REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

OPTIMA HEALTH PLAN

AS OF MARCH 31, 2010

Conducted from August 16, 2010

Through

February 11, 2011

By

Market Conduct Section II

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-1283337
NAIC: 95281

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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 Optima Health Plan, conducted at its Home Office in Virginia Beach, VA, as of March 31, 2010, 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-2011-00222.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 10th day of January, 2012.

Jacqueline K. Cunningham
Commissioner of Insurance

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TABLE OF CONTENTS

I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Optima Health Plan (hereinafter referred to as Optima), a Health Maintenance Organization (HMO), was conducted at Optima's office in Virginia Beach, 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 A of the Code of Virginia (hereinafter referred to as "the Code").

A previous Target Market Conduct Examination covering the period of July 1, 2006 through December 31, 2006 was concluded on July 29, 2009. As a result of that examination, Optima made a settlement offer, which was accepted by the State Corporation Commission on February 4, 2010, in Case No. INS-2009-00278. The scope of that examination originally included a review of Optima's claims handling practices, its procedures for the independent external review of final adverse utilization review decisions, and policy forms related to these areas. However, due to a number of circumstances and delays, the Bureau determined that it was appropriate to finalize that examination and review these areas during a separate examination. Optima was still in the process of complying with the Corrective Action Plan included in the prior Report during the current examination timeframe therefore, those areas were excluded from the current review.

A previous Market Conduct Examination covering the period of January 1, 2003 through December 31, 2003, was concluded on July 28, 2004. As a result of that examination, Optima made a settlement offer, which was accepted by the State Corporation Commission on January 7, 2005, in Case No. INS-2004-00319. Although

Optima had agreed after this earlier regulatory action to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where Optima had not done so. In the examiners' opinion, therefore, Optima 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 covered for the current examination, generally, was October 1, 2009 through March 31, 2010. The on-site examination was conducted at Optima's office in Virginia Beach from September 27, 2010, through October 26, 2010, and completed at the office of the State Corporation Commission's Bureau of Insurance on February 11, 2011. 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 Optima complied with various provisions of the Code and the regulations found in the Virginia Administrative Code. Compliance with the following was considered in this examination process:

14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations;
14 VAC 5-215-10 et seq.	Rules Governing Independent External Review of Final Adverse Utilization Review Decisions.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIP)
- Ethics and Fairness in Carrier Business Practices
- Policy and Other Forms

- Complaints
- Claim Practices
- Independent External Review of Final Adverse Utilization Review Decisions

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

II. COMPANY HISTORY

Optima Health Plan was licensed as an HMO in Virginia on August 31, 1984 under Chapter 43 of Title 38.2 of the Code of Virginia, as amended.

Optima was incorporated in the Commonwealth of Virginia on May 7, 1984, and commenced business on December 1, 1984, operating as an Individual Practice Association (IPA) Health Maintenance Organization. In 1999, Optima ended its relationship with the IPA of Southeastern Virginia and began to contract directly with health care providers.

The United States Department of Health and Human Services certified Optima as a federally qualified HMO under the provisions of Title XIII of the Public Health Service Act on May 30, 1985.

Optima was initially affiliated solely with Alliance Health System (later called Sentara Health System and currently called Sentara Healthcare). On December 31, 1990, the amended and restated articles of incorporation provided for 2 membership classes: the Sentara Healthcare membership class and the Maryview Hospital (Bon Secours) membership class. Sentara Healthcare had an 80% ownership interest in Optima and Maryview Hospital had a 20% ownership interest. Sentara Healthcare purchased Bon Secours' ownership interest in December 2003 and Bon Secours withdrew as a member.

On May 1, 1992, Optima entered into an Administrative Services and Marketing Agreement with Sentara Alternative Delivery Systems Corporation, currently named Sentara Health Plans, Inc. (SHP), which provides for such services as claims administration, underwriting, billing, financial and account management, information

systems, personnel, marketing, communications, member services, provider relations, and medical care management.

As of December 2009, Optima's service area included the cites of Charlottesville, Chesapeake, Colonial Heights, Emporia, Farmville, Franklin, Fredericksburg, Hampton, Hopewell, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Richmond, Suffolk, Virginia Beach and Williamsburg; and the counties of Albemarle, Accomack, Amelia, Buckingham, Brunswick, Caroline, Charles City, Charlotte, Chesterfield, Culpeper, Cumberland, Dinwiddie, Essex, Fluvanna, Gloucester, Goochland, Greene, Greensville, Hanover, Henrico, Isle of Wight, James City, King George, King and Queen, King William, Lancaster, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Powhatan, Prince Edward, Prince George, Richmond, Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland, and York .

Marketing efforts are carried out by account representatives, agents and brokers. Individual coverage is offered only to eligible individuals who are converting from a group policy. Optima offers Medicaid managed care products to individuals who qualify for Medicaid under a contract with the Department of Medical Assistance Services. Enrollment totaled 288,559 as of December 31, 2009.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

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

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 effective resolution of written complaints. Section 38.2-5804 A 1 of the Code requires a health carrier subject to Chapter 58 to maintain a record of complaints for no less than 5 years.

A sample of 40 was selected from a total population of 106 written complaints and appeals received during the examination time frame, as well as 2 final adverse decisions appealed to the Bureau of Insurance. The review revealed that Optima was in substantial compliance with these sections.

IV. ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for claims for health care services, every carrier subject to this title shall adhere to and comply with standards required under subsection B. 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.

A sample of provider contracts was not selected for review due to the fact that provider contracts were reviewed for compliance with § 38.2-3407.15 B of the Code during the previous examination. However, a review of claims associated with the sample provider contracts was not conducted during the previous exam, and it was agreed that this review would be included in the scope of the current examination.

PROVIDER CLAIMS

A sample of 25 out of a total population of 43,832 contracts in force during the examination time frame was selected in order to review a sample of claims associated with Optima's provider contracts. A sample of 163 out of a total population of 2,348 claims processed under the 25 sample provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution, the fee schedule, reimbursement policy or statement as to the manner in which claims will be

calculated and paid applicable to the provider or to the range of health care services reasonably expected to be delivered on a routine basis. The review revealed that Optima allowed more than the contracted amount in 20 instances. These 20 instances involved a total of $78.60 in overpayments, ranging from $.15 to $27.07 per claim. While allowing more than the contracted amount is not considered to be a violation of the Code, this practice may result in an increase in the coinsurance owed by the member on a given claim. Optima is cautioned to the potential for future violations.

V. 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 Optima complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Sections 38.2-316 B and 38.2-316 C 1 of the Code state that no rider shall be attached to a policy or contract unless the form of such rider has been filed with and approved by the Commission. The review revealed that in 3 instances Optima used 2 separate riders that were not filed with or approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. Optima agreed with the examiners' observations.

Section 38.2-3407.4 A of the Code requires that each HMO file its explanation of benefits (EOB) forms with the Commission for approval. These forms are subject to the requirements of §§ 38.2-316 and 38.2-4306 of the Code, as applicable. As discussed in Review Sheet PF10, the review revealed 9 instances where Optima failed to file EOBs issued to members on its behalf by its vision intermediary, placing Optima in violation § 38.2-3407.4 A of the Code in each instance. Optima agreed with the examiners' observations.

Due to the fact that violations of § 38.2-3407.4 A of the Code were discussed in a 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 such violations.

COPAYMENTS

14 VAC 5-211-90 B sets forth the requirements for the establishment, maintenance, and member notification of copayments. HMOs are required to keep accurate records of each enrollee's copayment expenses and notify the enrollee when the copayment maximum is reached. The HMO shall charge no additional copayment for the balance of the contract or calendar year, and within 30 days, the HMO shall promptly refund to the enrollee all copayments charged after the copayment maximum is reached.

A sample of 50 was selected from a total population of 1,710 individuals who reached their copayment maximum during the examination time frame. The review revealed 4 violations of 14 VAC 5-211-90 B. An example is discussed in Review Sheet PF01 where Optima failed to promptly refund copayment amounts charged after the copayment maximum was reached to the enrollee. The review also revealed that, in 4 instances, Optima was in non-compliance with its copayment maximum procedures, as outlined in its Schedule of Benefits.

Optima disagreed with the examiners stating, “refunds are at the provider level/office”. Optima indicated that it refunds the provider, or reverses overpayments to the provider, for members who have reached their copayment maximum. However, 14 VAC 5-211-90 B places the responsibility on the HMO to promptly refund to the enrollee all copayments charged after the copayment maximum is reached. Optima’s practice of sending the refund to the provider or reversing overpayments to the provider does not satisfy the requirements set forth in 14 VAC 5-211-90 B, placing Optima in violation of this section in each instance.

VI. 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 40 from a total population of 106 complaints received during the examination time frame. The review revealed that Optima was in substantial compliance with § 38.2-511 of the Code and its established procedures.

VII. 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, and per case payments for health care services provided by inpatient and outpatient facilities, and physicians. Optima's affiliate, Optima Behavioral Health (OBH), administers mental health and substance abuse benefits for Optima's products. In addition, Optima contracts with American Specialty Health Network (ASH) for chiropractic benefits and EyeMed Vision Care LLC for routine vision benefits.

PAID CLAIM REVIEW

Group

A sample of 100 was selected from a total population of 643,289 group claims paid 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. The review revealed 2 instances of non-compliance with this section. An example is discussed in Review Sheet CL03-MED where Optima held the member liable for an amount which exceeded the copayment prescribed by the member's Schedule of Benefits. Optima agreed with the examiners' observations.

Section 38.2-510 A 4 of the Code prohibits as a general business practice, refusing arbitrarily and unreasonably to pay claims. As discussed in Review Sheet CL12-MED, the review revealed 1 instance of non-compliance with this section. In this instance, the provider billed for 2 units of 1 procedure on the same claim line. While coverage for this procedure is limited to 1 per date of service, Optima denied coverage for both services stating "Deny-quantity for procedure exceeds max allowed for DOS". Given that the entire line was denied versus splitting the line into 2 lines to approve the first service and deny the second, Optima arbitrarily and unreasonably refused to pay this claim. Optima agreed with the examiners' observations.

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 settlements of claims in which liability has become reasonably clear. The review revealed 3 instances of non-compliance with this section. An example is discussed in Review Sheet CL11-MED where Optima received a claim which included both inpatient and emergency department services. Optima paid the entire claim at 50% of the billed amount after the deductible, when the Schedule of Benefits indicated inpatient services were payable at 50% after the deductible, and emergency department services were payable at 80%. Optima disagreed stating,

> "This is not a financial error. The payment is correct and member benefit is correct".

However, the Schedule of Benefits specifically states that out-of-network ermergency department services will be covered at 80% of the billed charges, and the member will be held responsible for 20%. By only paying 50% of the billed charges for the emergency department service, Optima failed to make a fair and equitable settlement of this claim.

Section 38.2-510 A 10 of the Code prohibits as a general business practice, making claim payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The review revealed 2 instances of non-compliance with this section. An example is discussed in Review Sheet CL04-MED, where Optima failed to provide the member with a statement, in the form of an EOB, setting forth the coverage under which payment was made. Optima disagreed stating,

> "other than the member's copayment/coinsurance there was no additional member responsibility and no recourse by the provider against the member".

However, in this instance, coinsurance was applied, and by not sending a statement setting forth the coverage under which payment was made, Optima failed to convey to the member the amount for which he could be responsible.

Individual Conversion

A sample of 70 was selected from a total population of 1,340 individual conversion claims paid during the examination timeframe. Of the 70 individual conversion claims, 15 were mental health claims.

The review revealed 5 instances where Optima failed to process the claim in accordance with the members' Schedule of Benefits. An example is discussed in Review Sheet CL05-IND where Optima applied a $9.00 copayment for a medication management visit with an in-network provider instead of applying a $30 copayment as prescribed by the member's Schedule of Benefits. Optima agreed with the examiners' observations.

Group Over $25,000

A sample of 40 was selected from an unknown population of group claims with an original billed amount exceeding $25,000 that were paid during the examination timeframe. The review revealed that the claims were processed in accordance with the terms of the policy.

Mental Health

A sample of 50 was selected from a total population of 29,866 mental health claims paid during the examination time frame.

The review revealed that the claims were processed in accordance with the terms of the policy.

Chiropractic

A sample of 25 was selected from a total population of 629 chiropractic claims paid during the examination time frame.

The review revealed 7 instances where Optima failed to process the claims in accordance with its Schedule of Benefits. An example is discussed in CL55-C where the Schedule of Benefits indicated that the member's copayment was $15.00, but the provider remittance advice indicated that the member was responsible for a $10.00 copayment. Optima agreed with the examiners' observations.

Section 38.2-510 A 10 of the Code prohibits as a general business practice, making claim payments to insureds or beneficiaries not accompanied by a statement

setting forth the coverage under which payments are being made. The review revealed 3 instances of non-compliance with this section. An example is discussed in Review Sheet CL52-C, where Optima failed to provide the member with a statement setting forth the coverage under which payment was made. Optima disagreed stating, "ASH does not issue member EOBs when a claim is paid to the provider." However, in this instance, coinsurance was applied, and by not sending a statement setting forth the coverage under which payment was made, Optima failed to convey to the member the amount for which he could be held responsible.

Vision Claims

A sample of 10 was selected from a total population of 46 vision claims paid during the examination time frame. One claim, from a self-funded group, was removed from the review. The review revealed that the sample claims were processed in accordance with the terms of the policy.

Pharmacy

A sample of 100 was selected from a total population of 1,037,559 pharmacy claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the policy.

Interest

Section 38.2-4306.1 B of the Code sets forth the requirement for the payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. Of the 395 paid claims reviewed by the examiners, there were 20 claims where interest was required to have been paid. The review revealed 3 instances where Optima underpaid the amount of interest due, and 2 instances where

Optima failed to pay interest. In the aggregate, Optima is in violation of § 38.2-4306.1 B of the Code in 5 instances.

Due to the fact that violations of § 38.2-4306.1 B of the Code were discussed in a 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 such violations.

DENIED CLAIM REVIEW

Group

A sample of 100 was selected from a total population of 77,549 group claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the policy.

Individual Conversion

A sample of 30 was selected from a total population of 238 individual conversion claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the policy.

Group Over $25,000

A sample of 30 was selected from an unknown population of group claims with an original billed amount exceeding $25,000 that were denied during the examination timeframe. The review revealed that the claims were processed in accordance with the terms of the policy.

Mental Health

A sample of 40 was selected from a total population of 3,359 mental health claims denied 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 coverage at issue. Section 38.2-510 A 4 of the Code prohibits as a general business practice, refusing arbitrarily and unreasonably to pay claims. 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 settlements of claims in which liability has become reasonably clear. As discussed in Review Sheet CL20-BH, the review revealed 1 instance of non-compliance with each section. In this instance, a claim from an in-network provider was denied with Remark Code DM20M, "Deny-not covered under mental health benefit". The claims system showed that the service was authorized, yet the member was held liable for the billed amount. Optima disagreed and explained that the dates of service were not authorized. However, according to Optima's provider manuals, it is the provider's responsibility to obtain authorization and the member should be held harmless from financial responsibility.

Chiropractic

A sample of 25 was selected from a total population of 748 chiropractic claims denied during the examination time frame. The review revealed 7 instances of non-compliance with its Schedule of Benefits. An example is discussed in CL63-C where the Schedule of Benefits indicated that the member copayment was $15.00, but the provider remittance advice indicated that the member was responsible for a $10.00 copayment. Optima agreed with the examiners' observations.

Vision

Optima informed the examiners that there were no vision claims denied during the examination time frame.

Pharmacy

A sample of 50 was selected from a total population of 336,035 pharmacy claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the policy.

SUMMARY

The review of paid and denied claims revealed that Optima's failure to comply with §§ 38.2-510 A 1, 38.2-510 A 4, 38.2-510 A 6, and 38.510 A 10 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.

Optima informed the examiners that its established practice is to settle claims within 30 calendar days of receipt. Therefore, the examiners allowed for a 30 calendar-day time frame as its established reasonable time to affirm or deny coverage after proof of loss was received.

The review revealed that of the 109 claims that were payable to the member or were denied and the responsibility of the member, Optima failed to affirm or deny coverage within a reasonable time, in 46 instances, in non-compliance with

§ 38.2-510 A 5 of the Code. An example is discussed in CL03-EMT where Optima failed to affirm a claim for emergency services submitted by a non-participating provider by not sending the member an EOB. Optima disagreed stating,

> "…the claims were paid at 100% of provider charges minus the member's coinsurance, other than the member's coinsurance there was no additional member responsibility and no recourse by the provider against the member".

However, in this instance, the member was responsible for a portion of the claim through coinsurance, and Optima did not have a contract in place with this provider that contained a hold harmless clause With claims from non-participating providers, the EOB affords the member related protection by supplying evidence of claim payment and notification of the member's financial responsibility. Therefore, due to Optima's failure to send an EOB, the member was not aware of the claim payment and the member did not receive notification of his financial responsibility.

Optima's failure to affirm or deny coverage within 30 calendar days of receipt of complete proof of loss occurred with such frequency as to indicate a general business practice placing Optima in violation of this section. Due to the fact that violations of § 38.2-510 A 5 of the Code were discussed in a 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 such violations.

THREATENED LITIGATION

The total population of 1 file involving threatened litigation was reviewed. The review revealed that Optima handled the file in substantial compliance with its procedures.

VIII. INDEPENDENT EXTERNAL REVIEW OF FINAL ADVERSE UTILIZATION REVIEW DECISIONS

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a Utilization review entity. 14 VAC 5-215 et. seq., Rules Governing Independent External Review of Final Adverse Utilization Review Decisions, sets forth the rules to carry out the provisions of Chapter 59 so as to provide (i) a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions made by a utilization review entity; (ii) procedures for expedited consideration of appeals in cases of emergency health care; (iii) standards, credentials, and qualifications for impartial health entities.

The entire population of 2 final adverse decisions that were appealed to the Bureau of Insurance during the examination time frame was reviewed.

FINAL ADVERSE DECISIONS

14 VAC 5-215-20 B requires that in the event of a final adverse decision, a utilization review entity shall provide to the covered person or treating health care provider requesting the decision a clear and understandable written notification of: (i) the right to appeal final adverse decisions to the Bureau of Insurance in accordance with the provisions of Chapter 59 of Title 38.2 of the Code of Virginia; (ii) the procedures for making such an appeal; and (iii) the binding nature and effect of such an appeal.

The review revealed that Optima was in substantial compliance and established procedures were in place to provide the required notice.

EXPEDITED APPEALS

14 VAC 5-215-50 I states that if an appeal that is reviewed as an expedited appeal results in a final adverse decision, the utilization review entity shall notify the person who requested the expedited review of the final adverse decision and notify the appellant, by telephone, facsimile, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance. The notification shall be followed within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal may be filed.

Optima informed the examiners that there were no requests for an expedited appeal of a final adverse decision during the examination time frame. However, the review revealed that Optima has procedures in place to provide the notification required by this section.

IX. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, Optima shall:

1. Establish and maintain procedures to ensure that all policy forms and riders are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
2. As recommended in a prior Report, immediately file its EOB forms, to include those forms used by its vendors, as required by § 38.2-3407.4 A of the Code;
3. Establish and maintain procedures to ensure the prompt refund of copayments charged in excess of copayment maximums, as required by 14 VAC 5-211-90 B;
4. Review and reopen all claims for members and families that satisfied their copayment maximum during the years 2006, 2007, 2008, 2009, 2010 and the current year and refund members where necessary, as required by 14 VAC 5-211-90 B. Send checks for the required refund along with letters 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 determined that this refund was not paid to you." After which, furnish the examiners with documentation that the required refund had been paid within 90 days of this Report being finalized;
5. Establish and maintain procedures to ensure that mental health claims are processed in accordance with Schedules of Benefits;
6. Review and revise procedures to ensure compliance with § 38.2-510 A 1, 38.2-510 A 4, 38.2-510 A 6, and 38.2-510 A 10 of the Code;

7. Establish and maintain procedures to ensure that chiropractic claims are processed in accordance with Schedules of Benefits;
8. As recommended in a prior report, revise and strengthen procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;
9. Review and reopen all claims where interest was due for the years 2006, 2007, 2008, 2009, 2010, and the current year and make interest payments where necessary as required by § 38.2-4306.1 B of the Code. Send checks for the required interest along with letters of explanation stating, "As a result of a Target Market Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been previously paid". Afterwhich, furnish the examiners with documentation that the required interest had been paid within 90 days of this Report being finalized;
10. Review claims discussed in Review Sheets CL02-MED, CL03-MED, CL12-MED, and CL32-HD and provide the examiners with documentation of any necessary adjustments made; and
11. Establish and maintain procedures to ensure that claims, including claims for emergency services received at non-participating facilities, are affirmed or denied within a reasonable time after proof of loss statements have been completed, as required by § 38.2-510 A 5 of the Code.

X. ACKNOWLEDGMENT

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

Todd Bryant, HIA, MHP and Laura Klanian 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
Life and Health Division
Bureau of Insurance

XI. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

POLICY AND OTHER FORMS
§ 38.2-316 B, 3 violations, PF10
§ 38.2-316 C 1, 3 violations, PF10
§ 38.2-3407.4 A, 9 violations, PF10
Copayments
14 VAC 5-211-90 B, 4 violations, PF01, PF05, PF06, PF07
CLAIM PRACTICES
§ 38.2-510 A 1, 3 instances, CL03-MED, CL11-MED, CL20-BH
§ 38.2-510 A 4, 2 instances, CL12-MED, CL20-BH
§ 38.2-510 A 5, 46 instances, CL03-IND, CL04-MED, CL05-MED, CL21-BH, CL22-BH, CL32-HD, CL33-HD, CL34-HD.rev, CL52-C, CL53-C, CL54-C, CL66-C, CL01-EMT (13), CL02-EMT (4), CL03-EMT (3), CL04-EMT (1), CL05-EMT (3), CL06-EMT (3), CL07-EMT (3), CL08-EMT (1), CL09-EMT (1), CL10-EMT (2)
§ 38.2-510 A 6, 4 instances, CL03-MED, CL11-MED, CL12-MED, CL20-BH
§ 38.2-510 A 10, 5 instances, CL04-MED, CL05-MED, CL52-C, CL53-C, CL54-C
§ 38.2-4306.1 B, 5 violations, CL02-MED, CL32-HD, CL34-HD, CL05-EMT, CL06-EMT

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

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
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May 11, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5664
RETURN RECEIPT REQUESTED

Stephen R. Ford, Senior Attorney
Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Ford:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Optima Health Plan (Optima) for the period of October 1, 2009 through March 31, 2010. 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 Optima, 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. Optima's 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, FLMI, AIRC
Supervisor, Market Conduct Section
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

OptimaHealth

Optima Health
4417 Corporation Lane
Virginia Beach, Virginia 23462

June 16, 2011

Julie R. Fairbanks, AIE, FLMI, AIRC
Supervisor – Market Conduct Section
Life and Health Division
State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Market Conduct Examination Report Exposure Draft– Reply

Dear Ms. Fairbanks:

Enclosed please find the response to the Exposure Draft of the Report on Market Conduct Examination for Optima Health Plan.

I am happy to discuss any of our responses with you if you desire. Please call me at (757) 552-7363 if I can be of assistance.

Sincerely,

Stephen Ford
Senior Attorney
Optima Health Plan

Enclosures

Corrective Action Plan

Based on the findings stated in the Market Conduct Examination Report, Optima shall:

1. Establish and maintain procedures to ensure that all policy forms and riders are filed with and approved by the Commission prior to use, as required by §§ 38.2-316 C 1 of the Code;

2. As recommended in a prior Report, immediately file its EOB forms, to include those forms used by its vendors, as required by § 38.2-3407.4 A of the Code;

3. Establish and maintain procedures to ensure the prompt refund of copayments charged in excess of copayment maximums, as required by 14 VAC 5-211-90 B;

   Optima does have a system in place to track member copayments and notify members within 30 days of reaching their maximum out of pocket amount. We believe that our process meets the requirements in 14 VAC 5-211-90 B. Our policy is as follows:

   OHP's claims system is configured to pull member responsibility on provider claims until the single and or family Maximum out of pocket amount (MOOP) is met. Once the MOOP has been met, a letter is generated and sent to both the member and provider informing them that the member has met his/her MOOP obligation and no further copayments or coinsurance amounts should be collected. In addition, once the MOOP has been met the provider is paid 100% of the allowable amount and the provider's remit reflects which claim is paid at 100% of allowable amount with no member responsibility. When Accounts Receivable posting (from remit) in the provider's office result in a credit balance because of OHP's notification that the MOOP has been met, providers are obligated to refund members promptly within 30 days.

   OHP's provider contracts obligate providers to make prompt refund within 30 days to members in the event of over payments or erroneous payments. In the event a refund is not received with 30 days of notification, OHP may recover over payments through remittance adjustment or other recovery actions.

   We believe our process meets the requirements of 14 VAC 5-211-90-B. We have verified that copayments were refunded to the members in the cases under review. We have evidence of such and can provide you with the documentation if needed.

4. Review and reopen all claims for members and families that satisfied their copayment maximum during the years 2006, 2007, 2008, 2009, 2010, and the current year and refund members where necessary, as required by 14 VAC 5-211-90 B. Send checks for

the required refund along with letters 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 determined that this refund was not paid to you." After which, furnish the examiners with documentation that the required refund had been paid within 90 days of this Report being finalized;

5. Establish and maintain procedures to ensure that mental health claims are processed in accordance with Schedule of Benefits;

6. Review and revise procedures to ensure compliance with § 38.2-510 A 1, 39.2-510 A 4, 38.2-510 A 6, and 38.2-510 A 10 of the Code;

7. Establish and maintain procedures to ensure that chiropractic claims are processed in accordance with Schedule of Benefits;

8. As recommended in a prior report, revised and strengthen procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;

   Optima will review and strengthen or clarify our procedures for payment of interest. We will also clarify definitions and timeframes in the policies, and include examples and time frames.

   We acknowledge that in some instances (5 of the 11 violations) the correct proof of loss date was not entered, and we will strengthen our policies and procedures around data entry.
   The report notes other violations of § 38.2-4306.1 B in review sheets, CL32-HD, CL34-HD, CL04-EMT, CL05-EMT, CL06-EMT, CL10-EMT which may be the result of a miscommunication between Optima staff and the examiners.

   First, it appears that the examiners used the date printed on the member's EOB as the date the claim was paid rather than the actual claim paid date. Since the EOB is generated after the claim has paid it appeared that Optima did not follow its own internal timeframe for affirming or denying claims, and it would appear that interest was calculated incorrectly.

   Second, the Policy and Procedure supplied to the examiners states that the interest calculation begins on the 31st day after proof of loss is received to the check date (including 3 days for mail). We did not clearly explain Optima's definition of "check date." The system uses the date that claims pass over from the claims system (A/P date) + 3 days for check processing and mailing to arrive at the 30 days at which time the interest should begin. Please find attached additional follow up responses to those

review sheets for the examiners consideration is assessing the interest payment violations. We apologize for any confusion concerning this area.

9. Review and reopen all claims where interest was due for the years 2006, 2007, 2008, 2009, 2010, and the current year and make interest payments where necessary as required by § 38.2-4306.1 B of the Code. Send checks for the required interest along with letters of explanation stating, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been previously paid". After which, furnish the examiners with documentation that the required interest had been paid within 90 days of this Report being finalized;

   We respectfully propose the following CAP remedies:
   First, review all re-adjudicated (non-original) claims from 2006 to 2010 to determine the correct amount of interest owed to correct any programming errors. Additionally, if the proof of loss date was incorrect, the date will be corrected and interest recalculated. During the previous audit, we were granted approval to remit checks less than $10 to the state as unclaimed property. We would like to request the same approval for this audit.

   Second, we would like to request that we not reopen 5 years worth of interest claims since that would be extremely labor intensive and would require extensive work-hours, due to a procedural documentation error that does not reflect our operational practices and our understanding of the requirements for interest payments.

   As stated above our system calculates the interest on late claims at the time the claims pass from the claims system to the Accounts Payable system. This is done the night before checks are generated. We changed our system after the last Market Conduct Audit to begin calculating interest at day 27, which allows 3 days for check processing and mailing. Our Policy and Procedures supplied to the examiners did not correctly reflect our internal process. It should state that the interest is calculated using the A/P date, including 3 days for check processing and mailing. We will revise our policy and procedure to accurately reflect our interest on late claims process.

10. Review claims discussed in Review Sheets CL02-MED, CL03-MED, CL12-MED, and CL32-HD and provide the examiners with documentation of any necessary adjustments made; and

11. Establish and maintain procedures to ensure that claims, including claims for emergency services received at non-participating facilities, are affirmed or denied within a reasonable time after proof of loss statements have been completed, as required by § 38.2-510 A 5 of the Code.

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

COMMONWEALTH OF VIRGINIA

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October 6, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5862
RETURN RECEIPT REQUESTED

Stephen R. Ford
Senior Attorney
Optima Plan
4417 Corporation Lane
Virginia Beach, VA 23462

RE: Response to Optima Health Plan for the Target Market Conduct Examination Exposure Draft

Dear Mr. Ford:

The Bureau of Insurance (BOI) has completed its review of your June 16, 2011, response to the Target Market Conduct Examination Report of Optima Health Plan (Optima) sent with my letter of May 11, 2011, as well as the additional documentation provided on July 7, 2011.

Your response indicates that Optima has concerns with certain items in the Corrective Action Plan of the Report. This letter addresses those concerns in the same order as presented in your June 16th response. However, since Optima's response will also be attached to the final Report, this letter does not address those issues where Optima indicated agreement and/or action taken as a result of the Report.

1. **Establish and maintain procedures to ensure the prompt refund of copayments charged in excess of copayment maximums, as required by 14 VAC 5-211-90 B;**

   Optima indicated that it has a system to track and notify members regarding copayment maximums in accordance with 14 VAC 5-211-90 B. However, the regulation further requires that an *HMO* shall promptly refund excess copayments to the enrollee. Optima's policy and practice to place responsibility on the *provider* to refund excess copayments does not relieve Optima of its responsibility to comply. Optima noted that it verified that excess copayments were refunded to enrollees for the cases under review. Although documentation is not required at this time, please be aware that Optima will be required to document that *all* relevant claims, where the member or family met the

copayment maximum between 2006 and 2011, have been reviewed and reopened and that necessary refunds have been made to the enrollee, within 90 days of the Report being finalized.

2. **As recommended in the prior Report, revise and strengthen procedures for payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;**

Upon review of the additional documentation provided with your response, the Report has been revised to reflect 5 violations of § 38.2-4306.1 B of the Code instead of 11. The following Review Sheets and their respective violations will remain in the Draft Report: CL02-MED, CL32-HD, CL34-HD, CL05-EMT, and CL06-EMT. The revised pages are enclosed for your review.

3. **Review and reopen all claims where interest was due for the years 2006, 2007, 2008, 2009, 2010, and the current year and make interest payments where necessary as required by § 38.2-4306.1 B of the Code. Send checks for the required interest along with letters of explanation stating, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been previously paid". After which, furnish the examiners with documentation that the required interest had been paid within 90 days of this Report being finalized;**

Our conversation on September 28, 2011 clarified Optima's proposal outlined in its June 16, 2011 letter. Optima's proposal is to reopen re-adjudicated or non-original claims for the years 2006, 2007, 2008, 2009, and 2010 to determine if the correct amount of interest was paid. However, based on our examination findings, 4 of the 5 claims where Optima failed to pay interest in accordance with § 38.2-4306.1 B of the Code were original claims and not re-adjudicated claims. Optima's proposal would not capture these 4 claims for reprocessing and payment; therefore, Optima's proposal to revise this corrective action is not acceptable.

In your response, Optima proposed to escheat interest amounts under $10 to the Commonwealth's Department of the Treasury, Unclaimed Property Division. While the Bureau may be willing to consider a minimum threshold for escheatment to the Unclaimed Property Division, Optima will be required to submit a spreadsheet with the interest amounts owed showing summary detail for all years in question before such determination is made.

In regards to the requirement that Optima review all claims where interest was due for the previous 5 years plus the current year, the examiners would note that a claims review has not been conducted on Optima since 2004. However, if Optima can document that the claims processing issue, which resulted in the underpayment of interest on the 5 claims cited in the Report, was isolated to a particular timeframe, the Bureau may be willing to limit the number of years for

which claims must be reviewed and reopened. This Corrective Action will remain in the Report as written.

Copies of the revised pages to the Report are attached and the only substantive revisions we plan to make before it becomes final. Optima will be required to document compliance with the Corrective Action Plan within 90 days after this exam is finalized.

On the basis of our review of this entire file, it appears that Optima has violated the Unfair Trade Practices Act, specifically § 38.2-510 A 5 of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 B, 38.2-316 C 1, 38.2-3407.4 A, and 38.2-4306.1 B of the Code; as well as 14 VAC 5-211-90 B and 14 VAC 5-211-160 6, Rules Governing Health Maintenance Organizations.

Violations of the above sections of the Code can subject Optima Plan to monetary penalties of up to $5,000 for each violation and the 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, FLMI, AIRC
Supervisor
Market Conduct Section II
Life and Health Division
Telephone (804) 371-9385

JRF/
cc: Althelia Battle

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

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November 1, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5916
RETURN RECEIPT REQUESTED

Stephen R. Ford
Senior Attorney
Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

RE: Response to Optima Health Plan for the Target Market Conduct Examination Exposure Draft

Dear Mr. Ford:

In my letter dated October 6, 2011, the Bureau addressed several concerns presented in your June 16, 2011 response to the Target Market Conduct Examination Report of Optima Health Plan (Optima), specifically regarding the Corrective Action Plan. Revised pages to the Report were included with that letter. Since the drafting of the October 6th letter, further review of the violations discussed in the Report has led the examiners to make additional revisions. The 4 violations of 14 VAC 5-211-160 6 discussed on page 15 of the Report have been removed, and the Area Violations Summary by Review Sheet has been revised accordingly.

With this letter, we are including a copy of the revised Report. The changes discussed in the October 6th letter and those mentioned above are the only substantive revisions we plan to make before it becomes final. Optima will be required to document compliance with the Corrective Action Plan within 90 days after this exam is finalized.

On the basis of our review of this entire file, it appears that Optima has violated the Unfair Trade Practices Act, specifically § 38.2-510 A 5 of the Code of Virginia.

In addition, there were violations of §§ 38.2-316 B, 38.2-316 C 1, 38.2-3407.4 A, and 38.2-4306.1 B of the Code; as well as 14 VAC 5-211-90 B Rules Governing Health Maintenance Organizations.

Violations of the above sections of the Code can subject Optima to monetary penalties of up to $5,000 for each violation and the 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, FLMI, AIRC
Supervisor
Market Conduct Section II
Life and Health Division
Telephone (804) 371-9385

JRF/
cc: Althelia Battle
Bob Grissom

Stephen R. Ford
Senior Attorney
Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462

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

530059

RE: Alleged Violations of the Unfair Trade Practices Act, specifically § 38.2-510 A 5 of the Code of Virginia as well as §§ 38.2-316 B, 38.2-316 C 1, 38.2-3407.4 A, and 38.2-4306.1 B of the Code, as well as 14 VAC 5-211-90 B, Rules Governing Health Maintenance Organizations.

Dear Ms. Battle:

This will acknowledge receipt of your letter dated November 8, 2011, concerning the above-captioned matter.

Optima Health Plan 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 $16,000, 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 cease and desist from future violations of §§ 38.2-316 B, 38.2-316 C 1, 38.2-510 A 5, 38.2-3407.4 A, and 38.2-4306.1 B of the Code, as well as 14 VAC 5-211-90 B Rules Governing Health Maintenance Organizations and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of March 31, 2010.

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,

Michael Dudley, President
Company Representative

11/23/11
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, DECEMBER 9, 2011

COMMONWEALTH OF VIRGINIA

At the relation of the

STATE CORPORATION COMMISSION

v. CASE NO. INS-2011-00222

OPTIMA HEALTH PLAN,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance, it is alleged that the Defendant, duly licensed by the State Corporation Commission ("Commission") to transact the business of a health maintenance organization in the Commonwealth of Virginia, in certain instances, has violated §§ 38.2-316 B, 38.2-316 C 1, and 38.2-3407.4 A of the Code of Virginia by failing to comply with policy and form filing requirements; violated § 38.2-510 A 5 of the Code of Virginia by failing to comply with claim settlement practices; violated § 38.2-4306.1 B of the Code of Virginia by failing to comply with the requirements of processing interest on claim proceeds; and violated 14 VAC 5-211-90 B by failing to comply with maximum copayment requirements.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-4316 of the Code of Virginia 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 of Virginia the sum of Sixteen Thousand Dollars ($16,000), waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order, and agreed to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of March 31, 2010.

The Bureau of Insurance 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 of Virginia.

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

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein be, and it is hereby, accepted;

(2) The Defendant cease and desist from any future conduct which constitutes a violation of §§ 38.2-316 B, 38.2-316 C 1, 38.2-510 A 5, 38.2-3407.4 A or 38.2-4306.1 B of the Code of Virginia, or 14 VAC 5-211-90 B of the Rules Governing Health Maintenance Organizations; and

(3) The papers herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to Stephen Ford, Senior Attorney, Optima Health Plan, 4417 Corporation Lane, Virginia Beach, Virginia 23462; 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 Battle.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission