REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

ANTHEM HEALTH PLANS OF VIRGINIA, INC.

AS OF DECEMBER 31, 2015

COPY

Conducted from June 28, 2016

Through

December 6, 2018

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-0357120
NAIC: 71835

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

STATE CORPORATION COMMISSION

BUREAU OF INSURANCE

I, Bryan Wachter, Principal Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Anthem Health Plans of Virginia, Inc. as of December 31, 2015, conducted at Anthem's Home Office 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-2020-00047 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 17th day of April, 2020.

Bryan Wachter
Principal Insurance Market Examiner

COPY

REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

ANTHEM HEALTH PLANS OF VIRGINIA, INC.

AS OF DECEMBER 31, 2015

COPY

Conducted from June 28, 2016

Through

December 6, 2018

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-0357120
NAIC: 71835

TABLE OF CONTENTS

I. SCOPE OF EXAMINATION 1

II. EXECUTIVE SUMMARY 3

III. COMPANY HISTORY 5

IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS) 7

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES 7
COMPLAINT SYSTEM 7
PROVIDER AND INTERMEDIARY CONTRACTS 9

V. INTERNAL APPEAL AND EXTERNAL REVIEW 10

VI. PROVIDER CONTRACTS 11

ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES 11
SUMMARY 13

VII. ADVERTISING 16

SUMMARY 19

VIII. POLICY AND OTHER FORMS 20

IX. AGENTS 23

APPOINTED AGENT REVIEW 23
COMMISSIONS 23
TERMINATED AGENT APPOINTMENT REVIEW 24

X. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT 25

UNDERWRITING/UNFAIR DISCRIMINATION 25

UNDERWRITING PRACTICES – AIDS 26
MECHANICAL RATING REVIEW 26

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT 27

XI. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS 28

PREMIUM & RENEWAL NOTICES 28

COPY

REINSTATEMENTS 29

XII. CANCELLATIONS/NONRENEWALS 33

XIII. COMPLAINTS 37

XIV. CLAIM PRACTICES 38

GENERAL HANDLING STUDY 38
PAID CLAIM REVIEW 38
DENIED CLAIM REVIEW 46
SUMMARY 51
OUT-OF-POCKET MAXIMUM 52
THREATENED LITIGATION 52

XV. CORRECTIVE ACTION PLAN 53

XVI. ACKNOWLEDGMENT 59

XVII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET 60

COPY

I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Anthem Health Plans of Virginia, Inc. (hereinafter referred to as "Anthem" or "the Company") was conducted under the authority of § 38.2-1317 of the Code of Virginia (hereinafter referred to as "the Code"). The examination included a detailed review of Anthem's fully-insured individual (grandfathered), small group and large group comprehensive major medical, dental, vision and stop-loss insurance coverage for the period beginning July 1, 2015 through December 31, 2015. The on-site examination was conducted at Anthem's office in Richmond, Virginia from June 28, 2016 to April 21, 2017, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on December 6, 2018.

The purpose of the examination was to determine whether Anthem was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC" or "regulations"). Anthem's practices were also reviewed for compliance with the Corrective Action Plans required as a result of the examiners' findings during the prior examination.

The first phase of the previous Target Market Conduct Examination covering the period of January 1, 2006 through June 30, 2008 was concluded on January 8, 2009. As a result of that examination, Anthem made a monetary settlement offer, which was accepted by the State Corporation Commission on June 25, 2009 in Case No. INS-2009-00067, in which Anthem 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 agreed to comply with the Corrective Action Plan contained in the Report.

COPY

The second phase of a previous Target Market Conduct Examination covering the period of January 1, 2008 through June 30, 2008 was concluded on June 25, 2010. As a result of that examination, Anthem made a monetary settlement offer, which was accepted by the State Corporation Commission on August 22, 2012 in Case No. INS-2012-00138, in which Anthem 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 agreed to comply with the Corrective Action Plan contained in the Report.

Although Anthem had agreed after the prior examination to change its practices to comply with the Code and regulations, the current examination revealed violations that were also noted in the previous Report. Therefore, in some instances Anthem knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The examiners may not have discovered every non-compliant activity in which the company was engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to Anthem during the course of the examination.

COPY

II. EXECUTIVE SUMMARY

During the course of the examination, the examiners reviewed complaints, provider contracts, internal appeal and external review, advertisements, policy forms, agents, underwriting, premium and renewal notices, collections, reinstatements, cancellations, non-renewals, rescissions, claim practices, to determine compliance with the Code, the applicable regulations, the terms of Anthem's insurance contracts and the company's policies and procedures.

The previous market conduct examination of Anthem was finalized in 2012. The examiners identified several compliance issues that were also present during the last examination, even though Anthem had agreed to change its practices to comply with Virginia's statutes and regulations. These violations could be construed as knowing and involved the provider contract provisions required by § 38.2-3407.15 B of the Code; the payment of interest required by § 38.2-3407.1 B of the Code; and the advising of the claimant of the insurer's acceptance or denial of the claim within 15 working days required by 14 VAC 5-400-60 A. Additionally, in accordance with § 38.2-3407.3 B of the Code, the violations of § 38.2-3407.3 A of the Code regarding the calculation of coinsurance are deemed knowing.

There are 494 violations and instances of noncompliance noted in this Report. The review of provider contracts revealed that some contracts contained an amendment that weakened the provision requiring Anthem to pay the provider in accordance with the fee schedule attached to the contract, and Anthem's contracts with pharmacies failed to contain the provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code. There were more advertising violations identified during the current examination,

COPY

and a large portion of these involved the use of statistics without the source being identified.

The policy form review revealed that the stop loss policies issued and applications used failed to contain a form number and were not filed and approved as required. In addition, Anthem's rate filing for stop loss contained potentially unlimited underwriter and management discretion which increases the potential for unfair discrimination. Anthem failed to provide evidence of timely notice of termination of appointment to agents in 73 of 80 sample files reviewed.

Several of Anthem's letters regarding cancellation and reinstatement were confusing and the letters sometimes indicated more than one date as the end of the grace period. Anthem's procedures for reinstatement and cancellation were not consistent and clear for all types of coverage.

There were 264 violations and instances of noncompliance noted during the Claims review. Overall, the Unfair Claims Settlement Practices review of Anthem's claims revealed smaller percentages of noncompliance than during the previous exam; however, there were systemic issues identified regarding ambulance claims that resulted in an internal audit by Anthem and re-adjudication of claims. The pharmacy claims review revealed that interest had not been paid in accordance with § 38.2-3407.1 B of the Code and that coinsurance was being calculated on the amount paid to the pharmacy benefit manager rather than the actual, lower, amount paid to the provider of services (the pharmacy), in violation of § 38.2-3407.3 A of the Code.

A corrective action plan (CAP) that must be implemented by Anthem was established to address these issues and others discussed in the Report.

COPY

III. COMPANY HISTORY

Richmond Hospital Association was chartered on October 14, 1935, as a health services plan. Its name was changed to Virginia Hospital Service Association in 1944 by charter amendment and again in 1968 to Blue Cross of Virginia.

The Associated Doctors of Virginia was chartered on October 21, 1944, as a health services plan providing medical/surgical and similar or related services. The following year, the name was changed to Virginia Medical Association. In 1968, the charter was amended to change the name to Blue Shield of Virginia. On March 31, 1982, Blue Shield of Virginia was merged into Blue Cross of Virginia, and the name was changed to Blue Cross and Blue Shield of Virginia. In 1986, Blue Cross and Blue Shield of Southwestern Virginia was reorganized and merged into Blue Cross and Blue Shield of Virginia.

On July 1, 1991, Blue Cross and Blue Shield of Virginia was granted authority under the provisions of § 38.2-4229.1 of the Code to convert to a domestic mutual insurer. Then on February 5, 1997, Blue Cross and Blue Shield of Virginia converted from a mutual insurance company to a stock insurance company. Blue Cross and Blue Shield of Virginia changed its name to Trigon Insurance Company, d/b/a Trigon Blue Cross Blue Shield and became a wholly-owned subsidiary of Trigon Healthcare, Inc. The membership interests of the company were converted into Class A common stock of Trigon Healthcare, Inc. or cash.

On July 31, 2002, Trigon Healthcare, Inc. and Anthem Inc. completed a merger in which Trigon Healthcare, Inc. merged into a wholly owned subsidiary of Anthem, Inc. that subsequently changed its name to Anthem Southeast, Inc. At that time, Trigon Insurance Company became a wholly owned subsidiary of Anthem Southeast, Inc. and its name

COPY

was changed to Anthem Health Plans of Virginia, Inc.

On November 30, 2004, Anthem, Inc. and WellPoint Health Networks, Inc. completed a merger in which WellPoint Health Networks, Inc. and all WellPoint subsidiaries merged with and into Anthem Holding Corp., a direct and wholly owned subsidiary of Anthem, Inc., with Anthem Holding Corp. as the surviving entity. In connection with the merger, Anthem, Inc. amended its articles of incorporation to change its name to WellPoint, Inc. In December 2014, WellPoint, Inc. changed its corporate name to Anthem, Inc.

Anthem markets group health and Medicare supplement insurance in Virginia, with the exception of the cities of Fairfax, Arlington, Alexandria, the town of Vienna, and the eastern half of Fairfax County.

As of December 31, 2015, Anthem's annual statement reported Virginia direct premiums written totaled $3,704,956,339. Enrollment for health products at the end of 2015 totaled 1,894,285.

COPY

IV. 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.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

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

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

The review revealed that Anthem was in substantial compliance.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain a complaint system approved by the Commission and the State Health Commissioner. 14 VAC 5-216-40 E 1 states that a health carrier shall notify the covered

COPY

person of the final benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than the timeframes established in subdivisions 1 and 2 of this subsection: 1. If an internal appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal. 2. If an internal appeal involves a post-service claim review request, the health carrier shall notify the covered person of its decision within 60 days after receipt of the appeal. Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy.

Although the examiners selected a sample of 72 from a population of 421 written complaints received during the examination time frame, 12 sample files were later determined to be files involving Anthem's affiliate HMO and were not reviewed. The examiners reviewed 60 sample files. The review revealed 3 violations of § 38.2-5804 A of the Code and 14 VAC 5-216-40 E 1, and 1 violation of subsection 1 of § 38.2-502 of the Code. Examples are discussed in the following paragraphs.

COPY

TIMELINESS

Anthem Health Plans of Virginia Member Claim Appeal Policy and Procedure states that Anthem "resolves and provides written notification of the disposition of the appeal to the member and/or the treating practitioner/provider within 30 calendar days from the receipt of the request for all pre-service and clinical appeals…" and "while plan documents allow 60 calendar days for all post-service appeals, the health plan's goal is to resolve all appeals and provide notification within 30 calendar days from the receipt of the request to

appeal." An example is discussed in Review Sheet MC02L-AN, where a review of the file revealed that Anthem failed to send written notice of the disposition of the appeal to the insured. This placed Anthem in noncompliance with its established internal procedures and resulted in a violation of 14 VAC 5-216-40 E 1 for failing to notify the insured of the decision and a violation of § 38.2-5804 A of the Code for the failure to maintain its established complaint system. Anthem agreed with the examiners' observations.

HANDLING

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. As discussed in Review Sheet MC05L-AN, the review revealed 1 violation of this section. Anthem's response to the insured incorrectly indicated that the plan was self-funded, in violation of the Code. Anthem agreed with the examiners' observations.

COPY

PROVIDER AND INTERMEDIARY CONTRACTS

The examiners reviewed a sample of 25 provider contracts from a population of 96,450 provider contracts in force during the examination time frame. The examiners also reviewed Anthem's contracts negotiated with intermediary organizations for providing health care services pursuant to an MCHIP.

Section 38.2-5805 B of the Code states that every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing. As discussed in Review Sheet EFCL08F-AN, the review revealed 1 violation of this section. Anthem indicated that it did not have "a copy of the exact contract" with the provider.

V. 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 determinations.

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.

The examiners reviewed the total population of 12 external reviews of final adverse determinations that occurred during the examination time frame.

Section 38.2-3561 J states that upon receipt of a notice reversing the adverse determination or final adverse determination, the health carrier promptly shall approve the coverage. The review revealed 2 violations of this section. An example is discussed in Review Sheet EX01L-AN, where Anthem's notification to the insured that coverage had been approved was not sent until 20 calendar days after the IRO's notification to Anthem that the denial was overturned. Anthem agreed with the examiners' observations.

COPY

VI. PROVIDER CONTRACTS

A review of Anthem's provider contracts was conducted to determine compliance with §§ 38.2-3407.15 B, 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code. Each section sets forth specific provisions that contracts between carriers and providers shall contain.

ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services.

Provider Contracts

The examiners reviewed a sample of 25 from a population of 96,450 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 23 instances where Anthem's contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	2	EF01B-AN
§ 38.2-3407.15 B 2	2	EF01B-AN
§ 38.2-3407.15 B 3	2	EF01B-AN
§ 38.2-3407.15 B 4	2	EF01B-AN
§ 38.2-3407.15 B 5	2	EF01B-AN
§ 38.2-3407.15 B 6	2	EF01B-AN
§ 38.2-3407.15 B 7	2	EF01B-AN
§ 38.2-3407.15 B 8	5	EF09D-AN
§ 38.2-3407.15 B 9	2	EF01B-AN

COPY

§ 38.2-3407.15 B 10	2	EF01B-AN

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid 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 5 violations of this section. An example is discussed in Review Sheet EF09D-AN, where an amendment to the provider contract contained language that inhibited the provider's ability to ensure claims were paid in accordance with the fee schedule. The amendment stated:

> The provider is responsible for reporting to Anthem any discrepancy in payment within sixty (60) calendar days of such payment. If the provider fails to do so within this time frame, Provider shall hold Anthem, Plan and Covered Individuals harmless from any underpayment.

Anthem disagreed with the examiners' observations and stated that:

> The cited provisions of 38.2-3407 [sic] are not implicated in any way by the noted contract language. The language comes from an amendment to the provider contract with this provider which is fully compliant with statutory requirements, and which is not affected at all by the amendment. The amendment sets forth responsibilities regarding Anthem's subsequently-negotiated payment of higher fees, in some agreed-upon circumstances, vs. the standard fees disclosed in the fee schedule attached to the contract. Since Anthem is paying higher fees over standard fees, all of which are fully disclosed, the language at issue recognizes that an error could occur when loading and paying the higher fees. Thus, the 60 day discrepancy reporting requirement is a contingency attached to the provider's right to receive higher, non-standard fees.

The examiners do not concur. Anthem's decision to offer the provider increased compensation by amending the provider contract would not exempt Anthem from the requirement to reimburse the provider in accordance with the negotiated fee schedule.

COPY

SUMMARY

The review revealed that 5 of the 25 sampled contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. Anthem's failure to amend its provider contracts to comply with § 38.2-3407.15 B occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code.

Due to the fact that in the prior Report it was recommended that Anthem establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code, the current violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9 and 38.2-3407.15 B 10 of the Code could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

COPY

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 400 claims from a population of 7,942 claims processed under the sample of 25 provider contracts selected for review.

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 5 instances where Anthem 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 EFCL03D-AN. Anthem agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code requires that any interest owing or accruing on a claim under § 38.2-3407.1 of the Code, shall be paid at the time the claim is paid or within 60 days thereafter. The review revealed 14 instances where Anthem failed to pay interest as required by this section, in violation of §§ 38.2-3407.15 B 3 and 38.2-3407.1 B of the Code. An example is discussed in Review Sheet EFCL01D-AN. Anthem agreed with the examiners' observations.

CARRIER CONTRACTS WITH PHARMACY PROVIDERS; REQUIRED PROVISIONS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:1 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions. The examiners reviewed the one contract between Anthem and it's intermediary that was subject to this section of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

COPY

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:1 B 1	1	EF03B-AN
§ 38.2-3407.15:1 B 2	1	EF03B-AN
§ 38.2-3407.15:1 B 3	1	EF03B-AN
§ 38.2-3407.15:1 B 4	1	EF03B-AN
§ 38.2-3407.15:1 B 5	1	EF03B-AN
§ 38.2-3407.15:1 B 6	1	EF03B-AN
§ 38.2-3407.15:1 B 7	1	EF03B-AN
§ 38.2-3407.15:1 B 8	1	EF03B-AN
§ 38.2-3407.15:1 B 9	1	EF03B-AN
§ 38.2-3407.15:1 C	1	EF03B-AN

COPY

VII. ADVERTISING

A review was conducted of Anthem's advertising materials to determine compliance with the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503 and 38.2-504 of the Code, 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).

COPY

Although a sample of 100 was selected from a population of 890 advertisements distributed in Virginia during the examination time frame, 5 sample advertisements were later determined to be files involving Anthem's affiliate HMO and were not reviewed. The examiners reviewed 95 sample advertisements. The review revealed that 15 of the advertisements contained violations. In the aggregate, there were 32 violations, which are discussed in the following paragraphs.

14 VAC 5-90-50 A states the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commission from the overall impression that the advertisement may be reasonably expected to create within the

segment of the public to which it is directed. The review revealed 7 violations of this section. An example is discussed in Review Sheet AD04D-AN, where the advertisement stated that "As a direct result of the [Future Moms] program, we've seen 40% fewer low birth weight babies." The examiners requested additional information to verify this statement. Anthem provided documentation regarding the internal calculations performed using information from a report sent to a client. The examiners would note that the documentation provided by Anthem failed to substantiate that there was a 40% reduction in low birth weight babies as a direct result of participation in the Future Mom's program; therefore, this statement is not accurate and has a tendency to mislead or deceive, in violation of this section.

COPY

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]." The review revealed 3 violations of this section. An example is discussed in Review Sheet AD07F-AN, where the invitation to inquire failed to contain the required disclosure. Anthem agreed with the examiners' observations and stated that "This piece is being removed from use in Virginia."

14 VAC 5-90-55 B states an invitation to inquire may include rate information without including information about benefit exceptions and reductions and limitations so long as the advertisement includes prominent disclaimers clearly indicating that (i) the rates are illustrative only; (ii) a person should not send money to the insurer in response to an application for coverage; and (iv) benefit exclusions and limitations may apply. Any

rate information mentioned in any advertisement disseminated pursuant to this section shall indicate the age, gender, and geographic location on which that rate is based. As discussed in Review Sheet AD02D-AN, the review revealed 1 violation of this section where the advertisement did not include the required prominent disclaimers. Anthem agreed with the examiners' observations.

14 VAC 5-90-60 A 2 states that an advertisement shall not contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," or similar words and phrases in a manner that exaggerates a benefit beyond the terms of the policy, but may be used only in such manner as to fairly describe the benefit. The review revealed 3 violations of this section. An example is discussed in Review Sheet AD07F-AN, where the advertisement stated, "All you need, all from Anthem" and "For all your health care needs, Anthem is your total health solution." Anthem agreed with the examiners' observations and stated that "This piece is being removed from use in Virginia."

14 VAC 5-90-90 A states that statistical information relating to any insurer shall not be used unless it accurately reflects all current and relevant facts. The review revealed 6 violations of this section. An example is discussed in Review Sheet AD01F-AN, where an advertisement included statistics regarding network participation from 6 years earlier (2009). Anthem agreed with the examiners' observations.

14 VAC 5-90-90 C states that the source of any statistics used in an advertisement shall be identified in the advertisement. The review revealed 11 violations of this section. An example is discussed in Review Sheet AD04F-AN, where the advertisement stated that "…when given more choices, our experience shows that 66% of employees buy less coverage in year 1, and over 70% keep this coverage in subsequent years of the private

COPY

exchange, helping your bottom line," but the advertisement failed to identify the source for these statistics. Anthem agreed with the examiners' observations.

14 VAC 5-90-110 states an advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. As discussed in Review Sheet AD07D-AN, the review revealed 1 violation where the advertisement stated that "THE BEST DISCOUNTS 5.4% savings vs. the competition & LARGEST NETWORKS 99% claims paid in network." The statement made an incomplete comparison of Anthem and other insurers. Anthem agreed with the examiners' observations and stated that "…this piece is no longer in use."

SUMMARY

Anthem violated 14 VAC 5-90-50 A, 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 2, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, and 14 VAC 5-90-110, which placed it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code

COPY

VIII. POLICY AND OTHER FORMS

A review was conducted to determine if Anthem complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

14 VAC 5-100-10 et seq. and § 38.2-316 of the Code set forth the filing and approval requirements for forms that are to be issued or issued for delivery in Virginia.

Sections 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code set forth the filing and approval requirements for group and individual policies, certificates of insurance, amendments, riders, and application/enrollment forms used in connection with any group accident and sickness insurance policy issued in Virginia. The examiners reviewed the policy forms contained in the underwriting sample files to determine if Anthem complied with the various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

SCHEDULE OF BENEFITS

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of the schedule of benefits prior to use. The review revealed 3 schedules of benefits that were issued prior to being filed and approved. An example is discussed in PF01F-AN. Anthem disagreed and explained that a typographical error in the form number resulted in the final “E” being inadvertently omitted on the form number on the issued form. The examiners would note that the issued form, with form number ABCBS-VA-PPO-SOB-T3S30-HSA (1/15), had not been filed with and approved by the Commission.

COPY

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and enrollment forms prior to use. As discussed in Review Sheet PF07F-AN, the review revealed that an application was used prior to being filed with and approved by the Commission. Anthem disagreed, and provided evidence of a filing for an application with form number OFF_VA (3/15). The examiners would note that the application used contained form number OFF_VA (1/15).

STOP LOSS POLICIES AND APPLICATIONS

Sections 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of policies and applications prior to use. As discussed in Review Sheet PF01JA-AN, the review revealed that the stop loss applications used and policies issued during the examination time frame had no form numbers; therefore, these stop loss applications and policies were not filed and approved. Anthem agreed with the examiners' observations.

COPY

SUMMARY

The following table summarizes Anthem's policy form violations:

Form Number	Description of Form	Code Section Violations	Review Sheet
ABCBS-VA-PPO-SOB-T3S30-HSA (1/15)	Schedule of Benefits	38.2-316 A 38.2-316 C 1	PF01F-AN
ABCBS-VA-PPO-SOB-T3S106-HSA (7/15)	Schedule of Benefits	38.2-316 A 38.2-316 C 1	PF02F-AN
ABCBS-VA-PPO-SOB-T3S31-HSA (1/15)	Schedule of Benefits	38.2-316 A 38.2-316 C 1	PF03F-AN

OFF_VA (1/15)	Application	38.2-316 B 38.2-316 C 1	PF07F-AN
NO FORM NUMBER	Stop Loss Application	38.2-316 B 38.2-316 C 1	PF01JA-AN
NO FORM NUMBER	Stop Loss Policy	38.2-316 A 38.2-316 C 1	PF01JA-AN

COPY

IX. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 of the Code. The agents and agencies designated in the sample of 68 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 that Anthem was in substantial compliance.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires the insurer 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 4 violations of this section. An example is discussed in Review Sheet AG25F-AN, where Anthem failed to appoint the agent within 30 days of the date of execution of the application, in violation of this section. Anthem agreed with the examiners' observations.

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 3 violations of this section. An example is discussed in Review Sheet AG02J-AN, where the examiners requested documentation regarding the commissions paid on a policy. Anthem provided the commission statement which confirmed that Anthem paid commissions to an agent that was not appointed, in violation of this section.

COPY

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment. A sample of 80 was selected from the population of 805 agents whose appointments terminated during the examination time frame.

As discussed in Review Sheet AG01F-AN, a review of the documentation provided by Anthem indicated that Anthem failed to provide notification to the agent of termination of the appointment in 63 instances. Additionally, as discussed in Review Sheet AG02F-AN, Anthem provided notification but failed to do so within 5 calendar days in 10 instances. Anthem partially agreed with both observations and indicated that it had changed its procedures. In total, there were 73 violations of § 38.2-1834 D of the Code.

COPY

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

The examination included a review of Anthem's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514 of the Code, the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620 of the Code, 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

COPY

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

UNDERWRITING REVIEW

The examiners reviewed all 6 stop loss policies; a sample of 35 from a population of 593 group policies; and a sample of 12 from a population of 3,881 individual dental and vision policies issued during the examination time frame.

The examiners also reviewed a sample of 15 from a population of 2,393 individual dental and vision applications declined during the examination time frame. The examiners were informed by Anthem that no group applications were declined during the examination time frame.

The review revealed no evidence of unfair discrimination and that coverage was underwritten or declined in accordance with established guidelines.

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 regarding HIV infection and AIDS. The review revealed that Anthem was in substantial compliance.

MECHANICAL RATING REVIEW

As discussed in Review Sheet UN01BW-AN, the review of the stop loss policy rates revealed that several steps or factors in the filed rates involve unlimited underwriter discretion. There are numerous underwriting adjustment factors included in the rate filing Actuarial Memorandum that Anthem referenced as support for its practices. The Actuarial Memorandum lists at least 12 different types of adjustments, including "management discretion", that would appear to fall under Step 23 ("Underwriting Adjustment") on the filed "Stop Loss Rating Manual, Section A, Worksheet 1, Development of Specific Stop Loss Rates." In addition, there are several other steps on this worksheet that involve underwriter discretion, including Steps 6, 7, 10, 14 and 17. Although Anthem's response indicated that its rating practices are non-discriminatory because every group is considered by management for a market adjustment of the rates, the examiners do not concur and would caution Anthem that without clear guidelines of when and how much of a discretionary adjustment is applied by either management or the underwriter, these adjustments have the potential to be discriminatory. Although there are no violations cited at this time, the examiners continue to have concerns regarding the potential for unfair discrimination, and a corrective action item will be included in this Report addressing the establishment and maintenance of specific underwriting procedures that

COPY

provide clear guidelines and ranges/limits on when and how much of a discretionary adjustment is applied for all rating steps that currently involve potentially unlimited underwriter discretion.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires an insurer 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 Anthem in the underwriting of its group and individual contracts were in substantial compliance.

COPY

XI. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS

Anthem's procedures for processing premium and renewal notices, collections and reinstatements were reviewed for compliance with its established procedures and the Code. Anthem's practices for notifying policyholders 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 & RENEWAL NOTICES

COPY

Section 38.2-3407.14 A of the Code states that an insurer issuing individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage shall provide in conjunction with the proposed renewal of coverage under any such policies prior written notice of intent to increase by more than 35 percent the annual premium charged for coverage thereunder. Section 38.2-3407.14 B of the Code states that a health carrier providing individual health insurance coverage shall provide in conjunction with the proposed renewal of coverage prior written notice of intent to increase the annual premium charge for coverage or any deductible required thereunder. Section 38.2-3407.14 C of the Code states that the notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of health insurance coverage described in subsection A and at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B.

Individual

A sample of 5 was selected from a population of 14 individual policies whose premium increased by more than 35%, and a sample of 40 was selected from a population

of 10,585 individual policies renewed during the examination time frame. The review revealed 5 violations of § 38.2-3407.14 C of the Code. An example is discussed in Review Sheet PB04D-AN, where Anthem failed to provide the notice required by this section at least 75 days prior to the proposed renewal of coverage. Anthem agreed and indicated that after a system error was discovered, renewal notices were prepared and sent extending the current rate until 75 days from the date of the renewal notice.

Group

The entire population of 7 groups whose premium increased by more than 35% was reviewed, and a sample of 15 was selected from a population of 3,697 groups renewed during the examination time frame. The review revealed that Anthem was in substantial compliance. However, as discussed in Review Sheet PB01D-AN, the examiners would encourage Anthem to strengthen its recordkeeping to accurately document the information that is included in the written notice of a renewal rate increase and when it is presented to the group.

COPY

REINSTATEMENTS

Individual Medical

A sample of 15 was selected from a population of 201 individual medical policies reinstated during the examination time frame.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 2 violations of this section. An example is discussed in Review Sheet

PB10L-AN, where Anthem's cancellation letter to the insured provided 62 days from the premium paid-to date for the insured to request reinstatement and pay all premium due. Although Anthem had conflicting procedures as to whether an insured had 60 or 61 days from the premium paid-to date to reinstate, none of its procedures allowed for 62 days. Anthem's letter to the insured included a time frame for reinstatement that was in non-compliance with Anthem's procedures and misrepresented the terms and conditions of the policy. Anthem partially agreed and indicated that it had reinstated the policy due to its error and that its letters had subsequently been revised.

Subsection 2 of § 38.2-508 of the Code states that no person shall unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner. As discussed in Review Sheet PB12L-AN, the review revealed 8 violations of this section. Anthem had conflicting procedures as to whether an insured had 60 or 61 days from the premium paid-to date to reinstate. The cancellation letters that Anthem sent to the insureds allowed a time frame for reinstatement that varied from 60 days to 76 days from the paid-to date. Anthem partially agreed with the examiners' observations. The examiners would note that Anthem allowed more time for reinstatement for some and less time for reinstatement for others, resulting in unfair discrimination.

The examiners would caution Anthem that since its letters tie the time frame for reinstatement to the date of the letter, any differences in the date of the processing of the

COPY

letter can change the number of days the insured is given to reinstate. Anthem's procedures tie the time frame for reinstatement to a fixed date, the last paid-to date. In addition, Anthem's procedures do not clearly indicate how many days after the paid-to date are allowed for reinstatement. The discrepancies in Anthem's procedures and letters increase the potential for unfair discrimination.

<u>Individual Dental</u>

A sample of 15 was selected from a population of 518 individual dental policies reinstated during the examination time frame.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 9 violations of this section. An example is discussed in Review Sheet PB03L-AN, where Anthem's cancellation letter to the insured indicated that coverage could not be reinstated; however, this was misleading because Anthem later reinstated the coverage. Anthem partially agreed that the letter was confusing, but Anthem indicated that the letter also included appeal rights if the insured disagreed with the decision, that Anthem had reinstated the policy due to its error applying payments, and that Anthem's letters had subsequently been revised. The examiners would note that the letter specifically stated that coverage could not be reinstated, which is misleading and misrepresented the terms and conditions of the policy because coverage was reinstated. If there are appeal processes and exception requests for reinstatement that are available

COPY

to the insured, Anthem's letter should reflect that fact and inform the insured of those situations in which coverage could be reinstated.

Group

A sample of 20 was selected from a population of 260 group policies reinstated during the examination time frame. The review revealed that Anthem was in compliance with its established procedures for reinstatement

COPY

XII. CANCELLATIONS/NONRENEWALS

The examination included a review of Anthem's cancellation/nonrenewal practices and procedures to determine compliance with the policy provisions, the requirements of § 38.2-508 of the Code covering unfair discrimination, and the notification requirements of § 38.2-3542 C of the Code.

Individual

A sample of 50 was selected from a population of 2,518 individual medical policies; a sample of 20 was selected from a population of 3,425 individual dental policies; and a sample of 20 was selected from a population of 154 individual vision policies cancelled during the examination time frame.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 12 violations of this section. Subsection 2 of § 38.2-508 of the Code states that no person shall unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner. The review revealed 4 violations of this section. An example of each is discussed in Review Sheet CN04D-AN. Anthem's October 6, 2015 letter to the insured provided 2 different dates as the end of the grace period: one paragraph informed the insured that the grace period to pay ended

COPY

on November 6, 2015, but another paragraph indicated that the grace period for claim payments ended on November 1, 2015. The policy only includes one grace period provision of 31 days. On November 2, 2015, Anthem sent another letter informing the insured that the policy was cancelled effective October 1, 2015. Anthem cancelled the policy 4 days prior to the date that Anthem informed the insured was the end of the grace period to pay. Anthem partially agreed with the examiners' observations and responded that:

> The grace period ended 31 days from the premium due date. However, the premium due date in the "Grace Letter" to avoid cancelation reflected a date 31 days from the date of that letter. This allowed the member a few extra days to remit payment. As indicated under "Claims payment during your grace period", although we allowed a few extra days to remit payment past the grace period expiration date, we would not have paid any claims as 11/01 [sic]. While a cancelation letter was sent prior to the 11/06 date, the policy canceled in our membership file on 11/02, if payment was received by 11/06, the policy would have been reinstated. We acknowledge that the Grace and Cancelation letters may have been confusing. In 2016 we went through an extensive letter rewrite in which we clarified the grace period.

The examiners maintain their position. Anthem cancelled the coverage prior to the date the insured was informed was the end of the grace period to pay, and Anthem provided two different dates as the end of the grace period. Anthem unfairly discriminated when terminating the coverage prior to the time frame allowed in its procedures and indicated on its letter, and the letters sent to the insured misrepresented the terms and conditions of the insurance policy. Although the examiners acknowledge that Anthem has indicated that it subsequently took steps to revise the template of the letters, any additional documentation provided regarding the letter revisions will be considered during the corrective action plan review.

COPY

Group

Of the policies cancelled during the examination time frame, a sample of 20 was selected from a population of 712 group medical policies, but Anthem failed to provide documentation for 5 sample files. A sample of 10 was selected from a population of 618 group dental policies, but Anthem failed to provide documentation for these sample files. A sample of 10 was selected from a population of 105 group vision policies, but Anthem failed to provide documentation for 8 of these sample files. The examiners reviewed 17 group cancellation files in the aggregate.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 2 violations of this section. Section 38.2-3542 C of the Code states that in the event the coverage is terminated due to nonpayment of premium by the employer, no such coverages shall be terminated by an insurer until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. The review revealed 2 violations of this section. An example of each is discussed in Review Sheet CN01D-AN. Anthem failed to send the required notice of termination, including the specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. In addition, although Anthem's cancellation letter informed the group that the coverage

COPY

had been terminated effective November 2, 2015, the screen prints from Anthem's system indicate that the group's coverage was cancelled effective November 1, 2015, which is not consistent with what is stated on its letter and is shorter than the 31-day grace period required by the policy. Anthem partially agreed with the examiners' observations and responded that:

> Notice included on invoice. In addition, delinquency notice mailed 11/16/2015 referencing the 31 day grace period. Termination [sic] letter with 12/2 day mailed on 12/7/2015. When funds were not received Anthem chose to write off the balance. When that occurred, our system required to cancelation [sic] on the 1st rather than the 2nd. However, the claims continue to pay for the 31 days, through 12/2/15.

The examiners do not concur. The proper notice, including the actual termination date, was not sent to the group 15 days prior to the cancellation, in violation of the Code. Anthem's letter to the insured did not accurately represent the effective date of Anthem's cancellation of the policy, and Anthem cancelled the policy with an effective date prior to the date the group was informed was the end of the grace period. Anthem did not provide any documentation to support its assertion that it "chose to write off the balance," causing its system to require a different termination date, and that the group's claims would continue to pay through the 31-day grace period. The only screen prints provided to the examiners indicate that the policy was cancelled effective December 1, 2015.

COPY

XIII. COMPLAINTS

Anthem's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include 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 by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The examiners reviewed a sample of 72 from a population of 421 written complaints received during the examination time frame. The review revealed that Anthem was in substantial compliance with this section.

COPY

XIV. CLAIM PRACTICES

The examination included a review of Anthem's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code, as well as 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of group and individual medical, mental health and substance use, dental, vision and pharmacy claims. Anthem contracted with an intermediary, Express Scripts, Inc. (ESI), for the processing of its claims for pharmacy services. The examiners also reviewed a sample of the payments made on stop loss policies.

PAID CLAIM REVIEW

Claims	Population	Sample
Paid Group and Individual Medical	1,310,125	615
Paid Mental Health and Substance Use	99,635	125
Paid Dental	155,127	71
Paid Vision	65,457	39
Paid Pharmacy	1,816,447	150
Stop Loss	1,031	10
Total	**3,447,822**	**1,010**

Paid Group and Individual Medical

A sample of 615 was selected for review from a population of 1,310,125 group and individual medical claims paid during the examination time frame.

Section 38.2- 510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 10 instances of noncompliance with this section. Section 38.2-514 B of the Code states that no person

COPY

shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 1 violation of this section. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of this section. An example of each is discussed in Review Sheet CL67J-AN. The EOB for a claim for services provided by an out-of-network provider failed to indicate that the difference between Anthem's allowable amount and the provider's billed amount was the insured's responsibility. Anthem agreed with the examiners' observations.

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed 15 instances of noncompliance with this section. Section 38.2- 510 A 6 of the Code states that no person shall, with such frequency as to indicate a general business practice, not attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 2 instances of noncompliance with this section. An example of each is discussed in Review Sheet CL26M-AN. The claim was originally received on June 6, 2015 and denied on June 16, 2015. Although no additional information was received, the claim was reopened and paid on July 28, 2015. Anthem failed to adopt and implement reasonable standards for the prompt investigation of this claim and failed to make a prompt, fair and equitable

COPY

settlement of this claim in which liability had become reasonably clear. Anthem agreed with the examiners' observations.

Paid Mental Health & Substance Use

A sample of 125 was selected from a population of 99,635 mental health and substance use claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 3 instances of noncompliance with this section. Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 1 violation of this section. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of this section. An example of each is discussed in Review Sheet CL22M-AN. The coinsurance amount indicated on the EOB was incorrect; therefore, Anthem misrepresented pertinent facts related to the coverages at issue and failed to provide an EOB that clearly and accurately disclosed the method of benefit calculation and the benefits payable under the contract. Anthem agreed with the examiners' observations.

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable

COPY

standards for the prompt investigation of claims arising under insurance policies. The review revealed 4 instances of noncompliance with this section. An example is discussed in Review Sheet CL49J-AN. The claim was received on June 15, 2015 and paid on September 28, 2015. Anthem failed to adopt and implement reasonable standards for the prompt investigation of this claim. Anthem agreed with the examiners' observations.

Paid Dental

A sample of 71 was selected from a population of 155,127 dental claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 1 instance of noncompliance with this section. Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 1 violation of this section. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of this section. An example of each is discussed in Review Sheet CL69J-AN. The EOB for a claim for services provided by an out-of-network provider failed to indicate that the difference between Anthem's allowable amount and the provider's billed amount was the insured's responsibility. Anthem disagreed, indicating that it had an agreement with a

COPY

vendor, Stratose, that authorized discounts from the out-of-network provider. The examiners would note that referring to out-of-network providers participating in this type of arrangement as being part of a network would be incorrect, misleading, and may result in confusion among plan members. The EOB indicated that the difference between the Allowed Amount and Submitted Amount was “Network Savings” and that the insured “Used Stratose DenteMax Network”; therefore, Anthem incorrectly referred to this arrangement as a “network” and indicated that the discount was “network savings”, misrepresented pertinent facts related to the coverages at issue and failed to provide an EOB that clearly and accurately disclosed the method of benefit calculation and the benefits payable under the contract.

Paid Vision

A sample of 39 was selected from a population of 65,457 vision claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Paid Pharmacy

A sample of 150 was selected from a population of 1,816,447 pharmacy claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 2 instances of noncompliance with this section. An example is discussed in Review Sheet CL19B-AN, where coinsurance was incorrectly applied to a claim when the EOC indicated that a copay was required. Anthem failed to respond to the examiners’ observations.

COPY

Section 38.2-3407.3 A of the Code states that an insurer that issues a contract pursuant to which the insured 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 insured. The review revealed 2 violations of this section. An example is discussed in Review Sheet CL77B-AN, where Anthem calculated the insured's coinsurance on an amount that exceeded the amount that the pharmacy was actually paid. Anthem disagreed and explained the calculation of its payment to the pharmacy benefit manager. The examiners would note that for this claim, the pharmacy (not the pharmacy benefit manager) is the provider of services, and the actual payment made to the pharmacy is less than the amount that Anthem used to calculate the insured's coinsurance. Therefore, Anthem calculated the coinsurance amount payable by the insured on an amount that exceeded the amount actually paid or payable to the provider of such services.

Please note that § 38.2-3407.3 B of the Code states that any insurer failing to administer its contracts as set forth herein shall be deemed to have committed a knowing violation of this section.

<u>Stop Loss</u>

A sample of 10 was selected from a population of 1,031 credits or payments made on stop loss policies during the examination time frame. In addition, the examiners also reviewed the 10 original stop loss underwriting sample files to determine whether payments were made in accordance with the policies.

COPY

Section 38.2-109 B of the Code of Virginia states that losses resulting from health care claims or expenses of health care in excess of a specific or aggregate dollar amount shall be clearly disclosed in the extent and duration of the liability assumed by the insurer once the policyholder's liability has been exceeded. The review revealed 1 violation of this section. Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 1 instance of noncompliance with this section. An example of each is discussed in Review Sheet CL02JA-AN. Although Anthem provided additional information regarding the calculation of the credits made under this policy, the specific stop loss limit applied by Anthem was not the specific stop loss limit that was stated in the policy. Therefore, Anthem failed to clearly disclose the liability assumed by the insurer and misrepresented pertinent facts relating to the coverage.

Subrogation

During the Ethics and Fairness in Carrier Business Practices review of provider claims, an issue was revealed concerning one of the sample provider claims that resulted in that provider claim being incorporated into the paid claims review.

Section 38.2-3405 B of the Code states that no such contract, subscription contract or health services plan shall contain any provision requiring the beneficiary of any such contract or plan to sign any agreement to pay back to any company issuing such a contract or creating a health services plan any benefits paid pursuant to the terms of such contract or plan from the proceeds of a recovery by such a beneficiary from any other source; provided, that this provision shall not prohibit an exclusion of benefits paid or

COPY

payable under workers' compensation laws or federal or state programs, nor shall this provision prohibit coordination of benefits provisions when there are two or more such accident and sickness insurance contracts or plans providing for the payment of the same benefits. Coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. As discussed in Review Sheet CL02D-AN, the review revealed 1 violation of this section. Anthem's initial processing of this claim involved subrogation. Anthem agreed with the examiners' observations.

INTEREST

Section 38.2-3407.1 B of the Code sets forth the requirement that interest on claims proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of the claim payment. The review revealed 70 violations of this section. There were 9 instances where the amount of interest due was underpaid. An example is discussed in Review Sheet CL47J-AN, where Anthem agreed that it underpaid the amount of statutory interest due. In 61 instances, no interest was paid. An example is discussed in CL54M-AN, where Anthem agreed that it failed to pay the statutory interest due.

Due to the fact that the prior Report included violations of § 38.2-3407.1 B of the Code, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

COPY

DENIED CLAIM REVIEW

Claims	Population	Sample
Denied Group and Individual Medical	152,388	260
Denied Mental Health and Substance Use	15,808	90
Denied Dental	28,211	37
Denied Vision	5,229	13
Denied Pharmacy	601,815	100
Total	**803,451**	**500**

Denied Group and Individual Medical

A sample of 260 was selected for review from a population of 152,388 group and individual medical claims denied during the examination time frame. Unfair claims settlement practices and violations are discussed in subsequent sections.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 3 instances of noncompliance with this section. Section 38.2-510 A 4 of the Code states that no person shall, with such frequency as to indicate a general business practice, refuse arbitrarily and unreasonably to pay claims. The review revealed 1 instance of noncompliance with this section. An example of each is discussed in review sheet CL13M-AN. This claim was denied with a reason code stating that "the patient was not an eligible member at the time services were rendered." The patient was a newborn child and, according to the EOC, was covered automatically from the moment of birth. Anthem misrepresented pertinent facts related to the coverages at issue and refused arbitrarily and unreasonably to pay the claim. Anthem agreed with the examiners' observations.

COPY

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed 10 instances of noncompliance with this section. An example is discussed in Review Sheet CL03M-AN. The original claim was received on January 27, 2015 and denied on February 17, 2015. A corrected claim was submitted on May 5, 2015 and was paid on July 7, 2015; therefore, Anthem failed to adopt and implement reasonable standards for the prompt investigation of this corrected claim.

Denied Mental Health & Substance Use

A sample of 90 was selected for review from a population of 15,808 mental health and substance use claims denied during the examination time frame.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue. The review revealed 1 instance of noncompliance with this section. Section 38.2-510 A 4 of the Code states that no person shall, with such frequency as to indicate a general business practice, refuse arbitrarily and unreasonably to pay claims. The review revealed 1 instance of noncompliance with this section. An example of each is discussed in Review Sheet CL24J-AN. The denial states, in part, that "Medical review is needed for this type of service. We have asked your provider to contact us for information regarding the review process." Anthem's Health Service Review guidelines indicate that the procedure code on the claim, 90832, does not require authorization; therefore, Anthem misrepresented pertinent facts related to the

COPY

coverages at issue and refused arbitrarily and unreasonably to pay the claim. Anthem agreed with the examiners' observations.

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed 5 instances of noncompliance with this section. An example is discussed in Review Sheet CL61M-AN. The claim was received on July 1, 2015 and paid on September 17, 2015. The claim was reopened on September 25, 2015, and an additional amount was paid on November 18, 2015. Anthem failed to adopt and implement reasonable standards for the prompt investigation of this claim.

Anthem disagreed with the examiners observations, stating that:

> The original claim was received on 9/3/2015 and paid on 9/15/2015. The Host Plan sent in a corrected claim on the provider's behalf on 11/8/2015 (create date of request). With the adjustment reason code of 287 used for high volume adjustments, this claim was not subject to prompt pay interest in accordance with BCBSA BlueCard guidelines.

The examiners do not concur and would note that the screen print provided by Anthem indicates that the receipt date of the adjustment request was September 25, 2015. The claim was adjusted on November 18, 2015, which is 37 working days after the adjustment request was received.

Denied Dental

A sample of 37 was selected from a population of 28,211 dental claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

COPY

Denied Vision

A sample of 13 was selected from a population of 5,229 vision claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the policy provisions.

Denied Pharmacy

A sample of 100 was selected from a population of 601,815 pharmacy claims denied during the examination time frame.

Section 38.2-510 A 5 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The review revealed 1 instance of noncompliance with this section. Section 38.2-510 A 14 of the Code of Virginia states that no person shall, with such frequency as to indicate a general business practice, fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim. The review revealed 3 instances of noncompliance with this section. An example of each is discussed in Review Sheet CL58B-AN, where Anthem failed to send notification of a pharmacy claim denial to the insured. Anthem disagreed, indicating that the claim would have been rejected during the point-of-sale transaction at the pharmacy. The examiners would note that according to the screen prints, this claim was for services from a mail-order pharmacy, so the insured was not present during the transaction; therefore, Anthem failed to notify the insured of the denial of the claim and failed to provide a reasonable explanation of the basis for the denial.

COPY

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The sample of 1,010 paid claims and 500 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices. The review was conducted by adding 3 days to the date of the remit or check as the settlement date.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time. The review revealed 16 instances of noncompliance with this section. An example is discussed in Review Sheet CL01J-AN. Anthem agreed with the examiners' observations.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer. The review revealed 45 instances of noncompliance with this section. An example is discussed in Review Sheet CL62J-AN. Anthem agreed with the examiners' observations.

14 VAC 5-400-70 A requires that any denial of a claim shall be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial. The review revealed 7 instances of noncompliance with this section. An example is discussed in Review Sheet CL50M-AN, where Anthem failed to send a written denial. Anthem disagreed, indicating that it suppressed the EOB because the insured's policy had cancelled on 1/1/2014 and it wasn't sure if it had a correct address for the insured. The examiners would note that Anthem sent a notice acknowledging receipt of the claim and the claim file did not contain evidence of returned mail.

COPY

14 VAC 5-400-70 B requires an insurer to include a reasonable explanation of the basis for the denial of a claim in the written denial. The review revealed 32 instances of noncompliance with this section. An example is discussed in Review Sheet CL39J-AN, where the claim was incorrectly denied with a reason code indicating that Medical Review was needed for this type of service. Anthem agreed with the examiners' observations.

14 VAC 5-400-70 D requires an insurer to offer a claimant an amount that is fair and reasonable. The review revealed 17 instances of noncompliance with this section. An example is discussed in Review Sheet CL54J-AN, where Anthem incorrectly calculated its payment to an ambulance provider. Anthem agreed with the examiners' observations. Consequently, the examiners requested additional information in CLMEM03J-AN regarding ambulance and air ambulance payments. Anthem performed an internal audit of claims, and it has indicated that claims affected by this issue have been re-adjudicated and that, as of November 1, 2016, the system error has been corrected.

COPY

SUMMARY

For Large Group denied claims, Anthem's failure to comply with 14 VAC 5-400-60 A, 14 VAC 5-400-70 A and 14 VAC 5-400-70 B occurred with such frequency as to indicate a general business practice, placing it in violation of these sections. Regarding 14 VAC 5-400-70 A, the examiners note that Anthem indicated that its practice was to suppress EOBs if records show that a member's coverage had been cancelled, indicating that this was a general business practice.

Due to the fact that the prior Report included violations of 14 VAC 5-400-60 A, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

OUT-OF-POCKET MAXIMUM

The examiners reviewed a sample of 20 from a population of 15,139 insureds who had met their out-of-pocket maximum during the examination time frame. An additional sample of 5 members from the general claims population was also reviewed.

Section 38.2-510 A 1 of the Code states that no person shall, with such frequency as to indicate a general business practice misrepresent pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed 2 violations of this section. Section 38.2-510 A 6 of the Code states that no person shall, with such frequency as to indicate a general business practice not attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 2 violations of this section. An example of each is discussed in Review Sheet CL70J-AN. The Evidence of Coverage provided to the examiners reflected a $4,500.00 out-of-pocket maximum; however, the insured's cost-sharing accumulation was $5,307.34, which resulted in the insured being held responsible for $807.34 over their out-of-pocket maximum. In addition, Anthem failed to promptly refund to the insured all cost-sharing charged after the out-of-pocket maximum was reached. Anthem agreed with the examiners' observations.

COPY

THREATENED LITIGATION

Anthem informed the examiners that no claim files involving threatened litigation were received during the examination time frame.

XV. CORRECTIVE ACTION PLAN

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

1. Review and strengthen its procedures to ensure that it notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 1;
2. Review and strengthen its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;
3. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code, including every provider contract with a pharmacy, contains the specific provisions required by § 38.2-3407.15 B of the Code;
4. Amend all provider contracts containing language inhibiting the provider's ability to ensure that claims are paid in accordance with the fee schedule, an example of which is discussed in Review Sheet EF09D-AN, to remove such language, as required by § 38.2-3407.15 B 8 of the Code;
5. Strengthen its established procedures to ensure that all clean claims are paid within 40 days as required by § 38.2-3407.15 B 1 of the Code;
6. Strengthen and maintain procedures for the payment of interest on accident and sickness claim proceeds, including pharmacy claims, as required by § 38.2-3407.15 B 3 and § 38.2-3407.1 B of the Code;
7. Establish and maintain business practices to ensure that all contracts with an intermediary pursuant to which the intermediary has the right or obligation to

COPY

conduct audits of participating pharmacy providers, contain the specific provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code;

8. Strengthen and maintain procedures to ensure that the content of each advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive, as required by 14 VAC 5-90-50 A;
9. Strengthen and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A;
10. Strengthen and maintain procedures to ensure that each advertisement complies with the requirements regarding the words and phrases identified in 14 VAC 5-90-60 A 2;
11. Strengthen and maintain procedures to ensure that statistical information shall not be used in advertisements unless it accurately reflects all current and relevant facts, as required by 14 VAC 5-90-90 A;
12. Strengthen and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C;
13. Establish and maintain procedures to ensure that the accuracy of form numbers on issued forms is carefully confirmed to avoid typos or deletions;
14. Establish and maintain procedures to ensure that all Schedule of Benefits forms and applications are filed with and approved by the Commission, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;
15. Establish and maintain procedures to ensure that all Stop Loss policies and applications are filed with and approved by the Commission, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;

COPY

16. Strengthen its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;
17. Establish and maintain procedures to notify agents/agencies of termination of their appointments within 5 calendar days, as required by § 38.2-1834 D of the Code;
18. Establish and maintain specific underwriting procedures for Stop Loss rating that provide clear guidelines and ranges/limits on when and how much of a discretionary adjustment is applied for all rating steps that currently involve potentially unlimited underwriter and/or management discretion, and revise and re-file the rates as necessary, to prevent unfair discrimination, as required by § 38.2-508 of the Code;
19. Establish and maintain procedures to ensure that in the event coverage is terminated due to nonpayment of premium by the employer, Anthem provides the employer with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid, in order to maintain compliance with § 38.2-3542 C of the Code;
20. Establish and maintain clear and consistent procedures for cancellations and reinstatements, and revise its letters to provide clear and accurate information about the terms and conditions of the policy, the grace period, and the cancellation date or any other effective dates, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

COPY

21. Strengthen and maintain its recordkeeping involving the documentation of information that is included in the written notice of a renewal rate increase and when it is presented to the group;
22. Strengthen and maintain its procedures to ensure that the notice of intent to increase the premium charge or deductible is provided in writing at least 75 days prior to the proposed renewal of individual coverage, as required by § 38.2-3407.14 C of the Code;
23. Strengthen and maintain its established procedures to ensure that claims are processed in accordance with the requirements of § 38.2-510 of the Code and 14 VAC 5-400-10 et seq.;
24. Review and reconsider for re-adjudication all claims paid on the WGS system that required any manual processing and took longer than 15 working days to pay and all pharmacy claims that took longer than 15 working days to pay for the years of 2015, 2016, 2017, 2018, 2019 and the current year, as well as the claims discussed in the review sheets submitted to Anthem during the examination (for which a spreadsheet will be provided to Anthem), and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

COPY

25. As recommended in the prior Report, strengthen and maintain procedures for the payment of interest on accident and sickness claim proceeds, including pharmacy claims, as required by § 38.2-3407.1 B of the Code;
26. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services, and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;
27. Establish and maintain procedures, and revise existing practices, to ensure that all claims, including pharmacy claims, are processed in accordance with § 38.2-3407.3 A of the Code;
28. Provide the examiners with documentation regarding the number of claims that were re-adjudicated and the total amount of additional payments made, including interest, as a result of the internal audit of ambulance and air ambulance claims discussed in CLMEM03J-AN;
29. Establish and maintain procedures and claim system processes to ensure that accurate records of the accumulation of insured cost-sharing are kept; that each insured is notified when his or her out-of-pocket maximum is met; that Anthem does not charge additional cost-sharing for the remainder of the contract or calendar year, as appropriate; and that Anthem promptly refunds all cost-sharing payments charged after the out-of-pocket maximum is reached;

COPY

30. Review and reopen all claims for all insureds who exceeded their out-of-pocket maximum during the years of 2015, 2016, 2017, 2018, 2019 and the current year and promptly refund all cost-sharing payments charged to the insured after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the insured. 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 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;
31. Within 90 days of this report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

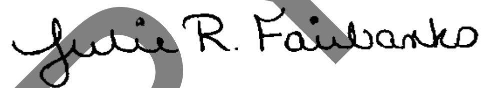
COPY

XVI. ACKNOWLEDGMENT

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

Bryan Wachter, FLMI, AIRC, MCM, CIE, Laura Wilson, MCM, Melissa Gerachis, FLMI, AIRC, AMCM, Janay Brown, MCM, Freddie Oliver, MCM, Daniel Abbondanzo, and Julie Atkins of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,



Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

COPY

XVII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaints/Appeals
14 VAC 5-216-40 E 1, **3 violations**, MC01L-AN, MC02L-AN, MC03L-AN
§ 38.2-5804 A 3 violations, MC01L-AN, MC02L-AN, MC03L-AN
Subsection 1 of § 38.2-502, 1 violation, MC05L-AN
Provider Contracts
§ 38.2-5805 B, 1 violation, EFCL08F-AN
INTERNAL APPEAL AND EXTERNAL REVIEW
§ 38.2-3561 J, 2 violations, EX01L-AN, EX02L-AN
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 2, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 3, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 4, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 5, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 6, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 7, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 8, 5 violations, EF01B-AN, EF02B-AN, EF01D-AN, EF09D-AN, EF02F-AN
§ 38.2-3407.15 B 9, 2 violations, EF01B-AN, EF02B-AN
§ 38.2-3407.15 B 10, 2 violations, EF01B-AN, EF02B-AN
Provider Claims

COPY

§ 38.2-3407.15 B 1, 5 violations, EFCL01D-AN, EFCL03D-AN, EFCL09D-AN, EFCL16D-AN, EFCL18D-AN
§ 38.2-3407.15 B 3, 14 violations, EFCL01B-AN, EFCL02B-AN, EFCL03B-AN, EFCL04B-AN, EFCL05B-AN, EFCL06B-AN, EFCL07B-AN, EFCL08B-AN, EFCL09B-AN, EFCL10B-AN, EFCL11B-AN, EFCL01D-AN, EFCL16D-AN, EFCL18D-AN
REQUIRED PROVISIONS IN CARRIER CONTRACTS WITH PHARMACY PROVIDERS
§ 38.2-3407.15:1 B 1, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 2, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 3, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 4, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 5, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 6, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 7, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 8, 1 violation, EF03B-AN
§ 38.2-3407.15:1 B 9, 1 violation, EF03B-AN
§ 38.2-3407.15:1 C, 1 violation, EF03B-AN
ADVERTISING
14 VAC 5-90-50 A, 7 violations, AD03D-AN, AD04D-AN, AD11D-AN, AD12D-AN, AD13D-AN, AD06F-AN, AD07F-AN
14 VAC 5-90-55 A, 3 violations, AD02D-AN, AD06F-AN, AD07F-AN
14 VAC 5-90-55 B, 1 violation, AD02D-AN
14 VAC 5-90-60 A 2, 3 violations, AD02D-AN, AD05D-AN, AD07F-AN

COPY

14 VAC 5-90-90 A, 6 violations, AD01D-AN, AD03D-AN, AD04D-AN, AD01F-AN, AD03F-AN, AD09F-AN
14 VAC 5-90-90 C, 11 violations, AD02D-AN, AD04D-AN, AD06D-AN, AD07D-AN, AD08D-AN, AD12D-AN, AD02F-AN, AD04F-AN, AD06F-AN, AD07F-AN, AD08F-AN
14 VAC 5-90-110, 1 violation, AD07D-AN
POLICY AND OTHER FORMS
§ 38.2-316 A, 4 violations, PF01F-AN, PF02F-AN, PF03F-AN, PF01JA-AN
§ 38.2-316 B, 2 violations, PF07F-AN, PF01JA-AN
§ 38.2-316 C 1, 6 violations, PF01F-AN, PF02F-AN, PF03F-AN, PF07F-AN, PF01JA-AN (2)
AGENTS
§ 38.2-1812 A, 3 violations, AG25F-AN (2), AG02JA-AN
§ 38.2-1833 A 1, 4 violations, AG25F-AN (2), AG01JA-AN, AG02JA-AN
§ 38.2-1834 D, 73 violations, AG01F-AN (63), AG02F-AN (10)
RENEWALS, PREMIUM NOTICES, COLLECTIONS, REINSTATEMENTS
Renewals
§ 38.2-3407.14 C, 5 violations, PB03D-AN, PB04D-AN, PB05D-AN, PB06D-AN, PB07D-AN
Reinstatements
Subsection 1 of § 38.2-502, 11 violations, PB01L-AN, PB02L-AN, PB03L-AN, PB04L-AN, PB05L-AN, PB06L-AN, PB07L-AN, PB08L-AN, PB09L-AN, PB10L-AN, PB11L-AN
Subsection 2 of § 38.2-508, 8 violations, PB12L-AN (8)

COPY

CANCELLATIONS/NON-RENEWALS/RESCISSIONS
Subsection 1 of § 38.2-502, 14 violations, CN01D-AN, CN02D-AN, CN03D-AN, CN04D-AN, CN05D-AN, CN06D-AN, CN07D-AN, CN08D-AN, CN09D-AN, CN10D-AN, CN11D-AN, CN12D-AN, CN13D-AN, CN14D-AN
Subsection 2 of § 38.2-508, 4 violations, CN02D-AN, CN04D-AN, CN05D-AN, CN14D-AN
§ 38.2-3542 C, 2 violations, CN01D-AN, CN13D-AN
CLAIM PRACTICES
§ 38.2-109 B, 1 violation, CL02JA-AN
§ 38.2-510 A 1, 23 instances of non-compliance, CL19B-AN, CL23B-AN, CL03J-AN, CL04J-AN, CL05J-AN, CL06J-AN, CL08J-AN, CL11J-AN, CL12J-AN, CL17J-AN, CL24J-AN, CL67J-AN, CL69J-AN, CL70J-AN, CL71J-AN, CL02JA-AN, CL13M-AN, CL22M-AN, CL26M-AN, CL28M-AN, CL35M-AN, CL41M-AN, CL42M-AN
§ 38.2-510 A 3, 34 instances of non-compliance, CL01J-AN, CL02J-AN, CL03J-AN, CL04J-AN, CL05J-AN, CL06J-AN, CL07J-AN, CL08J-AN, CL09J-AN, CL12J-AN, CL14J-AN, CL16J-AN, CL18J-AN, CL33J-AN, CL34J-AN, CL37J-AN, CL39J-AN, CL43J-AN, CL49J-AN, CL60J-AN, CL61J-AN, CL63J-AN, CL01M-AN, CL02M-AN, CL03M-AN, CL15M-AN, CL16M-AN, CL18M-AN, CL21M-AN, CL26M-AN, CL29M-AN, CL41M-AN, CL54M-AN, CL61M-AN
§ 38.2-510 A 4, 2 instances of non-compliance, CL24J-AN**,** CL13M-AN
§ 38.2-510 A 5, 1 instance of non-compliance, CL58B-AN
§ 38.2-510 A 6, 4 instances of non-compliance, CL70J-AN, CL71J-AN, CL26M-AN, CL41M-AN
§ 38.2-510 A 14, 3 instances of non-compliance, CL53B-AN, CL58B-AN, CL69B-AN

COPY

§ 38.2-514 B, 3 violations, CL67J-AN, CL69J-AN, CL22M-AN

§ 38.2-3405 B, 1 violation, CL02D-AN

§ 38.2-3407.1 B, 70 violations, CL01B-AN, CL02B-AN, CL04B-AN, CL05B-AN, CL06B-AN, CL07B-AN, CL08B-AN, CL09B-AN, CL10B-AN, CL11B-AN, CL12B-AN, CL13B-AN, CL14B-AN, CL15B-AN, CL016B-AN, CL17B-AN, CL18B-AN, CL20B-AN, CL21B-AN, CL22B-AN, CL23B-AN, CL24B-AN, CL25B-AN, CL26B-AN, CL27B-AN, CL28B-AN, CL29B-AN, CL30B-AN, CL31B-AN, CL32B-AN, CL33B-AN, CL34B-AN, CL35B-AN, CL36B-AN, CL37B-AN, CL38B-AN, CL39B-AN, CL40B-AN, CL41B-AN, CL42B-AN, CL43B-AN, CL44B-AN, CL45B-AN, CL46B-AN, CL47B-AN, CL48B-AN, CL49B-AN, CL50B-AN, CL51B-AN, CL73B-AN, CL74B-AN, CL75B-AN, CL78B-AN, CL79B-AN, CL07J-AN, CL08J-AN, CL16J-AN, CL18J-AN, CL34J-AN, CL46J-AN, CL47J-AN, CL48J-AN, CL49J-AN, CL62J-AN, CL63J-AN, CL03M-AN, CL09M-AN, CL30M-AN, CL54M-AN, CL61M-AN

§ 38.2-3407.3 A, 2 violations, CL77B-AN, CL80B-AN

§ 38.2-3407.4 B, 3 violations, CL67J-AN, CL69J-AN, CL22M-AN

14 VAC 5-400-50 A, 16 instances of non-compliance, CL01J-AN, CL15J-AN, CL26J-AN, CL27J-AN, CL33J-AN, CL43J-AN, CL47J-AN, CL48J-AN, CL49J-AN, CL62J-AN, CL66J-AN, CL23M-AN, CL24M-AN, CL30M-AN, CL39M-AN, CL43M-AN

14 VAC 5-400-60 A, 45 violations, CL01J-AN, CL10J-AN, CL15J-AN, CL17J-AN, CL19J-AN, CL21J-AN, CL23J-AN, CL27J-AN, CL28J-AN, CL29J-AN, CL30J-AN, CL31J-AN, CL32J-AN, CL33J-AN, CL41J-AN, CL44J-AN, CL45J-AN, CL46J-AN, CL47J-AN, CL48J-AN, CL52J-AN, CL57J-AN, CL62J-AN, CL04M-AN, CL05M-AM, CL07M-AN, CL11M-AN, CL23M-AN, CL24M-AN, CL27M-AN, CL28M-AN, CL30M-AN, CL31M-AN, CL32M-AN, CL33M-AN, CL34M-AN, CL39M-AN, CL44M-AN, CL49M-AN, CL50M-AN, CL51M-AN, CL56M-AN, CL57M-AN, CL59M-AN, CL62M-AN

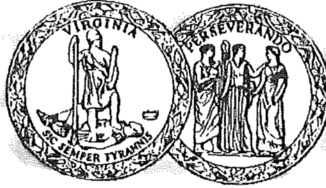
COPY

14 VAC 5-400-70 A, 7 violations, CL49M-AN, CL50M-AN, CL51M-AN, CL56M-AN, CL57M-AN, CL59M-AN, CL62M-AN
14 VAC 5-400-70 B, 32 violations, CL02J-AN, CL05J-AN, CL07J-AN, CL09J-AN, CL12J-AN, CL17J-AN, CL20J-AN, CL24J-AN, CL39J-AN, CL49J-AN, CL50J-AN, CL51J-AN, CL60J-AN, CL61J-AN, CL63J-AN, CL09M-AN, CL10M-AN, CL11M-AN, CL12M-AN, CL13M-AN, CL21M-AN, CL47M-AN, CL48M-AN, CL49M-AN, CL50M-AN, CL51M-AN, CL52M-AN, CL55M-AN, CL56M-AN, CL57M-AN, CL59M-AN, CL62M-AN
14 VAC 5-400-70 D, 17 instances of non-compliance, CL23B-AN, CL53B-AN, CL69B-AN, CL24J-AN, CL53J-AN, CL54J-AN, CL55J-AN, CL56J-AN, CL58J-AN, CL09M-AN, CL10M-AN, CL12M-AN, CL13M-AN, CL22M-AN, CL28M-AN, CL35M-AN, CL42M-AN

COPY

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA



P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

August 19, 2019

SENT VIA E-MAIL

Kimberly J. Stevens
Regulatory Compliance Director – VA
Anthem Health Plans of Virginia, Inc.
2015 Staples Mill Road
Richmond, VA 23230

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Stevens:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Anthem Health Plans of Virginia, Inc. for the period of July 1, 2015 through December 31, 2015. 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 Anthem Health Plans of Virginia, Inc. 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. Anthem Health Plans of Virginia, Inc. 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 R. Fairbanks, AIE, AIRC, FLMI, ACS, MCM
Manager
Life and Health Market Regulation Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Julie Blauvelt

COPY

P.O. Box 27401
Richmond, VA 23279

October 18, 2019

VIA EMAIL

Ms. Julie Fairbanks
BOI Manager
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

Re: Anthem Health Plans of Virginia, Inc., Exposure Draft Report

Dear Ms. Fairbanks,

Enclosed you will find Anthem Health Plans of Virginia, Inc.'s response to the 2015 Market Conduct Examination Draft Report. Each corrective action has been addressed. We can provide reference materials and supporting documentation for corrective actions that have already been addressed if necessary.

If I can provide any additional information, please do not hesitate to contact me.

Sincerely,

Kimberly Stevens

Kimberly Stevens
Compliance Director
O: (804) 354-2035
M: (804) 357-6393
kimberly.stevens@anthem.com

Enclosures

COPY

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Target Market Conduct Examination
Response to Recommendations
Anthem Health Plans of Virginia, Inc.

Below please find our responses to each of the recommendations in the draft report for Anthem Health Plans of Virginia, Inc. (Anthem/the Company).

1. Review and strengthen its procedures to ensure that it notifies the covered person of the final benefit determination within the appropriate time frame, as required by 14 VAC 5-216-40 E 1;

   Anthem has reviewed each of the appeal violations identified in the examination. The violations noted were a result of individual associate errors and do not reflect the Company's overall practice. The individual associates have been addressed. Anthem does have procedures in place to ensure covered persons are notified of the final benefit determination within the appropriate time frame as required by 14 VAC 5-216-40 E 1. These procedures are frequently reviewed with, and easily accessible by, our associates.

2. Review and strengthen its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code;

   The examination identified variances between Anthem's approved complaint system and some of the Company's practices.

   As a result, the Company has reviewed its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by § 38.2-5804 A of the Code. Further, associates received additional coaching on the importance of following, and monitoring, established policies and procedures.

   The Company's complaint system was revised to align with its practices, and the revised complaint system was approved by the Commission effective November 17, 2017, fully remediating this issue.

3. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code, including every provider contract with a pharmacy, contains the specific provisions required by § 38.2-3407.15 B of the Code;

   Provider contracts with a pharmacy contain the specific provisions required by § 38.2-3407.15 B of the Code. Pharmacy agreements were amended on November 4, 2016 (effective November 4, 2017), through the "Network Pharmacy Weekly", fully remediating this issue for pharmacy.

4. Amend all provider contracts containing language inhibiting the provider's ability to ensure that claims are paid in accordance with the fee schedule, an example of which is discussed in Review Sheet EF09D-AN, to remove such language, as required by § 38.2-3407.15 B 8 of the Code;

   Anthem will amend its direct contracts containing the "Special Compensation" amendment to remove the language inhibiting the provider's ability to ensure that claims are paid in according with the fee schedule, as required by § 38.2-3407.15 B 8 of the Code for new and renewing contracts. The revised language will read as follows:

COPY

The provider is responsible for reporting any discrepancy in payment within sixty (60) calendar days of such payment. If provider fails to do so, we reserve the right to recalculate underpaid claims at the standard applicable Anthem rate.

5. Strengthen its established procedures to ensure that all clean claims are paid within 40 days as required by § 38.2-3407.15 B 1 of the Code;

   Anthem reviewed each of the findings and agrees clean claims were not always paid as required by the Code. This was a result of an outdated guidelines for our CHIPS claims platform and human error on other claim platforms. The outdated guidelines were updated in 2017 and shared with the associates. For claims that were processed incorrectly, coaching was provided.

6. Strengthen and maintain procedures for the payment of interest on accident and sickness claim proceeds, including pharmacy claims, as required by § 38.2-3407.15 B 3 and § 38.2-3407.1 B of the Code;

   Anthem has taken significant steps to strengthen its procedures for the payment of interest due on claim proceeds, as required by the Code. Some examples of enhancements include:
   - Holding monthly meetings to discuss prompt pay issues;
   - Implementation of the Interactive Decision Guide, which is a tool that can be used by associates to help them correctly identify the clean claim date for adjustments;
   - Consolidation of training documents for clean claim date determinations; and
   - Internal targeted audits.

   Express Scripts revised its systems and processes to ensure that interest payments are made accordingly. This issue was completely remediated on November 20, 2017. Remediation included putting a process in place to ensure interest was paid when required and adjusting claims for January 1, 2015 – November 20, 2017. Claims paid on or after November 20, 2017, received the required interest. Anthem has terminated its relationship with Express Scripts since the Exam.

COPY

7. Establish and maintain business practices to ensure that all contracts with an intermediary pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, contain the specific provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code;

   Anthem will ensure its contracts with an intermediary pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, contain the specific provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code.

8. Strengthen and maintain procedures to ensure that the content of each advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive, as required by 14 VAC 5-90-50 A;

   Anthem has made significant progress in ensuring compliance with 14 VAC 5-90-50 A. The Company has provided additional training and coaching and has tools that are easily accessible which outline requirements. The Company will also take additional steps to further ensure compliance.

9. Strengthen and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A;

   Anthem has made significant progress in ensuring that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A. The Company has provided additional training and coaching and has tools that are easily accessible which outline requirements. The Company will also take additional steps to further ensure compliance.

10. Strengthen and maintain procedures to ensure that each advertisement complies with the requirements regarding the words and phrases identified in 14 VAC 5-90-60 A 2;

   Anthem has made significant progress in ensuring that each advertisement complies with the requirements regarding the words and phrases identified in 14 VAC 5-90-60 A 2. The Company has provided additional training and coaching and has tools that are easily accessible which outline requirements. The Company will also take additional steps to further ensure compliance.

11. Strengthen and maintain procedures to ensure that statistical information shall not be used in advertisements unless it accurately reflects all current and relevant facts, as required by 14 VAC 5-90-90 A;

   Anthem has made significant progress in ensuring that each invitation to inquire contains the disclosure required by 14 VAC 5-90-90 A. Associates have been coached on the importance of identifying all sources even if data is specific to the Company's statistics. Further, all advertisements will be reviewed to ensure any statistic is identified.

12. Strengthen and maintain procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C;

   Anthem has reviewed its procedures to ensure that the source of any statistic used in an advertisement is identified, as required by 14 VAC 5-90-90 C. Associates have been coached on the importance of identifying sources, even if the data is specific to the Company's statistics. Further, all advertisements will be reviewed to ensure any statistic is identified.

13. Establish and maintain procedures to ensure that the accuracy of form numbers on issued forms is carefully confirmed to avoid typos or deletions;

   The Company will look at ways to enhance its existing procedures to ensure that the accuracy of form numbers on issued forms is carefully confirmed to avoid typos or deletions.

14. Establish and maintain procedures to ensure that all Schedule of Benefits forms and applications are filed with and approved by the Commission, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;

   The violations identified during the Exam were the result of 1) human error and 2) a typographical error. Both violations have been addressed either by coaching or the standardization described in #13.

15. Establish and maintain procedures to ensure that all Stop Loss policies and applications are filed with and approved by the Commission, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;

COPY

The Company has procedures in place to ensure that all Stop Loss policies and applications are filed with and approved by the Commission as required by Code. The Company considered the review sheets and noted that associate error resulted in it appearing that policies and applications were not filed/approved.

16. Strengthen its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents;

    Anthem has strengthened its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 regarding the payment of commission to agents and the appointment of agents. Effective May 1, 2019, an improved process was put in place to identify un-appointed agents when submitting an application and to ensure they are appointed and communicated to within the required timeframes. These changes to the process ensures compliance, fully remediating this issue.

17. Establish and maintain procedures to notify agents/agencies of termination of their appointments within 5 calendar days, as required by § 38.2-1834 D of the Code;

    Effective May 12, 2017, the Company enhanced its systems and procedures, to ensure agents/agencies are notified of termination of their appointments within 5 calendar days as required by as required by § 38.2-1834 D of the Code effective May 12, 2017, which fully remediates this issue.

18. Establish and maintain specific underwriting procedures for Stop Loss rating that provide clear guidelines and ranges/limits on when and how much of a discretionary adjustment is applied for all rating steps that currently involve potentially unlimited underwriter and/or management discretion, and revise and re-file the rates as necessary, to prevent unfair discrimination, as required by § 38.2-508 of the Code;

    The Company will review our procedures for Stop Loss rating and enhance them accordingly.

19. Establish and maintain procedures to ensure that in the event coverage is terminated due to nonpayment of premium by the employer, Anthem provides the employer with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid, in order to maintain compliance with § 38.2-3542 C of the Code;

    Anthem continues to maintain its position that it was already compliant with §38.2-3542 C of the Code at the time of the Exam. However, we have enhanced our procedures, as well as enhanced our systems and implemented new communication procedures, to ensure that that in the event the coverage is terminated due to nonpayment of premium by the employer, that the Company provides the employer with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid, in order to maintain compliance with § 38.2-3542 C of the Code effective January 17, 2019.

20. Establish and maintain clear and consistent procedures for cancellations and reinstatements, and revise its letters to provide clear and accurate information about the terms and conditions of the policy, the grace period, and the cancellation date or any other effective dates, so as to prevent misrepresentations, as required by § 38.2-502 of the Code;

COPY

Anthem has reviewed its procedures for cancellations and reinstatements, and revised its letters to provide clear and accurate information about the terms and conditions of the policy, the grace period, and the cancellation date or any other effective dates, so as to prevent misrepresentations, as required by § 38.2-502 of the Code in May 2016, June 2016, and February 2018, which fully remediates this issue.

21. Strengthen and maintain its recordkeeping involving the documentation of information that is included in the written notice of a renewal rate increase and when it is presented to the group;

    Anthem has enhanced is recordkeeping involving the documentation of information that is included in the written notice of a renewal rate increase and when it is presented to the group effective September 5, 2016. In addition, the Company performs periodic audits on the process.

22. Strengthen and maintain its procedures to ensure that the notice of intent to increase the premium charge or deductible is provided in writing at least 75 days prior to the proposed renewal of individual coverage, as required by § 38.2-3407.14 C of the Code;

    The Company has procedures in place to ensure compliance with the Code. Due to a limited system error in the processing of September 2015 renewals, some members were not picked up in the renewal file. Once the error was discovered, updated renewal notices were prepared and sent providing the required notice period.

23. Strengthen and maintain its established procedures to ensure that claims are processed in accordance with the requirements of § 38.2-510 of the Code and 14 VAC 5-400-10 et seq.;

    The Company has comprehensive procedures in place to ensure compliance with § 38.2-510 of the Code and 14 VAC 5-400-10 et seq. and continuously looks at ways to further enhance its procedures. Clearly we had some instances that fell outside of our procedures and will analyze each of those instances to determine if additional training is necessary or if our procedures need to be adjusted in any way.

COPY

24. Review and reconsider for re-adjudication all claims paid on the WGS system that took longer than 15 working days to pay and all pharmacy claims that took longer than 15 working days to pay for the years of 2015, 2016, 2017, 2018 and the current year, as well as the claims discussed in the review sheets submitted to Anthem during the examination (for which a spreadsheet will be provided to Anthem), and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

    The Company reviewed all of the findings associated with claims paid on WGS and determined that they were a result of associate errors. These errors were outside of our established procedures. We respectfully request that the Bureau reconsider its request that the Company re-adjudicate all claims paid on WGS considering the findings were non-systemic, and re-adjudicating claims would not identify additional interest to be paid based on the nature of these manual errors.

Express Scripts strengthened its procedures to ensure claims were paid within 30 calendar days and revised its systems and processes to ensure that interest payments were made when claims took greater than 30 calendar days to pay. This issue was completely remediated on November 20, 2017. Remediation included putting a process in place to ensure interest was paid when required and adjusting claims for January 1, 2015 – November 20, 2017. Claims paid on or after November 20, 2017, received the required interest. Anthem terminated its relationship with Express Scripts since the Exam.

25. As recommended in the prior Report, strengthen and maintain procedures for the payment of interest on accident and sickness claim proceeds, including pharmacy claims, as required by § 38.2-3407.1 B of the Code;

    Anthem has taken significant steps to strengthen its procedures for the payment of interest due on claim proceeds, as required by the Code. Some examples of enhancements include:
    - Holding monthly meetings to discuss prompt pay issues;
    - Implementation of the Interactive Decision Guide, which is a tool that can be used by associates to help them correctly identify the clean claim date for adjustments;
    - Consolidation of training documents for clean claim date determinations; and
    - Internal targeted audits.

    Express Scripts revised its systems and processes to ensure that interest payments were made when claims took greater than 15 working days to pay. This issue was completely remediated on November 20, 2017. Remediation included putting a process in place to ensure interest was paid when required and adjusting claims for January 1, 2015 – November 20, 2017. Claims paid on or after November 20, 2017, received the required interest. Anthem terminated its relationship with Express Scripts since the Exam.

26. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services, and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;

    The Company believes it has made significant progress in ensuring its EOBs are clear and accurately set forth for the benefits payable under the contract. We implemented a new EOB based on consumer research for our WGS platform effective August 2018.

27. Provide the examiners with documentation that the mental health/substance use claim discussed in Review Sheet CL24J-AN, that was incorrectly denied because there was no authorization on file, has been re-adjudicated and paid;

    Anthem has adjusted the claim discussed in Review Sheet CL24J-AN accordingly. Please see Appendix A for supporting documentation.

28. Provide the examiners with documentation regarding the number of claims that were re-adjudicated and the total amount of additional payments made, including interest, as a result of the internal audit of ambulance and air ambulance claims discussed in CLMEM03J-AN;

COPY

Anthem will provide the examiners with documentation regarding the number of claims that were re-adjudicated and the total amount of additional payments made, including interest, as a result of the internal audit of ambulance and air ambulance claims discussed in CLMEM03J-AN.

29. Establish and maintain procedures and claim system processes to ensure that accurate records of the accumulation of insured cost-sharing are kept; that each insured is notified when his or her out-of-pocket maximum is met; that Anthem does not charge additional cost-sharing for the remainder of the contract or calendar year, as appropriate; and that Anthem promptly refunds all cost-sharing payments charged after the out-of-pocket maximum is reached;

    The Company was aware that issues existed with its accumulator tracking system during the time period under review. In addition, a backlog existed. A dedicated team was put in place to not only identify/address accumulator issues, but enhance procedures (e.g. automation), to ensure compliance. These issues have been completely resolved and all members have been made whole.

30. Review and reopen all claims for all insureds who exceeded their out-of-pocket maximum during the years of 2015, 2016, 2017, 2018 and the current year and promptly refund all cost-sharing payments charged to the insured after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the insured. 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 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;

    As outlined in #29, the Company has worked through its accumulator issues and all members have been made whole.

COPY

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

March 13, 2020

SENT VIA EMAIL

Kimberly Stevens
Director, Compliance
Anthem Health Plans of Virginia, Inc.
2015 Staples Mill Road
Richmond, Virginia 23230

RE: Anthem Health Plans of Virginia, Inc.'s (Anthem) Response to the Draft Examination Report

Dear Ms. Stevens:

The examiners have received and reviewed Anthem's response to the Draft Report dated October 18, 2019. This letter will primarily address those areas of the response where Anthem 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. Please be advised that Anthem is required to provide documentation substantiating all actions taken to comply with the Corrective Action Plan (CAP) upon finalization of the exam and within the timeframe established by the Report. This also includes procedures and business practices that have been strengthened, implemented or revised, as well as any regulatory addendums and contracts that have been amended.

COPY

Corrective Action #3

The examiners acknowledge that Anthem has terminated its relationship with Express Scripts since the Exam time frame. However, Anthem will be required to provide documentation demonstrating that its contracts with its current PBM and pharmacy providers include the language required by § 38.2-3407.15 B of the Code. The Report appears correct as written.

Corrective Action #4

Anthem's proposed language does not comply with the fee schedule or §38.2-3407.15 B 8 of the Code, and it will not satisfy the requirements of the CAP. The reimbursement amounts contained in Anthem's provider contracts, including the fee schedule and any Special Compensation amendments to the provider contract, are the reimbursement amounts that have been agreed upon under the provider contract, and

any language inhibiting the provider's ability to ensure that claims are paid in accordance with the agreed-upon reimbursement amounts is in violation of the Code. Any revisions to payments must be in accordance with the fee schedule, including any Special Compensation amendments, and any reasonable limits to the time frame for reimbursement amount adjustment periods in the provider contract should be applied equally to both Anthem and the provider. The Report appears correct as written.

Corrective Action #7

Anthem will be required to provide documentation demonstrating that its contracts with its current PBM and pharmacy providers contain the specific provisions required by §§ 38.2-3407.15:1 B and 38.2-3407.15:1 C of the Code. The Report appears correct as written.

Corrective Action #15

Although the examiners acknowledge that Anthem indicates that "…associate error resulted in it appearing that policies and applications were not approved," the entire population of issued Stop Loss policies and applications reviewed by the examiners failed to include form numbers and, therefore, are not considered filed and approved. Anthem will be required to provide documentation of steps taken to ensure that all Stop Loss applications and policies are filed with and approved by the Commission, and that all Stop Loss applications used and policies issued contain form numbers, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code. The Report appears correct as written.

COPY

Corrective Action #18

Anthem will be required to provide its plans for enhancements and a copy of all documentation, including any additional rate filings. The Report appears correct as written.

Corrective Action #24

This CAP item requires Anthem to **review** claims processed on the WGS system that took longer than 15 working days to pay and consider them for re-adjudication, and only those claims requiring adjustment would need to be re-adjudicated. The examiners acknowledge that Anthem indicates that the findings during the examination were the result of associate errors. Therefore, this CAP item has been revised in the Report to require that Anthem review and consider for re-adjudication all claims paid on the WGS system **that required any manual processing** and took longer than 15 working days to pay and all paid pharmacy claims that took longer than 15 working days to pay for the years of 2015,2016, 2017, 2018, 2019 and the current year and make interest payments where necessary, as required by § 38.2-3407.1 of the Code. This CAP item has also been revised to include the year 2019. In addition, Anthem's response indicates that Express Script's procedures and systems were revised to ensure that interest was paid

for claims that took longer than 30 calendar days to pay; however, § 38.2-3407.1 of the Code requires that interest be computed from the 15th working day to the date of claim payment. Anthem will be required to document that interest has been paid correctly for all pharmacy claims.

Corrective Action #25

The examiners acknowledge that Anthem has terminated its relationship with Express Scripts since the examination time frame. Anthem will be required to provide documentation demonstrating that Anthem and its current PBM have procedures in place to comply with the payment of interest as required by § 38.2-3407.1 B of the Code. The Report appears correct as written.

Corrective Action #27

The examiners acknowledge the additional documentation provided by Anthem. This CAP item has been removed from the Report.

Corrective Action #30

This CAP item has been revised to include the year 2019.

Additional Report Revisions

The Area Violations Summary by Review Sheet has been revised to specify that violations are of subsection 1 of § 38.2-502 and subsection 2 of § 38.2-508. Additionally, as discussed in the Bureau of Insurance's (Bureau) letter to HealthKeepers, Inc. dated January 16, 2020, a CAP item has been added to the Anthem Report requiring that Anthem comply with the requirements of § 38.2-3407.3 of the Code going forward for pharmacy claims. The findings citing violations of § 38.2-3407.3 of the Code will remain in the Report; however, no monetary forfeiture will be assessed for these violations.

A copy of the entire Report with the revised pages noted is attached for your review, 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 Anthem violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, subsection 2 of § 38.2-508, and § 38.2-514 B of the Code, in addition to 14 VAC 5-90-50 A, 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 2, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-110 of Rules Governing the Advertisement of Accident and Sickness Insurance, and 14 VAC 5-400-60 A, 14 VAC 5-400-70 A, and 14 VAC 5-400-70 B of Rules Governing Unfair Claim Settlement Practices.

It also appears that Anthem violated §§ 38.2-109 B, 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.1 B,

COPY

38.2-3407.3 A, 38.2-3407.4 B, 38.2-3407.14 C, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15:1 B 1,38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3 , 38.2-3407.15:1 B 4 , 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, 38.2-3407.15:1 B 9, 38.2-3407.15:1 C, 38.2-3542 C, 38.2-3561 J, 38.2-5804 A, and 38.2-5805 B of the Code, in addition to 14 VAC 5-216-40 E 1 of Rules Governing Internal Appeal and External Review.

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

COPY

P.O. Box 27401
Richmond, VA 23279

Ms. Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
1300 E. Main Street
Richmond, VA 23219

Alleged Violations of §§ 38.2-109 B, 38.2-316 A, 38.2-316 B, 38.2-316 C 1, subsection 1 of § 38.2-502, subsection 2 of § 38.2-508, 38.2-514 B, 38.2-1812 A, 38.2-1833 A1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.1 B, 38.2-3407.3 A, 38.2-3407.4 B, 38.2-3407. 14 C, 38.2-3407. 15 B 1, 38.2-3407. 15 B 2, 38.2-3407. 15 B 3, 38.2-3407. 15 B 4, 38.2-3407. 15 B 5, 38.2-3407. 15 B 6, 38.2-3407. 15 B 7, 38.2-3407. 15 B 8, 38.2-3407. 15 B 9, 38.2-3407. 15 B 10, 38.2-3407. 15:1 B 1, 38.2-3407. 15:1 B 2, 38.2-3407. 15:1 B 3, 38.2-3407. 15:1 B 4, 38.2-3407. 15:1 B 5, 38.2-3407. 15:1 B 6, 38.2-3407. 15:1 B 7, 38.2-3407. 15:1 B 8, 38.2-3407. 15:1 B 9, 38.2-3407. 15:1 C, 38.2-3542 C, 38.2-3561 J, 38.2-5804 A, and 38.2-5805 B of the Code, in addition to, 14 VAC 5-90-50 A, 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 2, 14 VAC 5-90-90 A, 14 VAC 5-90-90 C, 14 VAC 5-90-110 of <u>Rules Governing the Advertisement of Accident and Sickness Insurance</u>, 14 VAC 5-216-40 E 1 of <u>Rules Governing Internal Appeal and External Review</u>, 14 VAC 5-400-60 A, 14 VAC 5-400-70 A, and 14 VAC 5-400-70 B of <u>Rules Governing Unfair Claim Settlement Practices</u>
Case No. INS-2020-00047

COPY

Dear Ms. Blauvelt,

This will acknowledge receipt of the Bureau of Insurance's letter dated March 20, 2020, concerning the above-referenced matter.

Anthem wishes to make a settlement offer for the alleged violations cited above. Further, we agree to:

1. Mail a check payable to the Treasurer of Virginia in the amount of $132,600 separately.

2. Comply with the corrective action plan set forth in the exam report as of December 31, 2015.

3. Acknowledge Anthem's right to a hearing before the State Corporation Commission in this matter and waive that right if the State Corporation Commission accepts this offer of settlement.

Confidential

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.

Sincerely,

Anthem Health Plans of Virginia, Inc.

Jeff Ricketts
(Signed)

Jeff Ricketts
(Type or Print Name)

Plan President, Virginia
(Title)

March 31, 2020
(Date)

COPY

200410270

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, APRIL 13, 2020

Document Control Center 04/13/20@2.51 PM

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2020-00047

ANTHEM HEALTH PLANS OF VIRGINIA, INC.,
Defendant

SETTLEMENT ORDER

COPY

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that Anthem Health Plans of Virginia, Inc., duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated § 38.2-109 B of the Code of Virginia ("Code") by failing to clearly disclose the liability assumed by the insurer; §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code by failing to use insurance policies or forms on file and approved by the Commission; § 38.2-502 (1) of the Code by misrepresenting the benefits, advantages, conditions or terms of an insurance policy; § 38.2-508 (2) of the Code by engaging in unfair discrimination; § 38.2-514 B of the Code by failing to make proper disclosures on explanation of benefits; § 38.2-1812 A of the Code by paying or sharing commissions with unlicensed or unappointed agents; § 38.2-1833 A 1 of the Code by accepting applications from unappointed agents; § 38.2-1834 D of the Code by failing to comply with the Commission's notification requirements of the termination of agent appointments; § 38.2-3405 B of the Code by improperly allowing the subrogation of claim payments; § 38.2-3407.1 B of the Code by failing to pay interest on accident and sickness claim proceeds; § 38.2-3407.3 A of the Code by failing to calculate coinsurance on the amount paid or payable to the provider;

§ 38.2-3407.4 B of the Code by failing to accurately and clearly set forth in the explanation of benefits the benefits payable under the contract; § 38.2-3407.14 C of the Code by failing to provide the required notice at least 75 days prior to the proposed renewal of coverage; §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, and 38.2-3407.15 B 10 of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in provider contracts; §§ 38.2-3407.15:1 B 1, 38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3, 38.2-3407.15:1 B 4, 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, and 38.2-3407.15:1 B 9 of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in carrier contracts with pharmacy providers or intermediaries; § 38.2-3407.15:1 C of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in provider and carrier contracts; § 38.2-3542 C of the Code by failing to provide the required notice of termination of coverage, including the specific date, not less than 15 days from the date of such notice, by which coverage will terminate if overdue premium is not paid; § 38.2-3561 J of the Code by failing to promptly approve coverage upon receipt of a notice reversing the adverse determination or final adverse determination; § 38.2-5804 A of the Code by failing to maintain the complaint system approved by the Commission; § 38.2-5805 B of the Code by failing to maintain written copies of provider contracts; 14 VAC 5-90-50 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* ("Rules"), by failing to use the proper format and content in advertisements, 14 VAC 5-90-55 A and 14 VAC 5-90-55 B of the Commission's Rules by failing to include the required provisions

COPY

and rate information in invitations to inquire, 14 VAC 5-90-60 A (2) by failing to comply with requirements applicable to advertisements of covered benefits; 14 VAC 5-90-90 A of the Commission's Rules by failing to use current and relevant facts in advertisements, 14 VAC 5-90-90 C of the Commission's Rules by failing to disclose the source of any statistics used in an advertisement; 14 VAC 5-90-110 of the Commission's Rules by making disparaging comparisons and statements in advertisements; 14 VAC 5-216-40 E (1) of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to notify the insured of the final benefit determination within a reasonable period of time; as well as 14 VAC 5-400-60 A of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to provide timely notification of acceptance or denial of claims; and 14 VAC 5-400-70 A and B of the Commission's Rules by failing to provide claimants with written notice of claim denials and by failing to provide a reasonable written explanation for such claim denials.

The Commission is authorized by §§ 38.2-218, 38.2-219, 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 the right to a hearing in this matter whereupon the Defendant, without admitting nor denying any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan set forth in the examination report as of December 31, 2015; has tendered to the Treasurer of Virginia the sum of One Hundred Thirty Two Thousand Six Hundred Dollars ($132,600); and has waived the right to a hearing.

COPY

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.

A COPY of this order shall be sent electronically by the Clerk of the Commission to: Kimberly Stevens, Regulatory Compliance Director, Anthem Health Plans of Virginia, Inc. at kimberly.stevens@anthem.com, 2015 Staples Mill Road, Richmond, Virginia 23230; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.

COPY