid the providers according to the fee schedules included with the provider contracts and failed to document that the vision provider contracts were amended to include the fee schedules provided in its response.

SUMMARY

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, failing to comply with § 38.2-3407.15, or to perform any provider contract provision required by that section. Priority's failure in 11 instances to perform the provider contract provisions, required by § 38.2-3407.15 B of the Code, occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code. In the prior Report, it was recommended that Priority establish and maintain procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims as required

by § 38.2-3407.15 B 8 (formerly § 38.2-3407.15 B 7) of the Code. Due to the fact that violations of § 38.2-3407.15 B 8 (formerly § 38.2-3407.15 B 7) of the Code were discussed in the prior Report, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

COPY

V. ADVERTISING/MARKETING COMMUNICATIONS

A review was conducted of Priority's advertising materials to determine compliance with § 38.2-4312 of the Code and the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503, and 38.2-504, as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of this regulation if it is determined by the Bureau of Insurance that the advertisement has the tendency or capacity to mislead from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-90-50)

14 VAC 5-90-170 A requires each insurer to maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement with a notation attached indicating the manner and extent of distribution and the form number of any policy advertised. The review revealed that Priority was in substantial compliance.

14 VAC 5-90-170 B requires each insurer to file with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company which states that, to the best of his/her knowledge, information, and belief, the advertisements complied, or were made to comply in all respects with the provisions of these rules and insurance laws of this Commonwealth. Priority filed its Certificate of Compliance as

required. However, the examination revealed that Priority's advertisements were not in compliance with the Code and regulations in all instances.

A sample of 25 advertisements from a total population of 195 was selected for review. The review revealed that 3 of the 25 advertisements selected contained violations. In the aggregate, there were 3 violations, which are discussed in the following paragraph.

14 VAC 5-90-50 A sets forth the requirements that the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Review Sheets AD01A-PR, AD02-PR and AD03A-PR refer to the 3 violations of this section. As discussed in Review Sheet AD01A-PR, Priority disseminated an invitation to inquire in the form of a flyer. The examiners originally observed that the flyer discussed benefits without disclosing that exclusions, reductions, or limitations may apply. Priority disagreed, stating that the identified service was part of a health program "...that provides non-insurance services." The examiners would respond that, although not advertising insurance benefits of the policy, this advertisement promotes services that are not available unless a policy is purchased. The advertisement does not specify that the services are not insurance and not covered benefits of the insurance plan and this omission has the capacity or tendency to mislead or deceive, in violation of this section.

SUMMARY

Priority violated 14 VAC 5-90-50 A, placing it in violation of Subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

VI. POLICY AND OTHER FORMS

Although a formal review of policy forms was not performed, the examiners reviewed the policy forms contained in the claim files to determine if Priority complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Section 38.2-3407.4 A of the Code requires that each insurer shall file for approval explanation of benefits (EOB) forms. The review revealed 31 instances in which Priority used an EOB form that was not filed with or approved by the Commission, in violation of this section. Examples are discussed in Review Sheet CL01Vision-PR. The review of vision claims revealed that the EOB form issued to Priority's members had been altered since it was filed for approval. Priority agreed with the examiners.

VII. PREMIUM NOTICES/REINSTATEMENTS

Priority's practices for the billing and collection of premiums and reinstatements were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM NOTICES

The examiners were provided with premium billing procedures used during the examination time frame. The procedures indicate that premium payment is due on or before the 1st of the coverage month. On as close to the 15th day of each month as possible, the Billing Supervisor runs a series of system reports and computer jobs during the bill generation process. The bills are printed, inserted and mailed.

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35%. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage.

Individual

Priority's renewal process is to generate letters that are:

...printed with the month and year that is the 3rd month prior to the actual renewal. By mailing the [sic] before the end of the third month prior, it ensures at least 60 days of notification. An August 1st renewal requiring 60-day notification will mail, for example, in May. If that letter mails at ANY time in the month of May, it has beaten the 60-day requirement. System restraints prevent printing the specific date.

Priority indicated that it did not have any individuals that received greater than a 35% premium increase at renewal during the examination time frame.

Group

The examiners were informed that the standard process for group renewals in the 15-99 market is to deliver a copy of the renewal to the Agent of Record, via the Priority Sales Representative, at least 3 weeks prior to the 60-day notification period to allow the Agent to deliver the renewal to the customer. The lead-time of 3 weeks is designed to provide the Agent adequate time to deliver and advise his client of the renewal notification. In addition, Underwriting mails the legal notification directly to the customer 4 working days prior to the end of the month preceding the 60-day notification date.

Priority informed the examiners that it does not track premium increases greater than 35% at renewal in the small group of 2-14 market, but it does send renewal notices to all groups prior to the 60-day notification period. For this reason, the examiners reviewed a sample of 50 from the population of 432 renewals in the small group of 2-14 market and found that none of the sampled small groups received a premium increase greater than 35% at renewal. For all other groups, the entire population of 4 groups receiving premium increases greater than 35% at renewal was reviewed.

The review revealed that Priority was in substantial compliance.

REINSTATEMENTS

Priority's procedures indicate that a group or individual is reinstated upon written request within 90 days of cancellation for non-payment of premium if all delinquent payments are made to bring the account current.

Individual

Priority indicated that it did not have any individuals request reinstatement during the examination time frame.

Group

A sample of 10 from a population of 30 reinstated groups was selected for review. The review revealed that Priority was in substantial compliance with its established procedures.

COPY

VIII. CANCELLATIONS/NON-RENEWALS

The examination included a review of Priority's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; and the notification requirements of 14 VAC 5-211-230 B and § 38.2-3542 of the Code.

Individual

A sample of 4 from a population of 8 individual contracts terminated during the examination time frame was selected for review.

14 VAC 5-211-230 B 1 states that an HMO shall not terminate coverage for services provided under a contract without giving the subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that, for termination due to nonpayment of premium, the grace period as required in 14 VAC 5-211-210 B 17 shall apply. The review revealed that Priority was in substantial compliance.

Group

A sample of 25 from a population of 469 groups terminated during the examination time frame was selected for review.

Section 38.2-3542 C of the Code requires an HMO to provide an employer, whose coverage is terminating due to nonpayment of premiums, with a written notice of termination 15 days before the date coverage will terminate, and that coverage shall not be permitted to terminate for at least 15 days after such notice has been mailed. The review revealed that Priority was in substantial compliance.

IX. COMPLAINTS

Section 38.2-511 of the Code requires that a complete record of complaints be maintained for all complaints received since the last examination or during the last 5 years, whichever is the more recent time period, and such records shall indicate the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

The examiners reviewed a sample of 10 from the population of 118 written pre-service, post-service and contractual appeals; a sample of 2 from the population of 4 expedited appeals; a sample of 2 from the population of 4 executive inquiries; and a sample of 3 from a population of 8 written complaints received during the examination time frame.

The review revealed that Priority was in substantial compliance.

X. CLAIM PRACTICES

The purpose of the examination was to review the claim practices for compliance with §§ 38.2-510 and 38.2-4306.1 of the Code, as well as 14 VAC 5-211-10 et seq., Rules Governing Health Maintenance Organizations.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims. Claims are defined as submissions for negotiated fee-for-service, per diem, per case payments for health care services provided by inpatient and outpatient physicians and facilities.

Priority has contracted with intermediaries for the processing of its claims for vision and chiropractic services. EyeMed processes vision claims and American Specialty Health Network (ASHN) processes chiropractic claims.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 148 was selected from a total population of 295,355 claims paid during the examination timeframe. The review revealed that the claims were processed in accordance with the contract provisions.

Mental Health & Substance Abuse

A sample of 86 was selected from a total population of 12,658 mental health and substance abuse claims paid during the examination time frame. Section 38.2-3412.1:01 C of the Code of Virginia requires that coverage for biologically based mental illnesses neither be different nor separate from coverage for any other illness,

for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

The review revealed 44 violations of this section. Examples are discussed in Review Sheet CL08B-PR in which Priority applied regular mental health copayments, instead of specialist copayments, for claims with biologically based mental illness diagnoses. By applying mental health copayments, Priority failed to treat the biologically based mental illnesses as any other illnesses for determining the copayment factors. Priority disagreed, stating:

The Company treats all mental health diagnosis codes the same. It does not differentiate between biologically based mental illness and other mental illnesses. The mental health benefits are not subject to separate deductibles; benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits. The copayments for mental illness services are not greater than those for other illnesses. The copayments for mental health and substance abuse benefits are less than the copayments for specialists for other illnesses. Priority does not believe the intent of Section 38.2-3412.1:01 C of the Code of Virginia is to prohibit an HMO from providing a better benefit for its members than is required by law. The rationale for reducing the mental health copayment in HMO products with high specialist copayments is because of the concern over the cost of an episode of treatment for a behavioral health or biologically based mental illness over time as compared to that of a physical illness. In general behavioral health or biologically based mental illness tend to include more frequent and regular interventions than physical illness, so lower copayments help reduce any financial barrier to care that would be imposed if a specialist copayment were required with every regular mental health visit.

Although the examiners acknowledge the rationale expressed in Priority's response, the examiners would note that § 38.2-3412.1:01 C of the Code clearly states that coverage for biologically based mental illnesses shall neither be different nor

separate from coverage for any other illness, to include applicable copayment factors. In the claims referenced above, the members sought services for diagnoses considered to be biologically based mental illnesses according to § 38.2-3412.1:01 E of the Code. Therefore, the copayments should not have been different than if the members had sought services from another type of specialty provider. It remains the opinion of the examiners that Priority's practice is in violation of the Code. However, since the review did not reveal any instances in which a copayment greater than the copayment for a service for any other illness was applied, no monetary penalty will be assessed for these violations.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. As discussed in Review Sheet CL03B-PR, the review revealed 1 instance of non-compliance with these 3 sections. According to the remarks in the claim file, Priority initially approved and then later re-processed and denied this claim because the 18 authorized visits had been exhausted. However, the EOB sent to the member did not discuss authorized visits or an authorization for services; rather, it indicated a different denial reason, stating, "Service exceeded the benefit limit outlined in your evidence of coverage." Therefore, the denial reason indicated on the EOB is not reasonable and does not

reflect the actual reason for the denial of the claim. In addition, the EOB held the member liable for the denied charges on the claim, but the member was seen by a participating provider. According to the member's evidence of coverage, the member must have a referral from a PCP to see another provider. The EOC further states, under "Approvals of care involving an ongoing course of treatment," that "*HMO providers* must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services." It continues by instructing that if the member is receiving care from a non-HMO provider, the member is required to request the extension. Since the member was receiving care from a participating provider, the EOC clearly states that it is the participating provider's responsibility to request an extension of authorization for treatment and the member should not have been held liable for this claim. Therefore, Priority misrepresented pertinent facts or policy provisions relating to coverages at issue, failed to make a fair and equitable settlement of the claim, and failed to provide a reasonable explanation of the basis in the insurance policy for the denial of the claim. Priority agreed with the examiners' observations.

Chiropractic

A sample of 4 was selected from an unknown population of chiropractic claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Ambulance

A sample of 7 ground ambulance claims was selected from an unknown population of ambulance claims paid during the examination time frame. No air

ambulance claims were identified in the population. The review revealed that the claims were processed in accordance with the contract provisions.

Vision

A sample of 20 claims was selected from a total population of 29,702 vision claim lines paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Pharmacy

A sample of 100 was selected from an unknown population of pharmacy claims paid during the examination time frame. Of the 100 claims in the sample, 37 claims were determined to be Medicaid claims and were not reviewed. Therefore, the examiners reviewed 63 claims. The review revealed that the claims were processed in accordance with the contract provisions.

Dental

A sample of 4 was selected from a total population of 38 dental claim lines paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Interest on Claims

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. As discussed in Review Sheet CL09B-PR, the review revealed 1 violation of this section in which Priority failed to pay interest as required.

The member was seen by her PCP, but the PCP used a different provider number and location than the provider number and location that was reflected in the member's file. The PCP was a participating provider under both provider numbers. Priority denied the claim, but there is no basis in the EOC to deny a claim for a PCP visit because the PCP used a different participating provider number than the one reflected in a member's file. Priority eventually paid the claim after repeated submission of the claim by the provider. Priority disagreed, stating:

This provider is affiliated with two distinct provider practices. This claim is denied correctly as member did not see this provider at the approved PCP location, [sic] on file. The provider, [sic] inadvertently forgot to notify Anthem of their change to the on call location. An exception was made to pay this claim in order to prevent member liability. Provider was notified to correct their error. Interest is not owed on this claim as it was denied correctly.

The examiners do not concur. The EOC instructs the member that they need to select a PCP from a directory of participating providers. The EOC defines a Primary Care Physician ("PCP") as "the HMO physician you must select to provide primary health care and to coordinate the other services you may require. PCPs specialize in the areas of general practice, family practice, internal medicine, and pediatrics." The EOC does not specify that a member must select only one location and/or one specific practice. The PCP continues to be the member's PCP regardless of which location or which of the PCP's participating provider numbers the PCP uses when submitting a claim. Therefore, Priority paid the above referenced claim after 30 calendar days from receipt of complete proof of loss and interest is due in the amount of \$3.11.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 115 was selected from a total population of 91,484 claims denied or adjusted during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to a claimant or enrollee under an HMO contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code requires that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed 3 instances in which Priority sent an EOB that failed to include all lines of the claim, in violation of these sections. An example is discussed in Review Sheet CL10B-PR, where Priority received a claim with 4 procedure codes listed separately by claim line. According to Priority's procedures, one claim number is assigned to all of the procedure codes submitted by a provider on one claim form, regardless of whether the claim form is received electronically or on paper. Benefits are determined for each billed procedure based on several factors, to include consideration of the other procedures that were performed and submitted on the same claim form. For this claim, Priority approved payment for 2 procedure codes and denied 2 procedure codes. Priority suppressed the EOB that included the paid procedures for which a copay was collected. The only procedures included on the EOB sent to the member were the denied procedures. The denial reason given for both procedures on the EOB stated, "This procedure is incidental when performed with another procedure," but the EOB did not include the related procedures for which benefits were paid and it is not clear which

other procedure Priority is referring to in the denial reason on the EOB. Therefore, Priority failed to clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider, and the benefits payable under the contract, in violation of the Code.

Priority disagreed, stating:

Explanations of Benefits are suppressed when Anthem pays the charges in full and there is no patient balance, when Anthem pays the allowable charge in full and there is no patient balance or when Anthem pays its full allowance and only a flat dollar co-payment remains. Members may request an EOB statement for the types of claims for which an EOB is not sent through an online application. Members may also access Anthem.com and view their claims information on-line. In addition, members can always request a copy of their EOB from a member services representative.

The examiners do not concur. The claim is split onto two separate EOBs, and one is suppressed. Neither EOB includes the entire claim, and neither EOB advises the member that a portion of the claim is on a different EOB. The member receives nothing showing the complete benefit calculation or the total benefits paid. Access to additional EOBs online or through a request made to a member services representative does not remedy the failure of the EOB that Priority actually sent to the member to clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider, and the benefits payable under the contract.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in

which liability has become reasonably clear. The review revealed 2 instances of non-compliance with these sections. An example of Priority's non-compliance with these sections is discussed in Review Sheet CL11B-PR, where Priority incorrectly held the member liable for charges on a claim. The denial reason on the EOB sent to the member stated, "This service is considered part of the original facility claim. As such, a separate claim for this service is not covered. We have asked the facility to combine these charges with their previously processed claim." The EOB showed the member as liable for charges; however, since the provider is participating and the original claim was processed and approved, the member should not be held liable for these charges. Priority misrepresented pertinent facts or insurance policy provisions concerning the coverages at issue and did not make a fair and equitable settlement of the claim. Priority agreed with the examiners observations and stated:

Claim was correctly denied. Notwithstanding, the denial reason was incorrectly coded in the system to show member liability on the EOB. Even though member liability is shown on the EOB, the provider is not allowed to bill the member. A correction was made on December 30, 2009 so that when this denial reason is used for a charge, the EOB will not show member liability.

The examiners do not concur that a provider would not bill a member if the EOB and provider remittance clearly show member liability. The examiners requested documentation that a corrected EOB and provider remittance were sent showing that the member does not have any liability on this claim. As of the writing of the Report, no documentation has been provided to the examiners. In addition, since Priority has identified this problem as a system-wide issue and not limited to this claim, Priority would be in non-compliance with §§ 38.2-510 A 1 and A 6 of the Code in each and

every instance that this denial code was used and member liability was incorrectly shown on an EOB and/or provider remittance.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. As discussed in Review Sheet CL02-PR, the review revealed 1 instance of non-compliance with this section. Priority incorrectly held a member liable for services performed at a non-par laboratory, as stated on the EOB. The member was referred to the laboratory by their participating provider and liability should have remained with the referring participating provider. Priority agreed with the examiner's observations.

Mental Health & Substance Abuse

A sample of 30 was selected from a total population of 2,946 mental health and substance abuse claims denied or adjusted during the examination time frame. Section 38.2-3412.1:01 C of the Code of Virginia requires that coverage for biologically based mental illnesses neither be different nor separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

The review revealed 6 violations of this section. Examples are discussed in Review Sheet CL08B-PR in which Priority applied regular mental health copayments, instead of specialist copayments, for claims with biologically based mental illness diagnoses. By applying mental health copayments, Priority failed to treat the

biologically based mental illnesses as any other illnesses for determining the copayment factors. As discussed in the Paid Claim Review section of this Report, Priority disagrees with the examiners' observations and, although the examiners acknowledge the rationale expressed in Priority's response, it remains the opinion of the examiners that Priority's practice is in violation of the Code. However, since the review did not reveal any instances in which a copayment greater than the copayment for a service for any other illness was applied, no monetary penalty will be assessed for these violations.

Section 38.2-514 B of the Code states that no person shall provide to a claimant or enrollee under an HMO contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code requires that an EOB shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL01B-PR, the review revealed 1 instance in which Priority sent an EOB that failed to include all lines of the claim, in violation of these sections. Priority received a claim with 2 procedure codes listed separately by claim line. According to Priority's procedures, one claim number is assigned to all of the procedure codes submitted by a provider on one claim form, regardless of whether the claim form is received electronically or on paper. Benefits are determined for each billed procedure based on several factors, to include consideration of the other procedures that were performed and submitted on the same claim form. For this claim, Priority approved payment for one procedure code and denied one procedure code. Priority suppressed the EOB that included the paid procedure for which a copay was collected.

The only procedure included on the EOB sent to the member was the denied procedure. The denial reason on the EOB stated, "This procedure is incidental when performed with another procedure," but the EOB did not include the related procedure for which benefits were paid and it is not clear which other procedure Priority is referring to in the denial reason on the EOB. Therefore, Priority failed to clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider, and the benefits payable under the contract, in violation of the Code.

Priority disagreed, stating:

The member is not responsible for the denied charge on this EOB. The only reason they received it was because of the note at the bottom that states that if the provider is non-par, they could be billed. The EOB clearly shows, however, that this provider is participating and the member does not owe anything.

The examiners do not concur. The claim is split onto two separate EOBs, and one is suppressed. Neither EOB includes the entire claim, and neither EOB advises the member that a portion of the claim is on a different EOB. The member receives nothing showing the complete benefit calculation or the total benefits paid. Priority failed to clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider, and the benefits payable under the contract.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy

for a denial of a claim. The review revealed that Priority was in non-compliance with these sections in 3 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Priority was in non-compliance with this section in 2 instances. An example of Priority's non-compliance with these 3 sections is discussed in Review Sheet CL05B-PR, where Priority did not provide a reasonable explanation of the basis for denial of a claim. Priority denied the service of a chest x-ray with a diagnosis code of 305.1 (tobacco use disorder). The denial reason on the EOB stated: "This service is not a covered benefit of the plan." However, there is nothing in the evidence of coverage (EOC) that excludes chest x-rays. The EOC states that "Your coverage does not include benefits for services related to smoking cessation, including stop smoking aids or services of stop smoking clinics." Although the diagnosis is tobacco related, the actual service, a chest x-ray, is not related to smoking cessation. Therefore, Priority provided an unreasonable explanation of the basis for denial of the claim and misrepresented pertinent facts concerning the coverages at issue. The member was also incorrectly held liable for the charges and Priority did not make a fair and equitable settlement of the claim. Priority disagreed with the examiners and stated:

This claim was denied correctly. The diagnosis code of 305.1 is a non-covered diagnosis regardless of what procedure codes are billed with it. This diagnosis was the primary and only diagnosis billed on the claim.

The examiners do not concur. The reason for denial indicated on the EOB stated, "this service is not a covered benefit of the plan." However, Priority's response indicates that the diagnosis code, not the service, is the reason for denial. The

examiners would also note that the diagnosis code of 305.1 (tobacco use disorder) is not excluded in the EOC and, thus, Priority's practice of denying all procedure codes billed with this diagnosis is in non-compliance with its EOC. Therefore, Priority provided an unreasonable explanation of the basis for denial, misrepresented pertinent facts concerning the coverages at issue, and did not make a fair and equitable settlement of the claim.

Chiropractic

A sample of 6 was selected from an unknown population of claims denied or adjusted during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Ambulance

A sample of 2 ground ambulance claims was selected from an unknown population of ambulance claims denied or adjusted during the examination time frame. No air ambulance claims were identified in the population. The review revealed that the claims were processed in accordance with the contract provisions.

Vision

A sample of 10 was selected from a total population of 281 vision claim lines denied or adjusted during the examination time frame. Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 2 of the Code prohibits, as a general business practice, failing to acknowledge and act

reasonably promptly upon communications with respect to claims arising under insurance policies. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed 2 instances of non-compliance with these sections. An example of Priority's non-compliance with these sections is discussed in Review Sheet CL04Vision-PR, where Priority took 140 calendar days to respond to a claim submission and incorrectly held the member liable for charges on a claim. Priority disagreed with the examiners' observations, and stated:

This transaction was denied as an incomplete submission attempt. Since the claim was not completed at the time of entry in the claim submission system used by Independent Network Providers, EyeMed does not treat this as a valid claim submission. When a provider does not complete a valid transaction, the Claims Adjudication System is unable to auto-adjudicate the claim transaction, causing the transaction to sit in a state of limbo. As such, the denial is created in an attempt to indicate to the Provider that he/she did not complete the claims transaction and, [sic] the submission needs to be attempted again. Though the notice (EOB) went out to the Member 4 months after the initial attempt by the Provider to electronically submit the claim, the transaction was not actually touched by the claims processor until that time had elapsed due to the fact that the provider had not completed the transaction.

The examiners do not concur. Although the claim was incomplete, Priority (or its designated vendor) received the claim transaction, and Priority is required to act upon it appropriately. Priority did not deny the claim until 4 months after the claim was received, but it did not receive any additional information within that time frame. Since the member went to a participating provider for services, the provider contract and hold harmless clause prevent the member from being held liable when the claim was not submitted correctly, but Priority incorrectly held the member liable for charges on the

claim. Therefore, Priority misrepresented pertinent facts regarding the coverages at issue and did not provide a prompt, fair and equitable settlement.

Pharmacy

A sample of 25 was selected from an unknown population of claims denied or adjusted during the examination time frame. Of the 25 claims in the sample, 12 were determined to be Medicaid claims and were not reviewed. Therefore, the examiners reviewed 13 claims. The review revealed that the claims were processed in accordance with the contract provisions.

Dental

A sample of 8 was selected from a total population of 500 dental claim lines denied or adjusted during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for denial of a claim. As discussed in Review Sheet CL14B-PR, the review revealed 1 instance of non-compliance with these sections. In this instance, Priority denied the claim because no authorization for the service was on file; however, the denial reason on the EOB stated, "This service is not a covered benefit of the plan." Further, the remarks in the claim file stated that this

service should be “approved per auth...” and the claim was later re-processed and paid. Although Priority disagreed with the examiners’ observations, its response stated, “Claim was originally processed through system and denied in error. Claim was adjusted using the original received date. Interest was paid on this claim.” Priority submitted documentation verifying that it re-processed the claim to pay the correct amount, with interest.

SUMMARY

Priority’s failure to comply with § 38.2-510 A of the Code did not occur with such frequency as to indicate a general business practice.

TIME SETTLEMENT STUDY

The time settlement study was performed to determine compliance with § 38.2-510 A 5 of the Code, which requires that coverage of claims be affirmed or denied within a reasonable time after proof of loss statements have been completed. The normally acceptable “reasonable time” is 15 working days from the receipt of proof of loss to the date a claim is either affirmed or denied. The term “working days” does not include Saturdays, Sundays, or holidays.

Priority’s established practice was to settle claims within 30 calendar days of receipt. Therefore, the examiners allowed for a 30-calendar day time frame to determine a reasonable time to affirm or deny claims after proof of loss was received.

Of the 94 claims reviewed by the examiners that were payable to the member or were denied and were the responsibility of the member, the review revealed 3 instances in which Priority failed to affirm or deny coverage within a reasonable time, in non-

compliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL15B-PR in which Priority took longer than 30 days to deny a claim. Priority agreed with the examiners. Priority's failure to comply with § 38.2-510 A 5 of the Code did not occur with such frequency as to indicate a general business practice.

SETTLEMENT ORDER - CLAIMS FOR EMERGENCY SERVICES

The Commission entered a final settlement order in Case INS-2007-00225 on January 14, 2008. The order requires Priority to comply with the reimbursement plan and subsequent payment methodology specified in Priority's letter of November 16, 2007, to the Bureau of Insurance.

The examiners reviewed a sample of 75 claims for emergency services from non-participating providers from an unknown population. Section 38.2-4312.3 B of the Code states that an HMO shall reimburse a hospital emergency facility and provider, less any applicable copayments, deductibles, or coinsurance, for medical screening and stabilization services rendered to meet the Federal Emergency Medical Treatment and Active Labor Act and related to the condition for which the member presented in the hospital emergency facility. Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Section 38.2-510 A 8 of the Code prohibits, as a general business practice, attempting to settle claims for less than the amount to which a reasonable man would have

believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

In its letter dated November 16, 2007, to the Bureau of Insurance, Priority's procedure for reimbursement of claims for emergency services from non-participating providers states that, after January 1, 2008, such claims containing a diagnosis code included on the EMTALA diagnosis list developed by its medical staff will be reimbursed by Priority directly to the non-participating provider or facility in an amount that such provider or facility will accept as payment in full, less any applicable deductible, copayment, or coinsurance.

The review revealed that Priority did not pay a claim for emergency services according to these procedures in 1 instance, placing it in non-compliance with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8; in violation of § 38.2-4312.3 B; and in non-compliance with the reimbursement plan and payment methodology required by the Order. As discussed in Review Sheet CL02ER-PR, the claim for emergency services contained a diagnosis code that is included on the EMTALA diagnosis list developed by Priority's medical staff; however, the member was held liable for the amount over the allowable charge and Priority failed to pay the provider directly for services. Priority disagreed, stating:

The following claims were all paid under the EMTALA settlement except for one, which had a primary diagnosis that is not on the EMTALA list. Anthem's procedural guideline as of 1/2/2008 is to pay claims as EMTALA only when the primary diagnosis is on the EMTALA DX list....

The examiners would respond that the payment methodology in the Order specifies that Priority will use diagnosis to identify EMTALA claims, but there is no

requirement or limitation in the Order that the EMTALA diagnosis be primary. Priority disagreed, stating:

The reprocessing of EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance although we have no written documentation of this discussion. The EMTALA list of diagnoses was purposely made broad to capture EMTALA events. If a claim does not have an EMTALA diagnosis as the primary diagnosis it is less likely to have been an EMTALA event.

The examiners do not concur. Priority's specified payment methodology, which is included in the Order, contains no limitation or requirement that the EMTALA diagnosis be primary. In addition, the examiners would note that the EMTALA list developed by Priority's medical staff contains E codes (diagnosis codes that begin with the letter "E"). The Coding Fundamentals section of the ICD-9 manual states, "E codes are never to be recorded as a principal diagnosis (first-listed in a non-inpatient setting) and are not required for reporting to CMS." Since the ICD-9 coding manual clearly indicates that E codes are never to be used as primary diagnosis codes, claims with E codes, which Priority included on its EMTALA list, will never be considered as EMTALA under Priority's current procedure.

Therefore, Priority is in violation of § 38.2-4312.3 B, and in non-compliance with the Order and with §§ 38.2-510 A 1, 38.2-510 A 6 and 38.2-510 A 8 of the Code, in 1 instance revealed during the review and in each and every instance in which a claim has not been processed as an EMTALA claim, although it has a diagnosis that is on Priority's EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.

Priority's admitted application of its internal procedures indicates a general business practice, placing it in violation of §§ 38.2-510 A 1, 38.2-510 A 6 and 38.2-510 A 8 of the Code.

THREATENED LITIGATION

There were no claims that involved threatened litigation during the examination time frame.

COPY

XI. CORRECTIVE ACTION PLAN

Effective October 19, 2010, Priority merged into HealthKeepers, Inc., with HealthKeepers, Inc. being the surviving entity of the merger. Based on the findings stated in this Report, the examiners recommend that HealthKeepers, Inc., on behalf of Priority, comply with all corrective actions noted in the Report of HealthKeepers, Inc., as well as implement the following corrective actions. HealthKeepers, Inc. shall:

1. Review all claims for participating providers in which the denial reason provided to the member stated: "This service is considered part of the original facility claim. As such, a separate claim for this service is not covered. We have asked the facility to combine these charges with their previously processed claim," from January 1, 2008, until Priority corrected its system and until the EOBs sent to the member and the provider remittances sent to the providers did not show member liability for these charges (represented as December 30, 2009, to the examiners). Determine those instances in which an EOB was sent to the member, and/or a provider remittance was sent to the provider, that incorrectly indicated that the member had liability for these charges. Reprocess those claims to send new EOBs to the members, and/or provider remittances to the providers, accurately indicating that no member liability exists for the charges. All EOBs and/or provider remittances should be accompanied by a statement or letter of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that an error was made in the explanation of the processing of this claim. Please accept this revised explanation of benefits

(provider remittance).” HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required corrections have been made, and corrected EOBs and/or remittances have been mailed, within 90 days of the Report being finalized;

2. Review all claims with a diagnosis code of 305.1, tobacco use disorder, from January 1, 2008, to the current year. Determine those instances in which a claim was denied for the service not being covered although neither the service nor the diagnosis code was excluded by the EOC. Reopen and reprocess those claims and reimburse affected members and/or providers according to the terms of the EOC and the provider contract. All checks for reimbursement should be accompanied by a letter of explanation stating that, “As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that an error in the payment of this claim was found. Please accept this check for an additional payment.” HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized; and
3. Review all claims for emergency services from non-participating providers from July 1, 2006, to the current year. Determine those instances where a claim has not been processed as an EMTALA claim, although it has a diagnosis that is on Priority’s EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to

the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

COPY

XII. ACKNOWLEDGMENT

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

Bryan Wachter FLMI, AIE, AIRC, Bill Benson, AIE, FLMI, ACS, Todd Bryant, HIA, MHP, and Laura Wilson of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks, AIE, FLMI, AIRC
Supervisor, Market Conduct Section II
Life and Health Division
Bureau of Insurance

CONFIDENTIAL

XIII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Provider Contracts
§ 38.2-5805 C 9, 6 violations, EF04HMO
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 2, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 3, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 4, 16 violations, EF03-HMO, EF04-HMO, EF05-HMO
§ 38.2-3407.15 B 5, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 6, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 7, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 8, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 9, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 10, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 11, 16 violations, EF03-HMO, EF04-HMO, EF05-HMO
Provider Claims
§ 38.2-3407.15 B 4 a ii c, 11 violations, EFCL03-PR, EFCL04-PR, EFCL05-PR
§ 38.2-3407.15 B 4 a ii d, 11 violations, EFCL03-PR, EFCL04-PR, EFCL05-PR
§ 38.2-3407.15 B 8, 11 violations, EFCL03-PR, EFCL04-PR, EFCL05-PR
ADVERTISING/MARKETING COMMUNICATIONS
14 VAC 5-90-50 A, 3 violations, AD01A-PR, AD02-PR, AD03A-PR
POLICY AND OTHER FORMS
§ 38.2-3407.4 A, 31 violations, CL01VISION-PR, CL01ASHN-PR

CLAIM PRACTICES
§ 38.2-514 B, 4 violations, CL01B-PR, CL10B-PR, CL12B-PR, CL13B-PR
§ 38.2-3407.4 B, 4 violations, CL01B-PR, CL10B-PR, CL12B-PR, CL13B-PR
§ 38.2-3412.1:01 C, 50 violations, CL08B-PR
§ 38.2-4306.1 B, 1 violation, CL09B-PR
§ 38.2-4312.3 B, 1 violation, CL02ER-PR
§ 38.2-510 A 1, 10 instances, CL01-PR, CL02ER-PR, CL03B-PR, CL03VISION-PR, CL04B-PR, CL04VISION-PR, CL05B-PR, CL06B-PR, CL11B-PR, CL14B-PR
§ 38.2-510 A 5, 3 instances, CL03VISION-PR, CL04VISION-PR, CL09B-PR
§ 38.2-510 A 6, 9 instances, CL01-PR, CL02ER-PR, CL03B-PR, CL03VISION-PR, CL04B-PR, CL04VISION-PR, CL05B-PR, CL11B-PR, CL14B-PR
§ 38.2-510 A 8, 1 instance, CL02ER-PR
§ 38.2-510 A 14, 6 instances, CL01-PR, CL03B-PR, CL04B-PR, CL05B-PR, CL06B-PR, CL14B-PR

COPY

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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March 15, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5527
RETURN RECEIPT REQUESTED

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Lough:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Priority Health Care, Inc. (Priority) the period of January 1, 2008 through June 30, 2008. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of Priority, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. Priority response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia P. Battle

Legal Department

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
PO Box 27401
Richmond, VA 23279
Tel 804 354-7283
Fax 804 354-7281



May 13, 2011

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report of
HealthKeepers, Inc., Priority Health Care, Inc. and Peninsula Health Care Inc.
Exposure Draft Corrective Action Item Response

Dear Ms. Fairbanks:

This letter is in response to the Market Conduct Examination Report Exposure Drafts issued by the Bureau for HealthKeepers, Inc, Priority Health Care, Inc. and Peninsula Health Care Inc.

Enclosed please find the responses to the Corrective Action Items identified in the Exposure Drafts. HealthKeepers, Inc. is responding on behalf of Priority Health Care, Inc. and Peninsula Health Care Inc.

Should you have any questions, please feel free to contact me at 404.842.8233 or 404. 357.4318.

Sincerely,

A handwritten signature in cursive script that reads "Marie Lough".

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
HealthKeepers, Inc.

Enclosure
cc: Owen Hunt

Response to Recommendations HealthKeepers, Inc. on behalf of Priority Market Conduct Examination Report

1. **Review all claims for participating providers in which the denial reason provided to the member state: "This service is considered part of the original facility claim. As such, a separate claim for this service is not covered. We have asked the facility to combine these charges with their previously processed claim, "from January 1, 2008, until Priority corrected its system and until the EOBs sent to the member and the provider remittances sent to the providers did not show member liability for these charges (represented as December 30, 2009, to the examiners). Determine those instances in which an EOB was sent to the member, and/or a provider remittance was sent to the provider, that incorrectly indicated that the member had liability for these charges. Reprocess those claims to send new EOBs to the members, and/or provider remittances to the providers, accurately indicating that no member liability exists for the charges. All EOBs and/or provider remittances should be accompanied by a statement or letter of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that an error was made in the explanation of the processing of this claim. Please accept this revised explanation of benefits (provider remittance)." HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required corrections have been made, and corrected EOBs and/or remittances have been mailed within 90 days of the Report being finalized.**

HealthKeepers, on behalf of Priority, did not intend to show member liability when it requested follow-up actions by the provider. A query identifying the claims that indicated member liability in error has been run. Claims will be reprocessed and EOBs and provider remittances and appropriate letter of explanation will be sent according to the Corrective Action Plan. HealthKeepers, on behalf of Priority, will provide the examiners with documentation that the required corrections have been made, and corrected EOBs and/or remittances have been mailed within 90 days of the Report being finalized.

2. **Review all claims with a diagnosis code of 305.1 tobacco use disorder, from January 1, 2008 to the current year. Determine those instances in which a claim was denied for the service not being covered although neither the service nor the diagnosis code was excluded by the EOC. Reopen and reprocess those claims and reimburse affected members and/or providers according to the terms of the EOC and the provider contract. All checks for reimbursement should be accompanied by a letter of explanation stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that an error in the payment of this claim was found. Please accept this check for an additional payment." HealthKeepers, on behalf of Priority, should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.**

HealthKeepers, on behalf of Priority will reprocess claims with the diagnosis code 305.1 with charges for services not excluded according to the terms of the EOC and the provider contract. All checks for reimbursement will be accompanied by a letter of explanation stating as directed in the Corrective Action Item. HealthKeepers, on behalf of Priority, will provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized. In addition, the claim processing system will be updated to reflect the same.

Response to Recommendations HealthKeepers, Inc. on behalf of Priority Market Conduct Examination Report

3. **Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.**

HealthKeepers, on behalf of Peninsula, respectfully disagrees with this Corrective Action Item. As indicated in HealthKeepers' additional response to Review Sheet CL01ER-HK, the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance, although we have no written documentation of this discussion. The discussion centered around the supposition that if in fact an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. When a claim is submitted, the provider may bill up to 12 diagnosis codes. At the line level, there is a diagnosis pointer and that pointer advises which diagnosis from the claim level should be used for that claim line. The current HCFA claim form has this diagnosis pointer field and can only point to one diagnosis per claim line. The provider determines the appropriate diagnosis for each claim line.

As previously indicated, the EMTALA list of diagnoses was purposely made broad to capture to EMTALA events. If a claim does not have an EMTALA diagnosis as the primary diagnosis it is less likely to have been an EMTALA event. An appeal process is set up to address any claim filed by a non-HMO provider for us to reconsider claims that are initially determined to be non-EMTALA. No appeals were received from Providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. However, if any appeals were received a review would have been done to determine if the claim was an EMTALA claim.

HealthKeepers, on behalf of Peninsula, requests an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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November 22, 2011

**CERTIFIED MAIL 7005 1820 0007 5460 5848
RETURN RECEIPT REQUESTED**

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Priority Health Care, Inc.
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

**Re: Market Conduct Examination Report
Exposure Draft**

Dear Ms. Lough:

The Bureau of Insurance (Bureau) has completed its review of your May 13, 2011, response to the Market Conduct Examination Report of Priority Health Care, Inc. (Priority), sent with my letter of March 15, 2011.

Effective October 19, 2010, Priority merged into HealthKeepers, Inc., with HealthKeepers, Inc. being the surviving entity of the merger. Based on the findings stated in the Report, the examiners recommended that HealthKeepers, Inc., on behalf of Priority, comply with the corrective actions in the Report, as well as comply with all corrective actions noted in the Report of HealthKeepers, Inc. Please note that any references to "Priority" in the remainder of this response will also refer to HealthKeepers, Inc., as it is the surviving entity of the merger.

Your response indicates that Priority has concerns regarding the writing of the Report. This letter addresses these concerns in the same order as presented in your May 13th response. However, since Priority's response will also be attached to the final Report, this response does not address those issues where Priority indicated agreement and/or action taken as a result of the Report. In your response, Priority requested an informal hearing to discuss certain issues in the event that the Bureau maintains the position presented in the Draft Report. However, additional information was not provided with your response for the examiners to consider. If Priority would like to provide the examiners with additional documentation or information pertinent to these issues, the examiners will readily consider such items. After any additional documentation or information has been considered, if Priority would like to schedule an

informal conference here at the Bureau, Priority may submit a request, along with a list of all issues or items that it would like to discuss.

- 3. Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on Priority's EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.**

Priority indicates that the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau, and that the discussion centered around the supposition that if, in fact, an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. However, Priority has no written documentation of the discussion. The examiners would note that the written settlement agreement regarding the processing of claims for emergency services from non-participating providers specifies that Priority will use diagnosis to identify EMTALA claims. The settlement agreement does not include a requirement or limitation that the EMTALA diagnosis be primary and the Bureau does not recall a discussion where both parties agreed to this practice. In order for Priority to comply with the settlement agreement, all diagnosis codes submitted with a claim must be considered, both when processing the claim and when determining if the claim is an EMTALA claim. Further, the EMTALA list developed and used by Priority contains 1,172 E codes (diagnosis codes that begin with the letter "E"). E codes comprise roughly 25% of all of the diagnosis codes on the list. In the Coding Fundamentals section of the ICD-9 manual, it states that "E codes are never to be recorded as a principal diagnosis (first-listed in a non-inpatient setting) and are not required for reporting to CMS." Since the ICD-9 coding manual clearly indicates that E codes are never to be used as primary diagnosis codes, claims with these codes will never be considered as EMTALA under Priority's current procedure. If Priority's intent was to make the EMTALA list "...broad to capture EMTALA events," it has negated that intention by considering only the primary diagnosis code when determining if a claim is EMTALA and thereby excluding one quarter of all codes on its own list.

Priority states that an appeal process has been set up to address any claim filed by a non-HMO provider so that Priority can reconsider claims that are initially determined to be non-EMTALA. Priority also states that no appeals were received from providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. In response, the examiners would note that a standard operating procedure that requires a claimant to appeal before an insurer will process a claim correctly would be an unfair claims settlement practice and a violation of § 38.2-510 of the Code. In addition, the examiners would note that these providers are non-participating and, as such, are not privy to Priority's participating provider manual which

discusses appeal procedures, and the provider remittances sent to these non-participating providers do not alert the provider to the special appeal process. The Corrective Action items and the Report appear correct as written.

During the review of the response to the Report, the examiners have discovered typos on p.51 of the Report. These typos have been corrected and a revised page is attached.

A copy of the revised page to the Report is attached and is the only substantive revision we plan to make before it becomes final. Once the matter has been concluded, Priority will receive a final copy of the Report, which will include the revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that Priority has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

Violations of the above sections of the Code of Virginia can subject Priority to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:

Enclosures

cc: Althelia P. Battle

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
Post Office Box 27401
Richmond, VA 23279
Tel 804 354-7000
www.anthem.com



December 29, 2011

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report
Exposure Draft – Additional Information

Dear Ms. Fairbanks:

This letter is in response to your November 22, 2011 communications regarding the Market Conduct Examination Report Exposure Drafts for HealthKeepers, Inc., Priority Health Care, Inc. and Peninsula Health Care Inc. HealthKeepers, Inc. is responding on behalf of Priority Health Care, Inc. and Peninsula Health Care Inc. with respect to the EMTALA claims corrective action.

Attached please find additional information for the examiners' consideration. If the examiners maintain the position that certain corrective action is required, HealthKeepers, Inc. will submit a request for an informal conference along with a list of all issues or items that it would like to discuss.

Should you have any questions, please feel free to contact me at 404.357.4318.

Sincerely,

A handwritten signature in cursive script that reads "Marie Lough" with a small "JD" to the right.

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
HealthKeepers, Inc.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Review and revise its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code.

Original Response

HealthKeepers has reviewed its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code. With respect to Review Sheet EF04-HMO, HealthKeepers believes that the addition of supplemental language to the "hold harmless" clause does not essentially change the meaning of the clause nor does it limit member rights.

Additional Response

The Bureau in its 11/22/2011 response maintains that by amending the "hold harmless" clause with additional language referencing the effectiveness of changes to the language, the "hold harmless" clause no longer reads as essentially set forth in Section 38.2-5805 C 9 of the Code. The supplemental language is a holdover from the former HMO regulation (14VAC5-210-10 et seq.). In the former HMO regulation, that language was specifically required to be part of the hold harmless provision in provider contracts. If that specific hold harmless provision was not included in a provider contract, payments under those contracts would not have been considered covered expenses. HealthKeepers, Inc. maintains that inclusion of the supplemental language formerly required by the HMO regulation does not fundamentally change the meaning of the clause nor does it limit member rights.

As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407. 15 B of the Code.

Original Response

HealthKeepers has reviewed its procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407.15.

HealthKeepers, Inc. maintains its position regarding its response to EF01-HMO that addresses the language found in the Standard Terms and Conditions of provider agreements that states the provider has 40 calendar days from the post mark date of an amendment to the agreement to notify HealthKeepers of termination. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue include this corrective action in its Report.

EyeMed has advised that its contracts with providers were updated in December 2008 to include the provisions required by the Code.

Additional Response

HealthKeepers, Inc. will request an informal hearing to discuss this issue.

As recommended in prior Report, establish and maintain procedures to ensure adherence to the compliance with the minimum fair business standards in the

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

processing and payment of claims as required by Sections 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code.

Original Response

HealthKeepers, Inc. has procedures in place to ensure adherence to the compliance with the minimum fair business standards in the processing and payment of claims as required by Sections 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code. The examiners commented that HealthKeeper's did not provide documentation that would verify the date that EyeMed mailed fee schedules to its providers. EyeMed advised HealthKeeper's, Inc. that it has updated its policies and procedures to document the date that fee schedules were mailed to its providers.

Additional Response

HealthKeepers, Inc. will review its current procedures and strengthen the procedures as necessary to ensure adherence to the compliance with the minimum fair business standards in the processing and payment of claims as required by Sections 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code.

Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-50 A, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

Original Response

The examiners identified two instances that non insurance benefits were not identified as such. HealthKeepers, Inc. will review and revise its procedures to ensure that invitations to inquire identify that certain services are not insurance and not covered benefits under the plans in order to comply with 14 VAC 5-90-50 A, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

Additional Response

As requested by the examiners, HealthKeepers, Inc. will provide evidence of revisions made to the advertisements or evidence that these advertisements are no longer in use in Virginia.

Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contractholders were not notified in writing 60 days prior to such increase as required by Section 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days written notice to the contractholder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Original Response

HealthKeepers, Inc. has conducted a review of all the group renewals released outside of the standard 2-14 market renewal production process for each month in the time period on or after January 30, 2006. The review of these group renewals for refund of premium amounts collected in excess of the 35% increase is based on:

1. Groups receiving greater than a 35% increase excluding premium increases resulting from employees aging into a higher age band
2. Groups identified in #1 who then received less than 60 days notice
3. Groups whose coverage remained in force and paid premiums at the rate increases in excess of 35%.

A report will be created listing any groups due refunds and the amount of the premium to be refunded. HealthKeepers will refund any premium amounts affected by less than 60 days notice. Documentation of the refunds and letters will be furnished to the examiners no later than 90 days after the Report is finalized.

Additional Response

In the Bureau's 11/22/2011 response, the examiners state that the code does not appear to support HealthKeepers, Inc.'s exclusion of premium increases resulting from employees aging into a higher age band. Section 38.2-3407.14 of the Code only states "intent to increase by more than 35 percent the annual premium charged for coverage thereunder". It does not specify what is included or excluded. The renewal notice for the Anthem 2-14 market includes the chart of the renewal rates by age band, gender and membership type for any employee of that employer who is enrolled at the time the renewal is produced or who may be employed during the policy year. The rates displayed in this chart for the renewal effective date compared to the chart for the current policy year is the increase in the annual premium. An example of the age banded chart in the renewal package is attached.

Employees who age into a higher age band or change membership types (add dependents), and therefore are charged an increased premium, are outside of the annual premium setting determined by the insurer. Likewise, employee terminations or new hires that result in a higher premium for the employer are outside of the annual premium setting determined by the insurer. Therefore, HealthKeepers has excluded premium increases due to aging into a higher age band.

Revise and strengthen its procedures for the payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.

Original Response

The two instances cited in Review Sheets CL-10B-HK and CL-15B-HK, were a result of human error. HealthKeepers believes that its procedures are adequate to ensure payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.

Additional Response

HealthKeepers, Inc. will review and revise its procedures as necessary to mitigate future errors.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Establish and maintain procedures to ensure that coverage for biologically based mental illnesses neither be different or separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles, as required by Section 38.2-3412.1:01 C of the Code.

Original Response

HealthKeepers maintains its position taken in the response to Review Sheet CL01-HK and others that providing a better benefit than required by Section 38.2-3412.1:01 C of the Code is not violative of the law. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

Additional Response

HealthKeepers, Inc. acknowledges the removal of this Corrective Action item from the Report.

Establish and maintain procedures to ensure compliance with Sections 38.2-510 A 1, 38.2-510 A 6, and 38.2 510 A 8 of the Code.

Original Response

HealthKeepers acknowledges that the examiners determined that findings related to Sections 38.2-510 of the Code did not constitute a general business practice. HealthKeepers will review its procedures to ensure compliance with Section 38.2-510 of the Code.

Additional Response

The Bureau in its 11/22/2011 response clarified that its review of claims for emergency services revealed that HealthKeepers, Inc. failed to comply with Sections 38.3-510 A 1, 38.2-510 A 6 and 38.2 A 8 of the Code did occur with such frequency as to indicate a general business practice. Additionally, the Bureau stated that HealthKeepers has not fully complied with this Corrective Action until it established and maintains procedures that ensure claims for emergency services are processed in accordance with the final settlement order in Case INS-2007-00225 and in accordance with the Code. HealthKeepers, Inc. maintains that its procedures for processing emergency services are compliant and will request an informal hearing to discuss this issue if the Bureau maintains its position.

Establish and maintain procedures to ensure compliance with Section 38.24312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.

HealthKeepers respectfully disagrees with this Corrective Action Item. Please refer to the Response to Corrective Action Item 13.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

Original Response

HealthKeepers respectfully disagrees with this Corrective Action Item. As indicated in HealthKeepers' additional response to Review Sheet CL01ER-HK, the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance, although we have no written documentation of this discussion. The discussion centered around the supposition that if in fact an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. When a claim is submitted, the provider may bill up to 12 diagnosis codes. At the line level, there is a diagnosis pointer and that pointer advises which diagnosis from the claim level should be used for that claim line. The current HCFA claim form has this diagnosis pointer field and can only point to one diagnosis per claim line. The provider determines the appropriate diagnosis for each claim line.

As previously indicated, the EMTALA list of diagnoses was purposely made broad to capture EMTALA events. If a claim does not have an EMTALA diagnosis as the primary diagnosis it is less likely to have been an EMTALA event. An appeal process is set up to address any claim filed by a non-HMO provider for us to reconsider claims that are initially determined to be non-EMTALA. No appeals were received from Providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. However, if any appeals were received a review would have been done to determine if the claim was an EMTALA claim.

HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

Additional Response

In its 11/22/2011 response, the Bureau reiterates that all diagnosis codes must be considered both when processing the claim and determining if a claim is an EMTALA claim. The ICD-9-CM Official Guidelines for Coding and Reporting Guidelines include the requirement that the provider list first the code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. Adherence to the guidelines is required under the Health Insurance Portability and Accountability Act. If a claim is an EMTALA claim a provider would submit an EMTALA diagnosis first.

The Bureau also indicated that a standard operating procedure that requires a claimant to appeal before an insurer will process a claim correctly would be an unfair claim settlement practice and a violation of Section 38.2-510 of the Code. HealthKeepers

**Response to Recommendations
HealthKeepers, Inc.
Market Conduct Examination Report**

disagrees that its appeal process violates Section 38.2-510 of the Code. A provider is expected to bill with specificity as indicated above. In the event a provider did not list an EMTALA diagnosis as the diagnosis chiefly responsible for the services provided and the claim was processed as non-EMTALA, HealthKeepers appeals process allows for a review of the claim.

In addition, the Bureau indicated that HealthKeepers EMTALA diagnosis code list includes E-codes that are not to be used as primary diagnosis codes. HealthKeepers maintains that even without the inclusion of E-codes, the EMTALA diagnosis code list is broad enough to capture EMTALA events.

HealthKeepers, Inc. will request an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

COPY

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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February 14, 2012

**CERTIFIED MAIL 7005 1820 0007 5460 6159
RETURN RECEIPT REQUESTED**

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Priority Health Care, Inc.
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

**Re: Market Conduct Examination Report
Exposure Draft**

Dear Ms. Lough:

The Bureau of Insurance (Bureau) has completed its review of your December 29, 2011, additional response to the Market Conduct Examination Report of Priority Health Care, Inc. (Priority).

Effective October 19, 2010, Priority merged into HealthKeepers, Inc., with HealthKeepers, Inc. being the surviving entity of the merger. Based on the findings stated in the Report, the examiners recommended that HealthKeepers, Inc., on behalf of Priority, comply with the corrective actions in the Report, as well as comply with all corrective actions noted in the Report of HealthKeepers, Inc. Please note that any references to "Priority" in the remainder of this response will also refer to HealthKeepers, Inc., as it is the surviving entity of the merger.

In your December 29th letter, Priority amended its May 13, 2011, response to include additional information for the examiners' consideration regarding the writing of the Report. This letter addresses Priority's additional responses in the same order as presented in your December 29th response. However, since Priority's response will also be attached to the final Report, this response does not address those issues where Priority indicated agreement and/or action taken as a result of the Report. Priority should note that upon finalization of this exam, Priority will be given approximately 90 days to document compliance with **all** of the corrective actions in the Report.

Priority has indicated that it plans to request an informal conference in the event that the Bureau maintains the position that certain corrective actions are required. If upon receipt and review of this response, Priority decides to request an informal conference to discuss its concerns, Priority may submit such a request, along with a list

of all issues or items that it would like to discuss to me at julie.fairbanks@scc.virginia.gov. Upon receipt, I will coordinate with you and Bureau staff to schedule a meeting at everyone's earliest convenience.

- 1. Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on Priority's EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers, Inc., on behalf of Priority, should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.**

Priority states that if a claim is an EMTALA claim, a provider would submit an EMTALA diagnosis first. However, an EMTALA diagnosis code does not have to be the first code listed in order for the claim to be an EMTALA claim. The examiners would continue to note that the written settlement agreement regarding the processing of claims for emergency services from non-participating providers specifies that Priority will use diagnosis to identify EMTALA claims. The settlement agreement does not include a requirement or limitation that the EMTALA diagnosis be primary and the Bureau does not recall a discussion where both parties agreed to this practice. In order for Priority to comply with the settlement agreement, all diagnosis codes submitted with a claim must be considered, both when processing the claim and when determining if the claim is an EMTALA claim. An emergency services claim from a non-participating provider that has a diagnosis code on Priority's EMTALA list, whether it be primary, secondary, tertiary, or otherwise, should be processed as an EMTALA claim.

Priority disagrees that its appeals process violates § 38.2-510 of the Code, stating that in the event that a provider did not list an EMTALA diagnosis as the diagnosis chiefly responsible for the claim and the claim was processed as non-EMTALA, Priority's appeal process allows for a review of the claim. The examiners do not concur and would continue to note that a standard operating procedure, as described in Priority's previous response, that requires a claimant to appeal before an insurer will consider all information on the claim form and process a claim correctly would be an unfair claims settlement practice and a violation of § 38.2-510 of the Code. The examiners would also note that these providers are non-participating and, as such, are not privy to Priority's participating provider manual which discusses appeal procedures. In addition, the provider remittances sent to these non-participating providers do not indicate that the claim was processed as "non-EMTALA" and do not alert the provider to the special appeal process.

Priority states that even without the inclusion of E codes, Priority's EMTALA list is broad enough to capture EMTALA events. The examiners do not concur. The EMTALA list developed and used by Priority contains 1,172 E codes (diagnosis codes that begin with the letter "E"). E codes comprise roughly 25% of all of the diagnosis codes on the list. Since the ICD-9 coding manual clearly indicates that E codes are never to be used as

primary diagnosis codes, claims with these codes will never be considered as EMTALA under Priority's current procedure. In the final Settlement Order, Priority agreed to use the diagnosis codes on its list to determine if a claim is an EMTALA claim. Priority developed its own EMTALA list and developed its own procedure to exclude all but primary diagnosis codes from consideration. When Priority submitted the proposed list of EMTALA codes to the Bureau, Priority did not disclose that 1 in 4 codes on its EMTALA list would not be eligible for EMTALA reimbursement when following Priority's intended procedure. The Report appears correct as written.

Once the matter has been concluded, Priority will receive a final copy of the Report, which will include the revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that Priority has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

Violations of the above sections of the Code of Virginia can subject Priority to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

We will await further communication from you as to whether Priority wishes to schedule an informal conference or proceed with the settlement process. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:

Enclosures

cc: Althelia P. Battle



May 11, 2012

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report
Exposure Draft – Informal Conference
Additional Information

Dear Ms. Fairbanks:

This letter is in response to your April 23 and April 25, 2012 email communications related to the information requested of Anthem Health Plans of Virginia, Inc. ("Anthem") and its HMOs as a result of the April 23, 2012 Informal Conference.

Provider Contract Language

The Bureau asked that Anthem document when the 40 calendar day language was first included in Anthem and its HMOs provider contracts. The 40 calendar day language was first included in the contracts on January 1, 2007. Attached please find the pertinent amendments.

Interest on Claims

The Bureau asked that Anthem provide documentation to show that the majority of the 18 situations of unpaid interest cited in the Report were due to human error and calculations, and not due to a systemic problem. Subsequent to your email, Anthem provided additional documentation regarding Review Sheet CL76J-AN. After reviewing the additional information you advised that the Bureau will remove the interest violation from the Final Report.

Anthem maintains that the claims identified in Review Sheets CI23J-AN and CL26J-AN were processed appropriately based on member and provider contract provisions, and as such no interest was due because the claims were not clean claims as submitted initially. Medical providers are to bill for medical services using the appropriate medical diagnosis codes.

Interest was not paid on the remaining claims due to various human errors including the following:

- Interest not calculated and paid when a claim was processed after receipt of Coordination of Benefits information;
- Keying of incorrect re-receipt date of claims;
- TriMed record identified member as child not policyholder, when claim reprocessed interest inadvertently not paid; and

- Interest not paid on one claim reprocessed as part of a rework project due to incorrect provider number. Interest payments were generated for the other claims in the project but the identified claim was inadvertently excluded.

Claims analysts receive comprehensive claims adjudication training as new hires and receive additional training as regulatory and claims processing system changes occur. Claims are routinely audited to determine compliance with the adjudication procedures. Any follow-up refresher discussions are accomplished at team meetings.

Basis for Determining a Per Diem

The Bureau requested that we provide the basis for determining a per diem rate. The rate for non-participating inpatient behavioral health facilities is derived by the Company actuaries by calculating the weighted average per diem rate paid to all participating inpatient behavioral health facilities across the state. The Company used a state-wide weighted average to arrive at the non-participating per diem rate because each of our participating behavioral health facility contracts is individually negotiated.

The derivation of per diem rates for non-participating facilities follows the same "gross" rate methodology as would be applicable to any participating facility. In other words, if we paid all in-state, participating RTFs at a "gross" rate of \$500 per day, the per diem rate for non-participating RTFs would also be \$500 (the state-wide average of in-network rates).

In the case of a participating facility, the "gross" per diem rate has historically represented the total amount collectible by the facility from both the payer and the patient. The facility is then obligated under contract to write-off the difference, if any, between the "gross" per diem rate and their charge (i.e. the contractual discount). The same methodology has historically been applied to the setting of non-participating rates and claim processing functions. The only difference is that in the absence of a contract with the provider, there is nothing which would preclude the facility from collecting the difference between the "gross" per diem and the facility's charge from the patient.

EOB Suppression

The Bureau asked that Anthem provide an estimate of the number of complaints or inquiries that have been received regarding EOB Suppression. Anthem has determined that there have been no written complaints. Anthem does not track the reasons for EOB requests that come through customer service from either the member or providers.

During the Informal Conference several options were discussed for adding language to Anthem's policies and both company's EOBs in order to resolve the Bureau's concerns regarding EOB suppression. Anthem agrees to update its policies and contracts. But changing EOBs typically involves a significant amount of programming. While Anthem cannot commit to making changes because of unknown costs at this point, we can look at making language changes the next time the EOBs are slated for modification for other business reasons that might make the cost of this effort absorbed into those changes.

Should you have any questions, please feel free to contact me at 404.357.4318.

Sincerely,

Marie Lough

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Anthem Health Plans of Virginia, Inc.

Attachments

COPY

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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June 4, 2012

**CERTIFIED MAIL 7005 1820 0007 5460 6395
RETURN RECEIPT REQUESTED**

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

**Re: Market Conduct Examination Report
Exposure Draft**

Dear Ms. Lough:

The Bureau of Insurance (Bureau) has completed its review of your May 11, 2012, letter providing the information requested of Anthem Health Plans of Virginia, Inc. (Anthem), HealthKeepers, Inc., Priority Health Care Inc. and Peninsula Health Care Inc. (collectively referred to as "the Company") during the April 23, 2012, informal conference. This letter addresses each item in the same order as presented in your May 11th response.

Provider Contract Language (all 4 reports)

After further discussion, the Bureau has determined that while the language in the Company's provider contracts allowing the provider 40 days from the postmark date of an amendment to notify the Company of intent to terminate the contract is inconsistent with the notification requirements set forth in § 38.2-3407.15 B 9 of the Code, the contract language is not in violation of this section. However, in order to ensure that every provider is afforded the rights under this section of the Code, the Company must establish and implement written procedures specifying that providers will be allowed the full 30 days from receipt of an amendment to notify the Company of intent to terminate the contract in the event that there is a delay in receiving notification.

The violations cited in each of the 4 Reports have been revised; however, the discussion regarding the contract language remains. A corrective action has also been added to address the establishment and implementation of the written procedures referenced above.

Interest on Claims (Anthem report only)

The examiners removed 1 violation of § 38.2-3407.1 B of the Code cited in Review Sheet CL76J-AN based on additional documentation provided by Anthem on April 26th. Upon receipt of your May 11th letter, the examiners reviewed Review Sheets CL23J-AN and CL26J-AN again, and have also removed the interest violations discussed in these two review sheets. The

violations of 14 VAC 5-400-40 A, 14 VAC 5-400-70 A and 14 VAC 5-400-70 D cited in these 2 review sheets will remain, in that the examiners maintain the position that policy provisions were misrepresented and Anthem failed to provide a reasonable explanation for the denial of the claim in these instances. It should be noted that in addition to removing these 2 interest violations, the number of instances where statutory interest was required to have been paid was reduced from 36 to 34.

Based on these revisions, Anthem failed to pay the required interest in 15 of the 34 instances where interest was due. In other words, interest violations were observed in 44% of the sample claims where interest was required to have been paid. Anthem continues to argue that these violations resulted from various human errors and should not be considered knowing violations and the Report should not reflect that Anthem is in violation of the Commission's Order to cease and desist. While the examiners acknowledge that these 15 claims were manually processed, 14 of the violations resulted from the claims processor's failure to document the date that complete proof of loss was received during the re-adjudication of a claim in order to determine the appropriate amount of interest due. The failure of each claims processor to gather the information necessary to determine if interest was due indicates a lack of training, procedures and proper file documentation. Anthem has been advised of the interest requirements set forth in § 38.2-3407.1 of the Code in several reports, and the application of these requirements does not vary based on the type of claim or how it is processed. Therefore, these violations could be considered knowing and Anthem is in violation of the Commission's Order to cease and desist. The Report appears correct as written.

Basis for Determining a Per Diem (Anthem report only)

Your explanation of the basis for determining a per diem has been reviewed, as well as the contract language provided during the April 23rd informal conference. While the information is appreciated, it does not warrant revisions to the Report. The revised contract language still does not explain to the insured that Anthem's procedure for calculating the allowed amount for non-participating facility claims involves subtracting charges for non-covered services from the per diem amount. Therefore, the corrective action remains. The Bureau is willing to discuss potential revisions to the contract language upon finalization of the Report.

EOB Suppression (all 4 reports)

While we understand that some of the changes required may be costly, we cannot allow the Company an indefinite amount of time to make these corrections. The Company will be permitted 120 days from the finalization of these Reports to document compliance with the Corrective Action Plan. The Bureau is willing to discuss options for complying with the Corrective Action Plan with the Company during that time.

We have attached a copy of each report incorporating the revisions discussed above for your review. If you have additional questions, please feel free to contact us.

Once the matter has been concluded, a final copy of each Report will be provided, which will include any revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review, it appears that Anthem has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-508 2, 38.2-510 A 5, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-610 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Violations of the above sections of the Code of Virginia can subject Anthem to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

On the basis of our review, it appears that HealthKeepers, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8 and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

Violations of the above sections of the Code of Virginia can subject HealthKeepers, Inc. to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

On the basis of our review, it appears that Peninsula Health Care, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A, 14 VAC 5-90-90 C, and 14 VAC 5-90-130 A.

Violations of the above sections of the Code of Virginia can subject Peninsula Health Care, Inc. to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

On the basis of our review, it appears that Priority Health Care, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

Violations of the above sections of the Code of Virginia can subject Priority Health Care, Inc. to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of these matters. The Reports will not become public documents until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:
Enclosures
cc: Bob Grissom
Althelia P. Battle

Marie Lough
Priority Health Care, Inc.
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS
Deputy Commissioner
Bureau of Insurance
Post Office Box 1157
Richmond, VA 23218

RE: Alleged Violations of the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-510 A 15, and 38.2-514 B of the Code of Virginia. In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

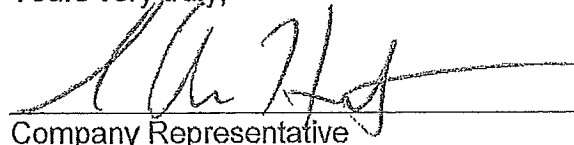
Dear Ms. Battle:

This will acknowledge receipt of your letter dated June 18, 2012, concerning the above-captioned matter.

HealthKeepers, Inc., on behalf of Priority Health Care, Inc., wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of \$40,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing, and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2008.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,



Company Representative

7/19/12

Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

120830125

AT RICHMOND, AUGUST 22, 2012

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COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2012-00139

PRIORITY HEALTH CARE, INC.,

Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Priority Health Care, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance as a health maintenance organization in the Commonwealth of Virginia ("Commonwealth"), in certain instances, violated § 38.2-502 (1) of the Code of Virginia ("Code") by misrepresenting the benefits, advantages, conditions or terms of an insurance policy; violated § 38.2-503 of the Code by making, publishing, disseminating, circulating, or placing before the public an advertisement, announcement or statement containing an assertion, representation or statement relating to the business of insurance which was untrue, deceptive or misleading; violated §§ 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-510 A 15, and 38.2-4306.1 B of the Code by failing to comply with claim settlement practices; violated § 38.2-514 B of the Code by failing to make proper disclosures; violated §§ 38.2-3407.4 A and 38.2-3407.4 B of the Code by failing to comply with explanation of benefits practices; violated §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code by failing to comply with ethics and fairness requirements for business practices; violated

§ 38.2-3412.1:01 C of the Code by failing to comply with the requirements of coverage for biologically based mental illness; violated § 38.2-4312.3 B of the Code by failing to comply with the requirements of patient access to emergency services; violated § 38.2-5805 C 9 of the Code by failing to comply with Managed Care Health Insurance Plan (MCHIP) requirements; and violated the provisions of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, specifically 14 VAC 5-90-50 A.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-4316 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke the Defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that the Defendant has committed the aforesaid alleged violations.

The Defendant has been advised of its right to a hearing in this matter, whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth the sum of Forty Thousand Dollars (\$40,000), waived its right to a hearing, and agreed to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2008.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of Priority Health Care, Inc., in settlement of the matter set forth herein be, and it is hereby, accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:

Marie Lough, Priority Health Care, Inc., 3350 Peachtree Road, N.E., POB 30302-445, Mail Code GAG004-0002, Atlanta, Georgia 30326-1039; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:

Joel H. Peak
Clerk of the
State Corporation Commission

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