REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

OPTIMUM CHOICE, INC.

AS OF June 30, 2013

Conducted from January 14, 2014

through

September 15, 2015

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 52-1518174
NAIC: 96940

COMMONWEALTH OF VIRGINIA

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I, Greg Lee, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Optimum Choice, Inc. as of June 30, 2013, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2016-00221 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 6th day of April, 2017.

Greg Lee

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Optimum Choice, Inc. (hereinafter referred to as OCI), a Health Maintenance Organization (HMO), was conducted 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 and 38.2-4315 of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

A previous Target Market Conduct Examination covering the period of July 1, 1999, through December 30, 2006, was concluded on January 16, 2008. As a result of that examination, OCI made a monetary settlement offer that was accepted by the State Corporation Commission on May 21, 2008, in Case No. INS-2007-00084 in which OCI agreed to the entry by the Commission of an order to cease and desist from any conduct that constitutes a violation of certain sections of the Code and regulations.

A Market Conduct Examination covering the period January 1, 2003, through December 31, 2003, was concluded on January 10, 2005. As a result of that examination, OCI made a monetary settlement offer that was accepted by the State Corporation Commission on September 26, 2005, in Case No. INS-2005-00181 in which OCI agreed to the entry by the Commission of an order to cease and desist from any conduct that constitutes a violation of certain sections of the Code and regulations.

In addition to the areas examined during the current examination period, OCI's practices were reviewed for compliance with the recommendations and corrective actions made to OCI as a result of the examiners' findings during previous examinations.

The period of time covered for the current examination, generally, was January 1, 2013, through June 30, 2013. The examination was initiated on January 14, 2014, at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia and was completed on September 15, 2015. The violations cited and the comments included in this Report are the opinions of the examiners.

The examiners may not have discovered every non-compliant activity in which the company is engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether OCI complied 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;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations; and
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review.

The examination included the following areas:

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

- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices/Collections/Reinstatements
- Cancellations/Nonrenewals
- Complaints
- Claim Practices
- Internal Appeal and External Review

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

II. COMPANY HISTORY

Optimum Choice, Inc. (OCI) was incorporated in the Commonwealth of Virginia on September 1, 1988 and was licensed as an HMO under Chapter 43 of Title 38.2 of the Code on November 30, 1990.

OCI was originally incorporated as a stock corporation on May 7, 1987, under the laws of the State of Maryland as Physicians Health Services of Maryland, Inc. On August 3, 1987, OCI amended its Articles of Incorporation to change its name to Physicians Health Services, Inc. OCI again amended its Articles of Incorporation on August 18, 1988, to change its name to Optimum Choice, Inc.

OCI was primarily created to address the needs of the small business market segment. On September 1, 1988, OCI was issued a certificate of authority to operate as an HMO by the Maryland Insurance Administration (MIA). OCI is licensed to transact business as a non-federally qualified HMO in the states of Delaware, Maryland, Virginia, West Virginia, and in the District of Columbia.

Until February 10, 2004, OCI was owned by Mid-Atlantic Medical Services, Inc. (MAMSI) an insurance holding company domiciled in the State of Maryland. On November 3, 2003, UnitedHealth Group Incorporated (formerly known as United HealthCare Corporation "United") filed a Form A with the MIA seeking approval of the acquisition of MAMSI and its subsidiary companies, which was approved on February 10, 2004. MU Acquisition LLC (MU), a then newly formed Delaware limited liability company and wholly-owned subsidiary of United, merged with MAMSI, with MU becoming the surviving entity. Simultaneously, MU changed its name to Mid-Atlantic Medical Services, LLC (MAMSL). As a result of the merger, the separate corporate

existence of MAMSI ceased and all of its direct and indirect subsidiaries, including OCI, became members of the United holding company system.

Effective January 1, 2012, MAMSL merged with and into United HealthCare Services, Inc., a Minnesota Corporation and wholly-owned subsidiary of United. As a result of this merger, OCI became a wholly-owned subsidiary of United HealthCare Services, Inc.

OCI's service area includes the Virginia cities of Alexandria, Bedford, Charlottesville, Chesapeake, Clifton Forge, Colonial Heights, Covington, Emporia, Fairfax City, Falls Church, Franklin, Fredericksburg, Hampton, Harrisonburg, Hopewell, Manassas, Manassas Park, Newport News, Norfolk, Norton, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, South Boston, Staunton, Suffolk, Virginia Beach, Waynesboro, Williamsburg and Winchester, and the Virginia counties of Accomack, Albemarle, Alleghany, Amelia, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Buchanan, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Clarke, Craig, Culpepper, Cumberland, Dickenson, Dinwiddie, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Greensville, Hanover, Henrico, Isle of Wight, James City, King George, King William, Loudoun, Louisa, Lunenburg, Madison, Middlesex, Montgomery, Nelson, New Kent, Northampton, Nottoway, Orange, Page, Patrick, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockingham, Russell, Shenandoah, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Westmoreland, Wise, Wythe, and York.

OCI operates solely in the group market and its membership in Virginia continues to decline. Total enrollment as of December 31, 2013, was 9,963 members. Total enrollment as of December 31, 2014, was 8,745 members.

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 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 states that an HMO shall establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

Administrative Letter 2011-05 stated that the Bureau of Insurance will provide carriers with an extension through January 1, 2012, to secure approval of their complaint system filings pursuant to § 38.2-5804 of the Code. Complaint system procedures revised or modified to address the requirements in the Law and the Rules must be filed with and approved by the Bureau on or before January 1, 2012.

As discussed in Review Sheet MC01, OCI failed to comply with the directives of the Administrative Letter and to establish and maintain a complaint system approved by the Commission during the examination time frame, in violation of 14 VAC 5-211-150 A and § 38.2-5804 A of the Code. OCI disagreed with the examiners' observations and responded that:

> The VA Bureau of Insurance (BOI) issued Administrative Letter 2011-05, dated 7/14/11 that exempted insurers from compliance with the new appeal requirements until 12/31/11. United does have a complaint system

> in place and the original complaint system was filed with the Bureau timely in December 2011. Our records indicate that there have been numerous resubmissions requested and discussions with the Bureau on this subject. Our last communication from the Bureau is dated January 16, 2014 in which it was requested that revised letters from our appeal department be submitted. The revised letters were submitted on February 5, 2014. To date we still await approval or further guidance from the Bureau. UnitedHealthcare Insurance Company, MD-Individual Practice Association, and Optimum Choice Inc. have and will continue to work with the Bureau and to make best efforts to achieve approval of its compliant filing system.

The examiners maintained our findings and responded that "…a review of the Bureau's records indicates that OCI failed to obtain approval of its complaint system procedures by January 1, 2012, as requested in Administrative Letter 2011-05."

The examiners reviewed a sample of 35 from a total population of 112 written complaints received during the examination time frame for compliance with OCI's established procedures and the requirements of the Code.

TIMELINESS

OCI's complaint and appeal procedures indicate that the company will advise its decision regarding a complaint within 60 days after receiving it; a decision will be provided within 15 days after receipt of a request for appeal of a pre-service request; and a decision regarding a post-service appeal will be provided within 30 days after receipt. A review of the sample selected revealed that OCI was in substantial compliance with its established procedures regarding timely handling of complaints and appeals.

HANDLING

Subsection 1 of § 38.2-502 of the Code states that no person shall make, circulate, cause or knowingly allow to be made, issued or circulated any statement that

misrepresents the benefits, advantages, conditions or terms of any insurance policy. Section 38.2-503 of the Code states that no person shall disseminate, circulate, or place before the public a statement relating to the business of insurance that is untrue or misleading.

The review revealed 10 instances in which OCI included misinformation in its response letter to a member for whom the provider had submitted an appeal. As discussed in Review Sheets CP01-oci through CP10-oci, the response letter to the member incorrectly stated that the member was not responsible for the charges related to the service. The letter then correctly advised the member that payment for the service was included in the reimbursement to the facility and was not reimbursable separately to the individual medical provider. Although the procedure was performed in a participating facility, the services were provided by a non-participating provider, and the original Explanation of Benefits (EOB) to the member listed the entire charge amount under "Amount you owe the provider." The appeal response letter provided information that contradicted the original EOB, and these statements were incorrect and misleading. OCI disagreed and stated, in part, that:

> The cited provisions regulate *advertisements* which are defined in 14 VAC 5-90-30 to specifically exclude *individual communications of a personal nature*. Administrative appeal letters are extremely personal to the individual policyholder or member and discuss specific health care services rendered to that individual. As a result, any inadvertent miscommunication that may have occurred in the administrative appeal letter is not a violation of the VA advertising provisions.

The company further stated that:

> Optimum Choice Inc., [sic] disagrees that statements in the appeal response letter indicating no member responsibility were incorrect or misleading. This HMO member's coverage includes pathology services and the member obtained services from an INN facility. Claims denied as

> submitted by this out-of-network pathologist with reimbursement code, "*IA – This service was performed in a facility setting. This code, when accompanied by a facility place of service, is not eligible for reimbursement to the physician*." In general, physicians reporting these laboratory tests on a claim with a facility place of service are indicating they are billing for the supervision of a hospital laboratory. There is almost never any direct patient care involved in these situations, no face to face encounter with a patient, and the physician is not actually reading the test or writing a separate written report. In the situations where this denial code is used, pathologists merely oversee the laboratory and the technical staff for quality control purposes. They do not render any professional services to individual members, and given that no specific, identifiable services are provided to individual members, we do not feel that separate charges from such a provider are warranted or legitimate. [Plan name] members are not responsible for such "**IA**" denial amounts.

The examiners maintained our findings and responded that §§ 38.2-502 and 38.2-503 of the Code address unfair trade practices related to representations made by the HMO to a member regarding the actual performance of the insurance contract and are not limited to advertising statements. The information in OCI's appeal response letter regarding the member's financial responsibility directly contradicted the member responsibility information provided in the EOB, with no explanation. The information provided in the appeal response letter was untrue and misleading.

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

The examiners reviewed a sample of 26 from an unknown population of provider contracts in-force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed that in 99 instances, OCI's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular Code Section, Number of Violations, and a Review Sheet Example are referred to in the table below.

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1 b	**18**	**EF05**
§ 38.2-3407.15 B 2	**18**	**EF22**
§ 38.2-3407.15 B 5 a	**18**	**EF16**
§ 38.2-3407.15 B 7	**1**	**EF10**
§ 38.2-3407.15 B 8	**23**	**EF01**
§ 38.2-3407.15 B 10	**21**	**EF08**

Examples of some of the violations cited are discussed in Review Sheet EF05, where the examiners initial observations stated, in part, that:

> A review of the file reveals that the Virginia Regulatory Requirements Appendix included with this Agreement does not include all of the provisions as required by § 38.2-3407.15 B of the Code of Virginia.
>
> Section 38.2-3407.15 B 1 b of the Code requires the carrier to maintain a written or electronic record of the receipt of a claim and states that the **person submitting the claim** [emphasis added] shall be entitled to inspect such record on request. "Person submitting the claim" includes the Provider, but **Provision 8 (c)** of the Appendix entitles only the "Customer" submitting the claim to inspect such record.
>
> Section 38.2-3407.15 B 2 of the Code requires the carrier to request required information from the **person submitting the claim** [emphasis

added] and states that the carrier may not refuse to pay a claim if the carrier has failed to timely notify the **person submitting the claim** [emphasis added] of the required information. **Provision 8 (d)** in the Agreement's Appendix excludes the Provider from this process by its use of "Customer submitting the claim."…

…Section 38.2-3407.15 B 5 a. of the Code allows the carrier to refuse to pay a claim for a previously authorized service if documentation provided by the **person submitting the claim** [emphasis added] clearly fails to support the claim as originally authorized. The use of "Customer submitting the claim" in **Provision 8 (h) (i)** of the Appendix includes no such allowance when documentation provided by the Provider fails to support the claim as originally authorized.

Section 38.2-3407.15 B 8 of the Code **requires the provider contract** [emphasis added] to include or attach, at the time it is presented, the fee schedule and all applicable material addenda, schedules and exhibits. This Code provision places no requirements on the provider. However, **Provision 8 (j)** of the Appendix requires the Provider to agree that all required documents and information have been provided. This language fails to set forth the requirement that the Agreement include these documents and information…

OCI disagreed with the examiners' observations and stated that:

In the Virginia Regulatory Requirements Appendix, the term "Customer," has the same meaning as "member," "enrollee," or "covered person". The position of the health plan is, the rights to claim information and the ability to view, access or control that information resides with the "member," "enrollee," or "covered person". The provider only acts as a proxy for the "member," "enrollee," or "covered person" and does not assume or obtain the "member's," "enrollee's," or "covered person's" rights when submitting claims on behalf of such parties…The only provider requirement in section 8(j) is to acknowledge that United is complying with its obligations and requirements as set-forth in Section 38.2-3407.15 B 8 of the Code.

The examiners maintained our observations and responded that:

Provisions 8 (c), 8 (d), and 8 (h) (i) of the Appendix exclude reference to the provider by referring to the "customer" submitting the claim rather than satisfying the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, and 38.2-3407.15 B 5 a of the Code of Virginia by referencing the "person" submitting the claim. "Customer" is stated to have the same meaning as "member," "enrollee," or "covered person," none of which could be interpreted to include the health care provider…

> …**Provision 8 (j)** places the requirement on the provider to agree that all required documents and information have been provided, while § 38.2-3407.15 B 8 of the Code requires the provider contract to include or attach, at the time it is presented, the fee schedule and all applicable material addenda, schedules and exhibits.

OCI failed to amend its provider contracts to comply with § 38.2-3407.15 B with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15, which prohibits as a general business practice failing to comply with § 38.2-3407.15 of the Code.

PROVIDER CLAIMS

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. 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 the standards required under subsection B.

The examiners reviewed a sample of 514 claims from a population of 691 claims processed under 26 of the sample provider contracts during the examination time frame.

Section 38.2-3407.15 B 1 of the Code states that a carrier shall pay any clean claim within 40 days of receipt of the claim. The review revealed 4 instances where OCI failed to pay a clean claim within 40 days, in violation of § 38.2-3407.15 B 1 of the

Code. An example is discussed in Review Sheet EFCL28. OCI agreed with the examiners' observation.

Section 38.2-3407.15 B 3 of the Code requires that any interest owing or accruing on a claim under § 38.2-4306.1, shall be paid at the time the claim is paid or within 60 days thereafter. The review revealed 4 instances where OCI failed to pay interest as required, in violation of §§ 38.2-3407.15 B 3 and 38.2-4306.1 B of the Code. An example is discussed in Review Sheet EFCL29, where OCI took 165 calendar days to pay a claim and failed to pay the statutory interest due. OCI agreed with the examiners' observations.

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 (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

The review revealed that OCI underpaid the fee schedule amount specified for the health care service provided in 3 instances, in violation of § 38.2-3407.15 B 8 of the Code in each instance. All 3 instances involved the same provider. An example is discussed in Review Sheet EFCL37. OCI agreed with the examiners' observations.

OCI's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.

V. ADVERTISING

A review was conducted of OCI'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 the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive 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).

The total population of 40 advertisements distributed in Virginia during the examination time frame was reviewed. The review revealed that 3 of the advertisements contained violations. In the aggregate, there were 8 violations, which are discussed in the following paragraphs.

14 VAC 5-90-170 A requires an HMO to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement. As discussed in Review Sheet AD01, the review revealed that OCI failed to include a notation in the file of the manner and extent of distribution in 1 of the 40 advertisements reviewed, in violation of this section. OCI agreed with the examiners' observation.

14 VAC 5-90-50 B states that advertisements shall be truthful and not misleading in fact or in implication. The review revealed 1 violation of this section. As discussed in Review Sheet AD01B, the advertisement stated that the HMO coverage advertised was "…provided by or through UnitedHealthcare of the Mid-Atlantic, Inc. and Optimum Choice, Inc." This statement is untrue. One of these entities, not both, can provide coverage. OCI agreed with the examiners' observations.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]." As discussed in Review Sheet AD09, the review revealed 1 violation of this section. OCI agreed and stated that it "…is working on a plan to bring the materials into full compliance."

14 VAC 5-90-60 B 1 states that an invitation to contract shall disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy. As discussed in Review Sheet AD01A, the review revealed 1 violation of this section. OCI's pre-enrollment brochure failed to disclose the applicable exceptions, reductions, and limitations. OCI agreed with the examiners' observations.

14 VAC 5-90-60 B 3 states that when an advertisement refers to a dollar amount, a period of time for which any benefit is payable, the cost of the policy, a specific policy benefit, or the loss for which a benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD09,

where the Direct Team Small Business Proposal referenced dollar amounts; policy costs; specific policy benefits; and the losses for benefits were payable, and failed to disclose the exceptions, reductions, and limitations. OCI agreed with the examiners' observations.

14 VAC 5-90-120 A states that an advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits. The review revealed 1 violation of this section. As discussed in Review Sheet AD09A, the advertisement stated that OCI offers a "Network with national reach…with more than 712,000 physicians and 5,500 hospitals nationally." OCI agreed with the examiners' observations.

14 VAC 5-90-130 A states that the name of the actual insurer, the form number or numbers of the policies advertised, and the form number of any application shall be stated on all invitations to contract. An invitation to contract shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

As discussed in Review Sheet AD01B, the review revealed 1 violation of this section. The form number or numbers of the policy, group application, and enrollment form were not stated in the pre-enrollment brochure. Additionally, the enrollee would not be able to determine the entity underwriting the group HMO coverage offered. The prominent inclusion of the trade name of the parent company and the listing of the legal names of multiple affiliated insurance companies and an affiliate HMO had the

capacity to mislead the prospective enrollee as to the true identity of the underwriting entity. OCI agreed with the examiners' observations.

SUMMARY

OCI violated 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, 14 VAC 5-90-60 B 1, 14 VAC 5-90-60 B 3, 14 VAC 5-90-120 A, 14 VAC 5-90-130 A and 14 VAC 5-90-170 A, which placed it in violation of subsection 1 of § 38.2-502 and §§ 38.2-503 and 38.2-4312 of the Code.

VI. POLICY AND OTHER FORMS

A review of policy forms in use during the examination time frame was performed to determine if OCI complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Sections 38.2-4306 A 2, 38.2-316 A, and 38.2-316 C 1 of the Code and 14 VAC 5-211-60 A prohibit the use of contracts, Evidences of Coverage (EOCs), and any applicable amendments to these forms prior to filing the forms with and receiving approval from the Commission. 14 VAC 5-211-60 A requires all contracts, EOCs, and applicable amendments to be identified by a form number in the lower left-hand corner of the first page of the form. Other forms, such as the group application and enrollment forms, must also be filed with the Commission for approval under §§ 38.2-316 B and 38.2-316 C 1 of the Code.

GROUP CONTRACTS

The examiners selected a sample of 8 from a population of 47 group contracts. issued during the examination time frame.

The review revealed that, in 8 instances, OCI issued a group contract or a revised group contract, prior to the contract being filed with and approved by the Commission, in violation of §§ 38.2-316 A, 38.2-316 C 1 of the Code and 14 VAC 5-211-60 A. An example is discussed in Review Sheet PF03B, where in 7 instances, OCI issued a group contract with the policy form number PolGHMO.H.05.VA, prior to the group contract being filed with and approved by the Commission. OCI agreed with the examiners' observations

EVIDENCE OF COVERAGE

Section 38.2-4306 A 2 of the Code and 14 VAC 5-211-60 A state that no evidence of coverage (EOC), or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form has been filed with and approved by the Commission.

The review revealed that, in 23 instances, OCI issued an EOC or an amendment to the EOC that had not been filed with and approved by the Commission, in violation of § 38.2-4306 A 2 of the Code and 14 VAC 5-211-60 A. An example is discussed in PF01B, where, in 7 instances, OCI issued a revised EOC with policy form number GHMO.05.VA, prior to the revised form being filed with and approved by the Commission. OCI agreed with the examiners' observations.

APPLICATIONS/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code require that application and enrollment forms be filed with and approved by the Commission.

The review revealed that, in 3 instances, OCI used a group application form that had not been filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. Two of the applications were paper application forms, and one was an electronic application form. In each instance, the applications failed to contain a policy form number in the lower left-hand corner of the form. An example is discussed in Review Sheet PF29B. OCI agreed with the examiners' observations.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each HMO shall file its EOBs 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.

The review revealed that OCI was in substantial compliance.

SCHEDULE OF CHARGES

Section 38.2-4306 B 1 of the Code and 14 VAC 5-211-60 B prohibit the use of schedules of charges or amendments to the schedules of charges until a copy of the schedule or amendment has been filed with and approved by the Commission.

The review revealed that OCI was in substantial compliance.

COPAYMENTS

14 VAC 5-211-90 B sets forth the requirements for the establishment, maintenance, and member notification of copayments. If an HMO has an established copayment maximum, it shall keep accurate records of each enrollee's copayment expenses and notify the enrollee when the maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the copayment maximum is reached. The HMO shall not charge additional copayments for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all copayments charged after the copayment maximum is reached.

The examiners reviewed a sample of 9 from a total population of 91 enrollees who had met their copayment maximum during the examination time frame.

The review revealed that, in 4 instances, OCI failed to notify the enrollee no later than 30 days after the HMO had processed sufficient claims to determine that the copayment maximum was reached. Additionally, OCI failed to refund to the enrollee the copayments charged in excess of the maximum, in violation of 14 VAC 5-211-90 B in each instance. An example is discussed in Review Sheet PF36B. OCI agreed with the examiners' observations.

VII. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 and § 38.2-4313 of the Code. The 19 agents and 6 agencies designated in the sample of 8 new business files were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A and 38.2-4313 of the Code require that a person be licensed prior to soliciting contracts or acting as an agent in the Commonwealth.

The review revealed 6 violations of these sections. An example is discussed in Review Sheet AG03, where a person solicited an HMO contract for OCI prior to obtaining a license in the Commonwealth. OCI disagreed with the examiners' observations, stating, in part, that:

> These individuals are Sales Operations Specialists (SOS). Their role is not to sell, solicit or negotiate contracts but rather to provide internal back-end support to the account executives and agents/brokers….an SOS does not receive any commission or valuable consideration for services based on the sale of a group. During the period under review of January –June 2013 an SOS could receive incentive pay that was based on the entire Mid-Atlantic Health Plan, not limited to Virginia.

The examiners responded that according to documentation provided by OCI, the SOS was involved in the sales process and received valuable compensation arising from the sale of the group HMO contract. This incentive compensation is direct consideration that arose from the insurance sales transaction and the SOS was required to have been licensed.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires an HMO to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 3 violations of this section. An example is discussed in Review Sheet AG08, where OCI failed to appoint an agent within 30 days of the date of execution of the first application submitted by a non-appointed agent. OCI disagreed with the examiners, stating, in part, that:

> [The agent] was originally appointed in 2011, please find attached confirmation. During a routine audit of the State's records it was determined that the records no longer matched for [the agent]. Appointment was then resubmitted for 2013.

The examiners would respond that the Commission's records clearly indicate that the agent's appointment was administratively terminated on September 1, 2011, for the failure to comply with continuing education requirements and that OCI did not attempt to reappoint the agent until May of 2013.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commissions or other valuable consideration to an agent or agency that was not appointed or that was not licensed at the time of the transaction.

The review revealed 9 violations of this section. An example is discussed in Review Sheet AG10, where OCI paid commission or other valuable consideration to an agency that was not appointed. OCI responded that:

> [OCI] continues to disagree with the Observation as noted above, as [the agent] was appropriately licensed and appointed. But it appears that an error did occur and commissions were inadvertently paid to [the agency].

The examiners noted that although OCI considered its actions an inadvertent error, it paid commission to an agency that was not appointed, in violation of this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an HMO notify the agent within 5 calendar days and the Commission within 30 calendar days upon termination of the agent's appointment. A sample of 25 was selected from a total population of 58 agents whose appointments terminated during the examination time frame.

The review revealed that OCI was in substantial compliance.

VIII. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of OCI's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514, the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620, as well as 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions For Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine if OCI's underwriting guidelines were unfairly discriminatory and whether applications were underwritten in accordance with OCI's guidelines and that correct premiums were charged.

UNDERWRITING REVIEW

The examiners reviewed a sample of 8 from the total population of 47 groups issued during the examination time frame. The review revealed no evidence of unfair discrimination.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that OCI was in substantial compliance.

MECHANICAL RATING REVIEW

The review revealed that premiums were calculated correctly.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires an HMO to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The reviewed revealed that the disclosure authorizations used by OCI in the underwriting of its group business were in substantial compliance.

IX. PREMIUM NOTICES/COLLECTIONS/REINSTATEMENTS

OCI's procedures for processing premium notices, collections and reinstatements were reviewed for compliance with its established procedures.

OCI's practices for notifying contract holders of the intent to increase premium by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM NOTICES

Premium invoices are generated approximately two weeks prior to the due date. Invoices may contain charges for current and prior months not previously billed (retroactivity) and future months. In order to create an invoice, the group's demographic information is needed; there must be charges to create the invoice; and a contractual policy must exist. Invoices are generated through a nightly batch process. The invoices created are available to group contract holders to view.

The review revealed that OCI's premium notices were generated in accordance with its established procedures.

OCI's practices for notifying contract holders of the intent to increase premium by more than 35% were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

The total population of 1 group whose premium increased by more than 35% was reviewed. The review revealed that OCI was in substantial compliance with the notification requirements.

COLLECTIONS

Once the due date of the invoice has passed, the group contract holder may receive a statement with the past due balance or a phone call requesting the status of the payment. Smaller groups receive a statement, generated on the 12th-14th day after the due date of the invoice, alerting the customer they may be at risk for termination due to non-payment of premiums. If the balance is not paid by the end of the grace period, the contract is cancelled for nonpayment. Larger groups may receive a phone call or email requesting the status of their payment from the billing area. If the group remains delinquent, the group is escalated to an analyst for an additional call to be made. If a payment is not received for a second month, the analyst will make one attempt to obtain payment confirmation. If confirmation is not received, the group may be escalated to the market Chief Financial Officer to pursue payment confirmation. If a larger group pays outside their grace period for 3 of the last 6 months and has paid 2 consecutive months outside the grace period, they qualify to receive a demand or severe payment letter.

The review revealed that OCI was in substantial compliance with its established procedures for collections.

REINSTATEMENTS

Groups seeking reinstatement as a result of termination for non-payment of premiums are required to pay all past due premiums and the current month's premium in full. Reinstatement requests must be received within 30 days of the termination statement date. Groups are allowed three reinstatements in a rolling 12-month period. At the time of the second reinstatement, a reinstatement letter is sent out to the group.

At the time of the third reinstatement, a final reinstatement letter is sent. There is an exception process in place for reinstatements outside of the guidelines listed.

A sample of 10 was selected from the total population of 39 groups whose coverage was reinstated during the examination time frame. The review revealed that OCI was in substantial compliance with its established procedures for reinstatement.

X. CANCELLATIONS/NONRENEWALS

The examination included a review of OCI's cancellation/nonrenewal 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 § 38.2-3542 of the Code and 14 VAC 5-211-230 B.

A sample of 19 was selected from a total population of 41 Group HMO contracts that were cancelled, non-renewed, or terminated during the examination time frame.

The review revealed that OCI was in substantial compliance with its established procedures, the policy provisions, and the notification requirements of § 38.2-3542 of the Code and 14 VAC 5-211-230 B.

Additionally, there was no evidence of unfair discrimination in the sample files reviewed.

XI. 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. A complaint is defined as "any written communication from a policyholder, subscriber, or claimant primarily expressing a grievance."

A sample of 35 was selected from a total population of 112 written complaints. The review revealed that OCI was in substantial compliance.

XII. CLAIM PRACTICES

The examination included a review of OCI's 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 and encounters. 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. Encounters consist of capitated payments made to providers by OCI.

OptumRx, Inc., an affiliate company, processed pharmacy claims.

PAID CLAIM REVIEW

Group Claims

A sample of 200 was selected from a total population of 41,218 claims paid during the examination time frame.

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. Section 38.2-510 A 3 of the Code prohibits as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 3 instances of non-compliance with these sections. An example is discussed in Review Sheet CL01, where OCI took 502 calendar days to process a claim for observation care at an outpatient hospital. OCI agreed with the examiners' observations.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting 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 settlements of claims in which liability has become reasonably clear. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract.

During the course of the copayment maximum review, it was revealed that in 2 instances, OCI applied an incorrect cost-sharing amount, in violation of § 38.2-3407.4 B of the Code and in non-compliance with §§ 38.2-510 A 1 and 38.2-510 A 6 of the Code. An example is discussed in CL01B, where OCI applied a coinsurance amount that was not supported by the EOC and sent an EOB to the member that misrepresented the benefits payable. OCI agreed with the examiners' observations.

Group Encounters

The examiners reviewed the 737 encounters where coinsurance was present from the total population of 13,501 capitated encounters paid during the examination time frame. "Coinsurance" is defined in 14 VAC 5-211-20 as "…a copayment expressed as a percentage of the allowable charge for a specific health care service."

Section 38.2-3407.3 A of the Code states that an HMO that issues a contract pursuant to which the enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the enrollee.

Section 38.2-3407.3 B of the Code states that any HMO failing to administer its contracts as set forth herein shall be deemed to have committed a knowing and willful violation of this section, and shall be punished as set forth in subsection A of § 38.2-218. Each claim payment found to have been calculated in non-compliance with this section shall be deemed a separate and distinct violation, and shall further be deemed a violation subject to subdivision D 1 c of § 38.2-218, permitting the Commission to require restitution in addition to any other penalties.

Section 38.2-218 D 1 c of the Code states that the Commission may require an HMO to make restitution in the amount of the direct actual financial loss for failing to pay amounts explicitly required by the terms of the insurance contract where no aspect of the claim is disputed by the insurer.

As discussed and documented in Review Sheet CLCAP, the review revealed that the coinsurance amounts calculated for each of the 737 capitated encounters were calculated using a dollar amount that exceeded the total amount actually paid or payable to the provider. OCI's actions constituted 737 knowing and willful violations of § 38.2-3407.3 A of the Code. In its response, to Review Sheet CLCAP, OCI indicated that it agreed with the examiners' observations and stated "...our research has shown that a coinsurance was incorrectly taken."

Pharmacy Claims

A sample of 50 was selected from a total population of 68,491 pharmacy claims paid during the examination time frame.

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

Interest

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.

The review revealed 5 violations of this section. An example is discussed in Review Sheet CL35, where OCI took 77 days to pay a claim and failed to pay the statutory interest due. OCI agreed with the examiners' observations. In every instance, (Review Sheets CL01, CL15, CL26, CL28 and CL35), no interest was paid.

DENIED CLAIM REVIEW

Group Claims

A sample of 100 was selected from a total population of 7,978 claims denied during the examination time frame.

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. Section 38.2-510 A 3 of the Code prohibits as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 2 instances of non-compliance with these sections. An example is discussed in Review Sheet CL42, where OCI took 70 calendar days to deny a claim from a network physician because "…notification was required but not received." OCI 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. Section 38.2-510 A 14 of the Code

prohibits as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed 2 instances of non-compliance with these sections. An example is discussed in Review Sheet CL25, where the claim was denied with an EOB message stating "…charges are not covered if you are injured performing a job…or for an illness that is covered by worker's compensation law." The documentation in the claim file contained an "Explanation of Bill Review" from the workers' compensation carrier that stated, "This workers' compensation claim has been denied." OCI agreed with the examiners' observations.

Section 38.2-3439 A 2 of the Code states that an HMO shall not deny coverage for a child who has not attained the age of 26 based on the presence or absence of the child's student status. As discussed in Review Sheet CL16, the review revealed 1 violation of this section. OCI disagreed with the examiners' observations stating that "The original claim closed (1/23/13) requesting the student status information. Due to no response within the timeframe given on the letter (45 days) the claim denied." The examiners responded that, "The statute prohibits a health carrier from denying or restricting covered health care services for the absence of the child's student status." OCI's actions in this instance were also in non-compliance with § 38.2-510 A 4 of the Code, which prohibits as a general business practice, refusing to arbitrarily and unreasonably to pay claims.

14 VAC 5-211-80 B states that an HMO shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other health care plans. In the event that benefits are provided by a health care plan, the determination of the order of benefits shall in no way restrict or impede the

rendering of services required to be provided by the health care plan. The HMO shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by other group policies, group contracts, or group plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided.

The review revealed 3 violations of this section. An example is discussed in Review Sheet CL40, where OCI disagreed with the examiners' observations and stated:

> Company respectfully disagrees with criticism. Claim ICN 4044221787 was denied for OI EOB, member updated COB online. Claim was then processed to deny with VO member did not obtain a valid referral from PCP prior to obtaining services from specialist as required by plan.

The examiners maintained our findings and responded that "OCI initially denied this claim on the 3/4/13 EOB for coordination of benefits information. The statute prohibits an HMO from restricting or impeding the provision of covered health care services because the enrollee has other coverage. When OCI denied the claim and held the enrollee liable for the cost of the services provided, it failed to provide a covered health care service to the member."

Group Encounters

The examiners were informed by OCI that there were no records kept of denied encounters.

Pharmacy

A sample of 25 was selected from a population of 4,261 pharmacy claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the contract.

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.

OCI failed to provide the examiners with its instructions, procedures, etc., to document compliance with § 38.2-510 of the Code regarding Unfair Claim Settlement Practices. Therefore, the examiners applied the 30-calendar day "reasonable time" standard used in the prior examination of claims. The review revealed OCI failed to affirm or deny coverage within a reasonable time in 13 instances. An example is discussed in Review Sheet CL42, where OCI took 70 calendar days to provide an EOB to the member denying the claim.

The failure to affirm or deny claims within a reasonable time did not occur with such frequency as to indicate a general business practice.

THREATENED LITIGATION

OCI informed the examiners that there were no claims that involved threatened litigation during the examination time frame.

XIII. INTERNAL APPEAL AND EXTERNAL REVIEW

Chapter 35.1 of Title 38.2 of the Code and 14 VAC 5-216-10 et seq. set forth the requirements for the establishment of a health carrier's internal appeal process and a process for appeals to be made to the Bureau of Insurance to obtain an external review of final adverse decisions.

On July 14, 2011, the Bureau of Insurance issued Administrative Letter 2011-05, the purpose of which was to provide a summary of the new internal appeals and external review process under Virginia law, and to provide guidance for the submission of complaint system filings revised to comply with these new requirements.

There were no appeals that obtained an independent external review of an adverse determination during the examination time frame; however, the 35 sample complaint files were reviewed for compliance with the Code and the directives of Administrative Letter 2011-05.

Section 38.2-503 of the Code states that no person shall disseminate, circulate, or place before the public a statement relating to the business of insurance that is untrue or misleading.

Administrative Letter 2011-05 states, in part, that "The Commissioner of Insurance will no longer render an order; instead, the decision that results from the review by the Independent Review Organization (IRO) is final and binding on the health carrier and the covered person (except to the extent that the covered person has remedies available under federal or state law). The IRO will communicate its decision to the covered person, the health carrier and the Bureau." The Administrative Letter further states that "There is no longer a filing fee (previously $50.00)", and "There is no

longer a minimum cost of denied services threshold (previously the minimum was $300.00)."

The review revealed 2 violations of the § 38.2-503 of the Code and 2 instances of non-compliance with the directives of the Administrative Letter. An example is discussed in Review Sheet EX01-oci, where the adverse determination letter incorrectly advises the covered person that the Commissioner will issue a written ruling upholding, reversing, or modifying the company's decision; that the health care benefit must exceed $300; and that a $50 filing fee must accompany the appeal request. OCI agreed with the examiners' observation.

XIV. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, the examiners recommend that OCI implement the following corrective actions. OCI shall:

1. As recommended in a prior Report, establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by 14 VAC 5-211-150 A and § 38.2-5804 A of the Code;
2. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by §§ 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 5 a, 38.2-3407.15 B 7, 38.2-3407.15 B 8 and 38.2-3407.15 B 10 of the Code;
3. Establish and maintain procedures to ensure that claims processed under a "provider contract" as defined in § 38.2-3407.15 A of the Code are processed in accordance with the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 of the Code;
4. As recommended in a prior Report, establish and maintain procedures to include in the advertising file, a notation of the manner and extent of distribution of each advertisement and the form number of the policy advertised, as required by 14 VAC 5-90-170 A;
5. Establish and maintain procedures to ensure that advertisements are truthful and not misleading in fact or implication, as required by 14 VAC 5-90-50 B;
6. Establish and maintain procedures to ensure that each invitation to inquire contains the disclosures required by 14 VAC 5-90-55 A;

7. Establish and maintain procedures to ensure that all invitations to contract disclose the exceptions, reductions and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B 1;

8. Establish and maintain procedures to ensure that when an advertisement refers to a dollar amount, a period of time for which any benefit is payable, the cost of the policy, a specific policy benefit, or the loss for which a benefit is payable, it also discloses those exceptions, reductions, and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B 3;

9. Establish and maintain procedures to ensure that an advertisement that is intended to be seen beyond the limits of the jurisdiction in which the insurer is licensed, does not imply licensing beyond those limits, as required by 14 VAC 5-90-120 A;

10. Establish and maintain procedures to ensure that the name of the actual insurer, the form number or numbers of the policy advertised, group application, and enrollment form are stated on all invitations to contract and that invitations to contract not use any trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device, which without disclosing the name of the actual insurer, would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, as required by 14 VAC 5-90-130 A;

11. Establish and maintain procedures to ensure that all group contracts are filed for approval prior to use, as required by §§ 38.2-316 A, 38.2-316 C 1 of the Code and 14 VAC 5-211-60 A;

12. Establish and maintain procedures to ensure that all EOC forms and amendments to EOC forms are filed for approval prior to use, as required by § 38.2-4306 A 2 of the Code and 14 VAC 5-211-60 A;

13. Establish and maintain procedures to ensure that all applications and enrollment forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;

14. Review and strengthen its established procedures to ensure that, when an enrollee meets the copayment maximum, OCI complies with the terms of the EOC and the requirements of 14 VAC 5-211-90 B;

15. Review and reopen all claims for all enrollees who exceeded his or her copayment/out-of-pocket maximum during the years of 2013, 2014, 2015 and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee/provider to whom benefits and interest are due. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the copayment/out-of-pocket maximum was collected in error. Please accept this refund amount." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized;

16. Establish and maintain procedures for compliance with §§ 38.2-1812 A, 38.2-1822 A and 38.2-1833 A 1 of the Code concerning the licensing of, appointment of, and payment of commission to, agents and agencies;

17. Provide the examiners with documentation substantiating that OCI has corrected the processing of the claims discussed in Review Sheets CL01B and CL02B and that OCI has refunded any monies owed to the members;

18. Review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, as required by § 38.2-3407.4 B of the Code;

19. For OCI, *and all of its affiliate insurance companies and HMOs issuing accident and sickness insurance policies or HMO contracts in the Commonwealth of Virginia that reimburse health care providers through capitated arrangements*, review all claim payments from 2013, 2014, 2015 and the current year and reimburse its covered persons and enrollees directly for all excess coinsurance amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized;

20. Strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;

21. Review and consider for re-adjudication all paid claims that took greater than 30 calendar days to pay; for the years of 2013, 2014, 2015 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 interest along with a letter of explanation or statement on the EOB that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

22. Establish and maintain procedures to ensure that coverage is not restricted or denied for a child who has not attained the age of 26 based on the presence or absence of the child's student status, as required by § 38.2-3439 A 2 of the Code;

23. Immediately bring its coordination of benefits claim handling practices and EOB forms into compliance with the requirements of 14 VAC 5-211-80 B;

24. Strengthen its procedures for compliance with §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 4, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code;

25. Establish and maintain procedures to ensure that complaint and appeal response letters provide complete, clear, and accurate information, as required by subsection 1 of § 38.2-502 and § 38.2-503 of the Code; and

26. Establish and maintain procedures to ensure that complaint and appeal response letters provide accurate information regarding external review procedures, in compliance with Administrative Letter 2011-05.

XV. ACKNOWLEDGMENT

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

Gregory Lee, FLMI, CIE, MCM, Laura Wilson, MCM, Bryan Wachter, FLMI, AIE, AIRC, MCM, and Melissa Gerachis, FLMI, AIRC, AMCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks

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XVI. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
14 VAC 5-211-150 A and § 38.2-5804 A, 1 violation, MC01
Subsection 1 of § 38.2-502, 10 violations, CP01-oci, CP02-oci, CP03-oci, CP04-oci, CP05-oci, CP06-oci, CP07-oci, CP08-oci, CP09-oci, CP10-oci
§ 38.2-503, 10 violations, CP01-oci, CP02-oci, CP03-oci, CP04-oci, CP05-oci, CP06-oci, CP07-oci, CP08-oci, CP09-oci, CP10-oci
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1 b, 18 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF08, EF12, EF13, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23
§ 38.2-3407.15 B 2, 18 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF08, EF12, EF13, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23
§ 38.2-3407.15 B 5 a, 18 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF08, EF12, EF13, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23
§ 38.2-3407.15 B 7, 1 violation, EF10
§ 38.2-3407.15 B 8, 23 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10, EF11, EF12, EF13, EF14, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23

§ 38.2-3407.15 B 10, 21 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF08, EF09, EF10, EF12, EF13, EF14, EF15, EF16, EF17, EF18, EF19, EF20, EF21, EF22, EF23
Provider Claims
§ 38.2-3407.15 B 1, 4 violations, EFCL25, EFCL27, EFCL28, EFCL29
§ 38.2-3407.15 B 3, 4 violations, EFCL25, EFCL27, EFCL28, EFCL29
§ 38.2-3407.15 B 8, 3 violations, EFCL37, EFCL38, EFCL39
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14 VAC 5-90-50 B, 1 violation, AD01B
14 VAC 5-90-55 A, 1 violation, AD09
14 VAC 5-90-60 B 1, 1 violation, AD01A
14 VAC 5-90-60 B 3, 2 violations, AD01A, AD09
14 VAC 5-90-120 A, 1 violation, AD09A
14 VAC 5-90-130 A, 1 violation, AD01B
14 VAC 5-90-170 A, 1 violation, AD01
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§ 38.2-316 A, 8 violations, PF03B (7), PF28B
§ 38.2-316 B, 3 violations, PF29B, PF30B, PF31B
§ 38.2-316 C 1, 11 violations, PF03B (7), PF28B, PF29B, PF30B, PF31B
§ 38.2-4306 A 2, 23 violations, PF01B (7), PF02B (7), PF04B (6), PF24B, PF26B, PF27B
14 VAC 5-211-60 A, 31 violations, PF01B (7), PF02B (7), PF03B (7), PF04B (6), PF24B, PF26B, PF27B, PF28B
Copayment Tracking
14 VAC 5-211-90 B, 4 violations, PF33B, PF34B, PF35B, PF36B

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§ 38.2-1812 A, 9 violations, AG01, AG02, AG03, AG06, AG07, AG08, AG09, AG10, AG11
§§ 38.2-1822 A and 38.2-4313, 6 violations, AG01, AG02, AG03, AG06, AG07, AG11
§ 38.2-1833 A 1, 3 violations, AG08, AG09, AG10
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§ 38.2-3407.3 A, 737 knowing and willful violations, CLCAP
§ 38.2-3407.4 B, 2 violations, CL01B, CL02B
§ 38.2-4306.1 B, 5 violations, CL01, CL15, CL26, CL28, CL35
§ 38.2-3439 A 2, 1 violation, CL16
14 VAC 5-211-80 B, 3 violations, CL38, CL40, CL43
§ 38.2-510 A 1, 2 instances of non-compliance, CL01B, CL02B
§ 38.2-510 A 2, 5 instances of non-compliance, CL01, CL15, CL16, CL19, CL42
§ 38.2-510 A 3, 5 instances of non-compliance, CL01, CL15, CL16, CL19, CL42
§ 38.2-510 A 4, 1 instance of non-compliance, CL16
§ 38.2-510 A 5, 13 instances of non-compliance, CL01, CL02, CL03, CL06, CL13, CL15, CL16, CL17, CL19, CL26, CL28, CL35, CL42
§ 38.2-510 A 6, 4 instances of non-compliance, CL01B, CL02B CL16, CL25
§ 38.2-510 A 14, 2 instances of non-compliance, CL16, CL25
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§ 38.2-503, 2 violations, EX01-OCI, EX02-oci

JACQUELINE K. CUNNINGHAM
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February 11, 2016

CERTIFIED MAIL 7014 1200 0001 3578 8016
RETURN RECEIPT REQUESTED

Mr. Joseph Stangl
Director, Regulatory Actions
Optimum Choice, Inc.
4 Research Way, 5th Floor
Shelton, CT 06484

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Stangl:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Optimum Choice, Inc. (OCI) for the period of January 1, 2013, through June 30, 2013. 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 OCI, 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. OCI'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

Julie Fairbanks, AIE, AIRC, FLMI, MCM
Supervisor, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia Battle

UnitedHealthcare®
A UnitedHealth Group Company

May 6, 2016

Ms. Julie R. Fairbanks
Principal Insurance Market Examiner
Market Conduct, Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

RE: Optimum Choice, Inc. Draft Market Conduct Examination Report as of June 30, 2013

Dear Ms. Fairbanks:

Optimum Choice, Inc. (OCI) would first like to thank the Bureau for allowing us an extension in providing this response.

I write to you today to provide you with OCI's response and proposed corrective action measures to the recommendations made by the Bureau in the draft report. Upon receipt of your approval, OCI will move forward with its proposed corrective measures.

OCI respectfully requests that any enclosed Exhibits and Attachments be maintained as proprietary and confidential.

Thank you for your time and consideration.

Sincerely,

Joseph Stangl
Director, Regulatory Affairs
UnitedHealthcare
4 Research Drive
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Commonwealth of Virginia
State Corporation of Insurance, Bureau of Insurance
Market Conduct Exam of
Optimum Choice, Inc.
January 1, 2013 – June 30, 2013

Corrective Action Plan of May 6, 2016

Based on the findings stated in this Report, the examiners recommend that OCI implement the following corrective actions. OCI shall:

1. As recommended in a prior Report, establish procedures to ensure that it maintains its established complaint system approved by the Commission, as required by 14 VAC 5-211-150 A and § 38.2-5804 A of the Code.

   Company Response: OCI currently has in place a filing team responsible for state required filings such as the Virginia required complaint system. The compliant system is currently filed and approved as of April 11, 2014.

2. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a (i), 38.2-3407.15 B 5, 38.2-3407.15 B 5 a, 38.2-3407.15 B6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code.

   Company Response:
   In regard to 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, and 38.2-3407.15 B 5a, OCI will update its Regulatory Appendix to include language referring to the provider.

   In regard to 38.2-3407.15 B 8, OCI will remove from Section 8j "provider hereby agrees that," of its Regulatory Appendix.

   In regard to 38.2-3407.15 B1, B3, B4, B4 a(i), B5, B9, and B11, in 2010 OCI updated its Regulatory Appendix which included updating the language pertaining to both these sections of the Virginia Code. A mass mailing of the Regulatory Appendix was made to all Virginia contracted providers. The updated Regulatory Appendix should have been provided to the exam team as part of the contract review; we apologize for the oversight and are attaching the 2010 Appendix herein. Please see sections 8b, 8e, 8f, 8j, 8h, 8k, and 8f d respectively. As a result, OCI disagrees with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to 38.2-3407 .15 B 10, the required language can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8g of both Regulatory Appendices (attached). As discussed with the Bureau on April 14, 2016, OCI agreed to move the requirement of 38.2-3407 .15 B 10 to its own provision within the Regulatory Appendix. This has been completed. As the Bureau's concern was mainly a placement issue, OCI continues to disagree that a violation is warranted and we would respectfully request this be taken into consideration and the alleged violation be removed.

In regard to 38.2-3407.15 B 7, the language requirements of 38.2-3407.15 B 7 can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8i of both Regulatory Appendices (attached). OCI would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

Please see 2005 and 2010 Regulatory Appendices included in Exhibit 1.

3. Establish and maintain procedures to ensure that claims processed under a "provider contract" as defined in § 38.2-3407.15 A of the Code are processed in accordance with the requirements of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 of the Code.

Company Response: OCI has reviewed and confirmed that policies are in effect and compliant pertaining to timely payment, interest, and reimbursing per fee schedules. OCI has distributed an educational memo to all claims staff in regard to these requirements.

4. As recommended in a prior Report, establish and maintain procedures to include in the advertising file, a notation of the manner and extent of distribution of each advertisement and the form number of the policy advertised, as required by 14 VAC 5-90-170 A.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-170 A.

5. Establish and maintain procedures to ensure that advertisements are truthful and not misleading in fact or implication, as required by 14 VAC 5-90-50 B.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-50 B.

6. Establish and maintain procedures to ensure that each invitation to inquire contains the disclosures required by 14 VAC 5-90-55 A.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable

legal/regulatory requirements, including 14 VAC 5-90-55 A.

7. Establish and maintain procedures to ensure that all invitations to contract disclose the exceptions, reductions and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B1.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 B1.

8. Establish and maintain procedures to ensure that when an advertisement refers to a dollar amount, a period of time for which any benefit is payable, the cost of the policy, a specific policy benefit, or the loss for which a benefit is payable, it also discloses those exceptions, reductions, and limitations affecting the basic provisions of the policy, as required by 14 VAC 5-90-60 B 3.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-60 B 3.

9. Establish and maintain procedures to ensure that an advertisement that is intended to be seen beyond the limits of the jurisdiction in which the insurer is licensed, does not imply licensing beyond those limits, as required by 14 VAC 5-90-120 A.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-120 A.

10. Establish and maintain procedures to ensure that the name of the actual insurer, the form number or numbers of the policy advertised, group application, and enrollment form are stated on all invitations to contract and that invitations to contract not use any trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device, which without disclosing the name of the actual insurer, would have the capacity or tendency to mislead or deceive as to the true identity of the insurer, as required by 14 VAC 5-90-130 A.

Company Response: OCI is in the process of implementing a revised advertising review process that will ensure that OCI advertising materials comply with applicable legal/regulatory requirements, including 14 VAC 5-90-130 A.

11. Establish and maintain procedures to ensure that all group contracts are filed for approval prior to use, as required by §§38.2-316 A, 38.2-316 C 1 of the Code.

Company Response: OCI has a dedicated filing team in place with a dedicated individual responsible for Virginia. In regard to forms PolGHMO.H.05.VA and PolPOS.H.05.VA, although we believe these were indeed filed and approved with the Bureau, we cannot locate an

approval and as such we will refile for approval. In regards to OCI's application forms, we have confirmed the most recent large and small group applications were filed and approved by the bureau on May 27, 2014, SERFF ID# UHLC-129129202.

Please see attached SERFF screen prints, Exhibit 2.

12. Establish and maintain procedures to ensure that all EOC forms and amendments to EOC forms are filed for approval prior to use, as required by § 38.2-4306 A 2 of the Code and 14 VAC 5-211-60 A.

Company Response: OCI has a dedicated filing team in place with a dedicated individual responsible for Virginia. In regard to OCI forms RXGHMO4TIER.H.06.VA, PolPOS.H.05.VA, RXNETGHMO.05.VA, and PolGHMO.H.05.VA, although we believe these were indeed filed and approved with the Bureau, we cannot locate an approval and as such we will refile for approval.

In regards to MHPAMD.GHMO.05.VA, the language the examiner stated as missing belongs to the "Specialist Physician" provision and is bracketed. Please refer to approved form under SERFF Filing ID#: UHLC-128112600. In regard to GHMOPOS.05.VA, the "Biologically Based Mental Illness" section was filed via an amendment with form number "MHPAMD.GHMO.05.VA" and was approved by the BOI on May 3, 2012 under SERFF Filing ID#: UHLC-128112600. In regard to PROSDEV.GIPAPOS.05.VA, that form was filed and approved by the BOI on January 28, 2010, under SERFF Filing #: UHLC-126424133. OCI disagrees with these violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to Policy Form #: GHMO.05.VA, the "Biologically Based Mental Illness" section was filed via an amendment form number "MHPAMD.GHMO.05.VA" and was approved by the BOI on May 3, 2012 under SERFF Filing ID#: UHLC-128112600. OCI disagrees with this violations and we would respectfully request this be taken into consideration and the alleged violation be removed.

Please see attached SERFF screen prints, Exhibit 2.

13. Establish and maintain procedures to ensure that all applications and enrollment forms are filed for approval prior to use, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code.

Company Response: OCI has a dedicated filing team in place with a dedicated individual responsible for Virginia. In regard to form PolGHMO.H.05.VA, although we believe it to be filed and approved by the Bureau, we cannot locate an approval and as such we will refile for approval. In regard to OCI's application forms, we have confirmed the most recent large and small group applications were filed and approved by the bureau on May 27, 2014, SERFF ID# UHLC-129129202.

Please see attached SERFF screen prints, Exhibit 2.

14. As recommended in the prior report, review and strengthen its established procedures to ensure that, when an enrollee meets the copayment maximum, OCI complies with the terms of the EOC and the requirements of 14 VAC 5-211-90 B.

Company Response: OCI has initiated a review of its internal procedures pertaining to copayment maximum. Upon conclusion of our review, necessary updates and improvements will be made as necessary.

15. Review and reopen all claims for all enrollees who exceeded his or her copayment/out-of-pocket maximum during the years of 2011, 2012, 2013, 2014, 2015 and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee/provider to whom benefits and interest are due. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the copayment/out-of-pocket maximum was collected in error. Please accept this refund amount." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized.

Company Response: OCI has automated processes in place for calculating members out of pocket expenses that have been tested and found to be fully functional. There are times in which manual intervention is needed and a human error can occur such as with the examples found by the examiner. Appreciating the Bureau's concern on this matter OCI would request the Bureau consider a review limited to January 2013 through December 2015. All claims prior to 2013 are archived and would require a labor intensive effort. OCI believes a three year look back is a reasonable compromise as only four claims were identified of concern.

16. Establish and maintain procedures for compliance with §§ 38.2-1812 A, 38.2-1822 A and 38.2-1833 A 1 of the Code concerning the licensing of, appointment of, and payment of commission to, agents and agencies.

Company Response: OCI has completed a project that involved reviewing and updating its Policy & Procedures (P&P) for the licensing, appointment and commission payments of internal and external agents. The P&P is compliant with the Virginia regulations cited above. Management has also provided guidance and training to the nationwide sales staff on internal employee licensing and appointment. Tighter controls have also been put into place to ensure payments of commissions are only made to appropriately licensed agents and brokers.

17. Provide the examiners with documentation substantiating that OCI has corrected the processing of the claims discussed in Review Sheets CL01B and CL02B and that OCI has refunded any monies owed to the members.

Company Response: In regard to CL01B, the incorrect benefit was selected by the processor

which led to the incorrect coinsurance being taken. The claim has been reprocessed to pay out the additional $750.00. Please find attached screen prints. In regard to CL02B, when the processor was manually entering the member's co-pay, he or she mis-keyed the $150.00 and only keyed $50.00. OCI agrees that this is an error but as the error was in the member's favor, OCI will not reprocess the claim to charge the additional $100.00 it should have paid.

Exhibit 3 attached

18. Review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, as required by § 38.2-3407.4 B of the Code.

Company Response: OCI has reviewed its procedures and determined that adequate measures are in place for when processors are required to intervene and manually enter a member's cost share.

19. For OCI, *and all of its affiliate insurance companies and HMOs issuing accident and sickness insurance policies or HMO contracts in the Commonwealth of Virginia that reimburse health care providers through capitated arrangements,* review all claim payments from 2011, 2012, 2013, 2014, 2015 and the current year and reimburse its covered persons and enrollees directly for all excess coinsurance amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized

Company Response: On page 35 of the draft report it is noted that 837 encounters contained the presence of coinsurance. We have had the opportunity to further review this file and it has been determined that 100 of the encounters were not paid as capitated and were provided to the examiners in error, we apologies for the error. We are including a list of these encounter claims. We respectfully request the report be updated accordingly.

As to the corrective action measures, the only UnitedHealth Group companies which pay providers on a capitated basis in Virginia are OCI and MD-Individual Practice Association, Inc. (MDIPA).

OCI understands the Bureau's concern and is committed to reviewing the root cause of the coinsurance display on EOBs issued to members whose providers are paid on a capitated basis ("the capitated providers"). Upon conclusion of our review, OCI would make applicable changes that would best serve our members. As to the Bureau's request for a remediation of claims 2011-to date, it is OCI's position that is not necessary and would like to take this opportunity to explain why.

First, OCI's capitated providers are aware, based on the language in their contract with us, that a capitated payment is considered payment in full for services rendered to OCI members. Other than a co-pay, the provider should not be taking any cost share from a member for services rendered (except in the case of a service that falls outside of the capitated arrangement). Second, capitated providers also receive a monthly report from us which details the members for which they receive a capitated payment. The report also displays the member's responsibility which is ONLY the co-pay. A sample copy is attached. Third, capitated claims are processed with remark code "NN". Both the member and provider

would see the remark code verbiage on the EOB.

The verbiage of the NN remark code reads as follows:

> Through a pre-paid agreement, these services are covered under a monthly payment. The member is not responsible to pay these expenses. However, if applicable to the plan, the member is responsible for the copay amount".

Fourth, OCI's EOB (filed and approved on March 20, 2012 SERFF # 127344808) states "This is not a bill. Do not pay" and "Please wait for provider bill before making a payment". OCI believes it to be very unlikely that a member would make a payment to a provider upon receipt of an EOB. EOB template is attached.

Given that the EOB contains clear and direct language advising the member not to pay the provider any sums in reliance on the EOB but to wait until billed by the provider, and because capitated providers would not be billing a member for any cost share above their co-pay, we suggest that it is reasonable to conclude that members in these scenarios did not make any overpayments of their cost share.

OCI understands the Bureau's concern and agrees that the EOB is incorrect as currently formatted, with respect to the coinsurance. We are committed to alleviating any member confusion and improving on our communications. OCI respectfully requests the Bureau reconsider the claims remediation for the above noted reasons. We would welcome the opportunity to discuss this matter further.

Exhibit 4 attached

20. Strengthen its procedures for the payment of interest due on claim proceeds, as required by §38.2-4306.1 B of the Code.

Company Response: OCI has reviewed and confirmed policies are in effect and compliant pertaining to the payment of interest. OCI has distributed an educational memo to all claims staff in regard to these requirements.

21. Review and consider for re-adjudication all paid claims that took greater than 30 calendar days to pay; for the years of 2011, 2012, 2013, 2014, 2015 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 interest along with a letter of explanation or statement on the EOB that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized.

Company Response: OCI continues to dispute the violations of Review Sheets CL06 and CL13. The following is a detailed explanation for each.

CL06- BOI Sample #04- The Company respectfully maintains its disagreement with this error. The date of 2/12/13 that is stamped on the document was not a date that was stamped by UnitedHealthcare. The stamped date and informational line at the top of the copy of the letter would have been applied by the provider for their own tracking purposes. The information was received by the Company on Julian date 13051, or February 20, 2013. The Julian date on paper documentation is contained in the sequence of numbers running vertically on the right side of the document, beginning with the fourth digit. As the information was received on February

20, 2013, and the payment was deposited to the provider's account on March 20, 2013 (day 28), the claim was processed timely.

CL13- BOI Sample #103- The Company respectfully maintains disagreement with this error. The date of payment for this claim was made is May 22, 2013. To clarify, it takes the company an "average" of 3-5 days to issue checks after the adjudication date. The adjudication date on this claim was May 21, 2013. In this case, it took 1 business day for the check to issue. The receive date of the claim is April 22, 2013. The claim was paid timely and did not require any interest; however, as the company adds additional time to allow for check issuance, interest was paid proactively. This dollar amount would not be recovered from the provider.

The pertinent claim detail is included for your ease of reference, please see Exhibit 5.

OCI agrees with the remaining five errors and attribute each to a manual processing intervention. The five errors, out of the 200 claim sample, equate to a 2.5% error rate where interest was not paid or was under paid. With an error ratio of 2.5%, OCI believes that requesting a review of claims for a five plus year period is excessive, simply based on the findings noted in the draft report. OCI proposes for a corrective action measure, management coaching to the individuals responsible for the errors.

22. Establish and maintain procedures to ensure that coverage is not restricted or denied for a child who has not attained the age of 26 based on the presence or absence of the child's student status, as required by § 38.2-3439 A 2 of the Code.

Company Response: The one claim of concern identified by the exam team was specific to Optum Behavioral Health (Optum). Optum has confirmed accurate policies are in place for dependents under the age of 26. Optum will distribute a memorandum to claims staff as a reminder of the policy.

23. Immediately bring its coordination of benefits claim handling practices and EOB forms into compliance with the requirements of 14 VAC 5-211-80 B.

Company Response: As in the response on the MD-IPA draft report, OCI disagrees with the Bureau's position on this matter. As noted in Review Sheet CL38 and CL40, OCI disagreed with the examiner's observation.

We would like to take this opportunity to elaborate on our process.

14 VAC 5-211-80 B states in part "until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided". OCI maintains confirmed member benefit coordination data within its systems. In each of the cases of the claims in question, the member had other coverage which had been previously confirmed as primary coverage, for the dates of service, and based on that the "benefit determination was made". OCI did not "restrict or impede the provision of covered health services" as the service was indeed rendered prior to the claim submission. Service was provided, the claim was submitted, benefits were determined, and it is only once that benefits were determined, that OCI sought to coordinate benefits. We are attaching a screen-print of the member's COB

screen for reference. Please see Exhibit 6.

OCI's procedures are in compliance with 14 VAC 5-211-80 B and the claims in question were processed accordingly. OCI continues to disagree with the violation and respectfully requests the findings pertaining to this matter (pages 38-39 of the draft report) as well as Recommendation 23 be removed from the report.

Additionally, and at the Bureau's request of MD-IPA, we are attaching a legal analysis of this matter. Please see Exhibit 7.

Exhibit 6 and Exhibit 7 attached

24. Strengthen its procedures for compliance with §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 4, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code.

Company Response: OCI has reviewed and confirmed policies are in effect and compliant pertaining to the denial of a claim. OCI has distributed an educational memo to all claims staff in regards these requirements.

25. Establish and maintain procedures to ensure that complaint and appeal response letters provide complete, clear, and accurate information, as required by subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in UHIC/OCI Corrective Action Plan of September 14, 2015.

26. Establish and maintain procedures to ensure that complaint and appeal response letters provide accurate information regarding external review procedures, in compliance with Administrative Letter 2011-05.

Company Response: This item has been addressed and all corrective action measures have been taken as communicated to the Bureau in the UHIC/OCI Corrective Action Plan of September 14, 2015.

27. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

Company Response: OCI will provide the requested documentation.

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

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August 23, 2016

CERTIFIED MAIL 7015 1520 0003 0918 9526
RETURN RECEIPT REQUESTED

Joseph Stangl
Director, Regulatory Affairs-Market Conduct
Optimum Choice, Inc.
4 Research Drive
5th Floor
Shelton, Connecticut 06484

RE: Optimum Choice, Inc.'s (OCI) Response to the Draft Examination Report

Dear Mr. Stangl:

The examiners have received and reviewed OCI's response to the Draft Report dated May 6, 2016. This response will primarily address those areas of the response where OCI disagreed with the findings and corrective actions of the Report or where upon further review, the examiners determined that modifications to the findings were necessary.

Corrective Action #2

The examiners acknowledge that OCI agrees to update its Regulatory Appendix to include language referencing the provider.

In regards to § 38.2-3407.15 B 8 of the Code, amending the Regulatory Appendix to delete the words "*provider hereby agrees that*" would not necessarily bring OCI's provider contracts into compliance with this section. Section 38.2-3407.15 B of the Code requires that every provider contract entered into by a carrier contain specific provisions and § 38.2-3407.15 B 8 of the Code states that no provider contract my fail to include or attach at the time it is presented to the provider for execution the fee schedule or reimbursement methodology. The examiners cannot determine whether the provision complies until all of the proposed revisions to the Virginia Regulatory Requirements Appendix are provided.

The requirements of § 38.2-3407.15 B 10 of the Code specifically refer to a carrier's provision of a policy required to be provided under subsections 8 or 9 of this section.

Section 8.(g) of the Virginia Regulatory Requirements Appendixes attached to OCI's response refers only to the provision of policies discussed in subsection 4 {8.(f) of the Appendixes}. The Bureau's concern was not primarily related to a "placement issue" and no changes to the Report are necessary.

The violations of §§ 38.2-3407.15 B 7, 38.2-3407.15 B 8 and 38.2-3407.15 B 10 of the Code discussed in Review Sheets EF07, EF10 and EF11 will remain in the Report. OCI's response failed to address the Regulatory Appendixes associated with the Behavioral Health and Physical Therapy provider contracts.

Based on the additional documentation and explanation provided, the other violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 4 a (i), 38.2-3407 15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 9 and 38.2-3407.15 B 11 of the Code will be removed from the Report.

Corrective Action #12

In regards to MHPAMD.GHMO.05.VA (Review Sheet EF24B), the examiners have reviewed the Serff filing and it is clear that the missing language was not bracketed as variable under the Definition of "*Primary Physician*", which was where the language was deleted from the issued form. No changes to the Report are necessary.

The violations associated with PF25B will be removed from the Report.

Policy Form #: PROSDEV.GIPAPOS.05.VA, Prosthetic Devices Amendment, was not filed and approved by the Commission on January 28, 2010 under SERFF Filing #: UHLC-126424133. This Serff filing does not refer to this form number and the violations associated with PF26B will remain in the Report.

In regards to Policy Form #: GHMO.05.VA, as documented in Review Sheet PF01B, OCI altered text in the Certificate of Coverage that was denoted by OCI in the form filing approved by the Commission as non-variable. No changes to the Report are necessary.

Corrective Action #15

The Report documents 4 errors in the calculation of copayment maximums in a sample of 9 from a population of 91 enrollees who had met their copayment maximum during the examination time frame. In all 4 instances, OCI failed to refund to the enrollee the copayments charged in excess of the maximum. While the violations and corrective action will remain in the Report, upon further consideration, Corrective Action Item #15 has been revised to require OCI to "Review and reopen all claims for all enrollees who exceeded his or her copayment/out-of-pocket maximum during the years of 2013, 2014, 2015 and the current year."

Corrective Action #19

Based on the additional documentation provided, the number of violations will be reduced to 737.

OCI stated in its' response that it "...is committed to reviewing the root cause of the coinsurance display on EOBs issued to members whose providers are paid on a capitated basis ("the capitated providers")" and that "Upon conclusion of our review, OCI would make applicable changes that would best serve our members." OCI also stated in its response that it "...agrees that the EOB is incorrect as currently formatted, with respect to the coinsurance" and that "We are committed to alleviating any member confusion and improving on our communications." OCI was notified of this issue on November 18, 2014, however there is no indication from OCI's response that the Company has implemented any measures to stop the errant display of coinsurance amounts on the EOBs sent to members/providers for capitated encounters.

While the Bureau acknowledges that it may be unlikely that a provider would bill the member for the coinsurance amount noted on the EOBs in these situations, OCI did inform each member that coinsurance was owed on these 737 claims in error and must therefore verify that excess coinsurance amounts were not collected by the provider. Any excess coinsurance amounts collected should be refunded to the member and evidence of such refund should be provided to the examiners once this corrective action is completed. This Corrective Action Item #19 will remain in the Report, and it has been revised to require a review of claims paid in 2013, 2014, 2015 and the current year.

Corrective Action #21

The violations associated with Review Sheet CL06 and CL13 will be removed.

The examiners have reviewed the claim files and it is not conclusive that the interest violations were solely attributable to manual processing interventions. Absent a detailed description of the claim system's ability to calculate statutory interest, the examiners cannot determine the amount of manual intervention required. There were 9 claims in the sample where interest was due and payable, and interest was not paid in 5 of those 9 instances. As such, the corrective action is warranted. Upon further consideration, the report has been revised to limit the corrective action to all claims paid in 2013, 2014, 2015 and the current year that took greater than 30 calendar days to pay. All interest amounts due should be paid directly to the provider or member regardless of the amount.

Corrective Action #6

The Bureau has reviewed and considered the legal analysis that was provided in response to the violations of 14 VAC 5-211-80 B noted in the draft report. While the Bureau does not object to OCI's process of determining coordination of benefits, the sole concern continues to be that OCI is telling the enrollee that he or she is responsible

for payment of the entire billed amount before the coordination of benefits determination has been made. 14 VAC 5-211-80 states as follows:

> A health care plan shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other policies, contracts, or health care plans. In the event that benefits are provided by a health care plan and another policy, contract, or health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The health maintenance organization shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by other policies, contracts, or plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided.

While OCI argues that this section only applies to concurrent care or pre-service situations, this subsection must be read as a whole with the remainder of the subsection. This section applies to all coordination of benefits issues, which may be at any stage of receiving a benefit or service – pre service, concurrently, or post service. Therefore the last sentence in this subsection must be read to mean that at any stage prior to a coordination of benefits determination; the member may not be held liable for the cost of covered services provided. The explanation of benefits (EOB) that OCI sent to this enrollee for this denied claim clearly indicated in the "patient responsibility" column that the enrollee was liable for the entire cost of the health care services provided. These amounts appear under the headings "total amount you owe the provider(s)" and "amount you owe." The member is not aware that this is a "formality" which will be reconciled upon receipt of the EOB from the primary carrier. These statements should not be made while the documentation to adjudicate the claim is incomplete. As such, OCI's current EOB procedures do not comply with the requirements of this section and the violations and Corrective Action will remain in the Report.

A copy of the entire Report with revised pages is attached and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that OCI violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and §§ 38.2-503 and 38.2-510 A 15 of the Code and 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, 14 VAC 5-90-60 B 1, 14 VAC 5-90-60 B 3, 14 VAC 5-90-120 A, 14 VAC 5-90-130 A and 14 VAC 5-90-170 A of Rules Governing Advertisement of Accident and Sickness Insurance.

It also appears that OCI violated §§ 38.2-316 A, 38.2-316 B, 38.2-316 C, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3407.3 A, 38.2-3407.4 B,

38.2-3439 A 2, 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 5 a, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 10, 38.2-4306 A 2, 38.2-4306.1 B, 38.2-4312, 38.2-4313 and 38.2-5804 A of the Code in addition to 14 VAC 5-211-60 A, 14 VAC 5-211-80 B, 14 VAC 5-211-90 B and 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations.

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

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter,

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Christopher J Mullins, CEO
Optimum Choice, Inc.
12018 Sunrise Valley Drive
Reston, Virginia 20191

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 and 38.2-510 A 15 of the Code and 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, 14 VAC 5-90-60 B 1, 14 VAC 5-90-60 B 3, 14 VAC 5-90-120 A, 14 VAC 5-90-130 A and 14 VAC 5-90-170 A of Rules Governing Advertisement of Accident and Sickness Insurance as well as §§ 38.2-316 A, 38.2-316 B, 38.2-316 C, 38.2-1812 A, 38.2-1822 A, 38.2-1833 A 1, 38.2-3407.3 A, 38.2-3407.4 B,
38.2-3439 A 2, 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 5 a, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 10, 38.2-4306 A 2, 38.2-4306.1 B, 38.2-4312, 38.2-4313 and 38.2-5804 A of the Code in addition to 14 VAC 5-211-60 A, 14 VAC 5-211-80 B, 14 VAC 5-211-90 B and 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations.

Dear Ms. Battle:

This will acknowledge receipt of your letter dated August 25, 2016, concerning the above-captioned matter.

Optimum Choice, 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 $49,000, 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 Market Conduct Examination Report as of June 30, 2013.

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,

CEO

February 2, 2017
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, MARCH 1, 2017

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2016-00221

OPTIMUM CHOICE, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Optimum Choice, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of a health maintenance organization in the Commonwealth of Virginia ("Virginia"), violated: §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C of the Code of Virginia ("Code") by failing to comply with policy and form filing requirements; § 38.2-502 (1) of the Code by misrepresenting the terms of the policy; §§ 38.2-503 and 38.2-4312 of the Code, as well as 14 VAC 5-90-50 B, 14 VAC 5-90-55 A, 14 VAC 5-90-60 B (1), 14 VAC 5-90-60 B (3), 14 VAC 5-90-120 A, 14 VAC 5-90-130 A, and 14 VAC 5-90-170 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, by failing to comply with advertising requirements; §§ 38.2-510 A (15) and 38.2-4306.1 B of the Code by failing to comply with claim settlement practices; § 38.2-1812 A of the Code by paying commissions for services as an agent to persons who were not properly licensed and appointed; § 38.2-1822 A of the Code by knowingly permitting unlicensed persons to act as agents; § 38.2-1833 A (1) of the Code by failing to comply with agent appointment requirements; § 38.2-3407.3 A of the Code by failing to comply with calculation of cost-sharing provisions;

§ 38.2-3407.4 B of the Code by failing to comply with explanation of benefits requirements; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (5), 38.2-3407.15 B (7), 38.2-3407.15 B (8), and 38.2-3407.15 B (10) of the Code by failing to comply with ethics and fairness requirements for business practices; § 38.2-3439 A (2) of the Code by failing to comply with dependent coverage for individuals to age 26 provisions; § 38.2-4306 A (2) of the Code by failing to comply with policy and form requirements; § 38.2-4313 of the Code by failing to comply with licensing of agents provisions; § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain an approved complaint system for each of its Managed Care Health Insurance Plans; and 14 VAC 5-211-60 A,[1] 14 VAC 5-211-80 B, 14 VAC 5-211-90 B, and 14 VAC 5-211-150 A of the Commission's Rules Governing Health Maintenance Organizations, 14 VAC 5-211-10 *et seq.*, by failing to comply with provisions related to health maintenance organizations.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a 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 Virginia the sum of Forty-nine Thousand Dollars ($49,000), 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, 2013.

[1] 14 VAC 5-211-60 was repealed effective January 1, 2015. *See* Virginia Register Volume 31, Issue 03.

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 the Defendant in settlement of the matter set forth herein 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: Joseph Stangl, Director, Regulatory Affairs – Market Conduct, Optimum Choice, Inc., 4 Research Drive, 5th Floor, Shelton, Connecticut 06484; 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:

Clerk of the
State Corporation Commission