REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

HEALTHKEEPERS, INC.

AS OF DECEMBER 31, 2015

Conducted from April 12, 2016

through

February 9, 2018

By

Market Conduct Section

Life and Health
Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-1356687
NAIC: 95169

COMMONWEALTH OF VIRGINIA

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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 HealthKeepers, Inc. as of December 31, 2015, conducted at HealthKeepers 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-2020-00046 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

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of HealthKeepers, Inc. (hereinafter referred to as HealthKeepers), a Health Maintenance Organization (HMO), was conducted under the authority of §§ 38.2-1317 and 38.2-4315 of the Code of Virginia (hereinafter referred to as "the Code"). The period of time covered for the current examination, generally, was July 1, 2015 through December 31, 2015. The on-site examination was conducted at HealthKeepers' office in Richmond, Virginia from July 25, 2016 through 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 HealthKeepers was in compliance with various provisions of the Code and the regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC" or "regulations"). HealthKeepers' practices were reviewed for compliance with the corrective actions made to HealthKeepers as a result of the examiners' findings during the prior examination.

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, HealthKeepers made a monetary settlement offer, which was accepted by the State Corporation Commission on August 22, 2012 in Case No. INS-2012-00141, in which HealthKeepers 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 HealthKeepers had agreed after the prior examination to change its practices to comply with the Code and regulations, the current examination revealed a

number of instances where HealthKeepers had not done so. In the examiners' opinion, therefore, HealthKeepers 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. Additionally, HealthKeepers is in violation of the Commission's Order to cease and desist issued August 22, 2012 in Case No. INS-2012-00141. Section 12.1-33 of the Code sets forth the penalties for such violations.

The examiners may not have discovered all non-compliant practices that the company may have been engaged in during the examination time frame. Failure to identify or comment on specific company practices in the Commonwealth of Virginia or 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 HealthKeepers during the course of the examination.

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, and claim practices, to determine compliance with the Code, the applicable regulations, the terms of HealthKeepers' certificates of coverage and the company's policies and procedures.

The previous market conduct examination of HealthKeepers was finalized in 2012. The examiners identified several compliance issues that were also present during the last examination, even though HealthKeepers 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 processing and payment of claims in accordance with §§ 38.2-3407.15 B and 38.2-510 A 15 of the Code; and the filing and approval of EOB forms as required by § 38.2-3407.4 A of the Code. 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 704 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 HealthKeepers to pay the provider in accordance with the fee schedule attached to the contract, and HealthKeepers' 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.

Although HealthKeepers was previously ordered to cease and desist from future violations of § 38.2-3407.4 A of the Code, the policy form review revealed that HealthKeepers used Explanation of Benefits (EOB) forms for chiropractic and vision claims and issued group contracts to groups prior to these forms being filed with and approved by the Commission. HealthKeepers failed to provide evidence of timely notice of termination of appointment to agents in 61 of 70 sample files reviewed. In 92 out of the 100 cost sharing files reviewed by the examiners, HealthKeepers failed to notify an enrollee when his or her out of pocket maximum was reached. In the 8 instances where notification was provided, there were 3 instances where the notice was given more than 30 days after HealthKeepers had processed sufficient claims to determine that the out of pocket maximum had been reached. In all, there were 95 violations of 14 VAC 5-211-90 B found during the cost sharing review. During the Claims review, 8 additional violations of this section were revealed.

The cancellations review revealed that, in 15 instances, coverage was terminated due to nonpayment of premium by the employer, but HealthKeepers failed to provide 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 violation of § 38.2-3542 C of the Code.

There were 336 violations and instances of noncompliance noted during the Claims review. Overall, the review of HealthKeepers' claims revealed higher percentages of noncompliance than during the previous exam. There were systemic issues identified regarding air ambulance claims that resulted in an internal audit by HealthKeepers and re-adjudication of claims. The review also revealed that HealthKeepers was incorrectly

denying claims for lack of prior authorization even though none was required and that HealthKeepers failed to recognize prior authorizations or pre-certifications that were on file at the time of claim submission. The chiropractic and pharmacy claims review revealed that coinsurance was being calculated on the amount paid to the chiropractic claims intermediary or pharmacy benefit manager rather than the actual, lower, amount paid to the provider of services (the chiropractor or the pharmacy), in violation of § 38.2-3407.3 A of the Code.

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

II. COMPANY HISTORY

HealthKeepers, Inc. (HealthKeepers), formerly known as HealthKeepers of Virginia, Inc., was incorporated on April 8, 1985 and on September 1, 1986 was licensed as an HMO under Chapter 43 of Title 38.2 of the Code.

HealthKeepers is a stock, for-profit HMO. On November 1, 1997, HMO Virginia, Inc., a wholly owned subsidiary of Trigon Administrators, Inc., and formerly known as Virginia Health Maintenance Organization, Inc., was merged into HealthKeepers. On November 1, 1998, Physicians Health Plan, Inc., a wholly owned subsidiary of Trigon Administrators, Inc., was also merged into HealthKeepers.

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. HealthKeepers became a wholly owned subsidiary of Anthem Southeast, 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.

Effective January 1, 2006, UNICARE Health Plan of Virginia, Inc. (UNICARE Health Plan), an affiliated HMO, merged into HealthKeepers. As a result of the merger, UNICARE National Services, Inc., UNICARE Health Plan's parent company, received 25

shares of HealthKeepers' common stock. Prior to the merger, HealthKeepers was a wholly owned subsidiary of Anthem Southeast, Inc. After the merger and as of July 31, 2015, HealthKeepers was 88.89% owned by Anthem Southeast, Inc. and 11.11% owned by UNICARE National Services, Inc.

On October 1, 2010, Priority, Inc. and Peninsula Health Care, Inc., both affiliates of HealthKeepers, Inc., were merged into HealthKeepers, Inc.

HealthKeepers' service area includes the Commonwealth of Virginia, the District of Columbia and the counties of Charles, Montgomery and Prince George in the State of Maryland.

Individual HMO contracts are available on the Federal exchange through navigators. Small group HMO contracts are available on the Federal exchange and marketing efforts for off-exchange individual, small group and large group HMO contracts are carried out by account representatives, agents, and brokers.

Total enrollment as of December 31, 2015 was 658,338 members, including Medicaid members.

III. OPERATIONS/ORGANIZATION DOCUMENTS

The purpose of this review was to determine if HealthKeepers is operating within the scope of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301 B of the Code and 14 VAC-5-211-10 et seq.

ENROLLEE PARTICIPATION

Section 38.2-4301 B 10 of the Code requires an HMO to submit to the Commission with its application for licensure a description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in § 38.2-4304 B of the Code, which requires that the governing body of an HMO establish a mechanism.

The examiners observed in Review Sheet OP01G, that HealthKeepers had "…failed to establish a mechanism to provide its enrollees with an opportunity to participate in matters of policy and operation during the examination timeframe" in violation of § 38.2-4304 B of the Code. HealthKeepers disagreed and stated that "HealthKeepers holds a quarterly Managed Care Advisory Committee which meets quarterly. This committee includes a member…as well as a substitute member…who are there to represent enrollees and provide input to that Managed Care Advisory Committee." The examiners maintained their findings and responded that "A review of the documentation provided by HealthKeepers indicates that it failed to establish its enrollee participation mechanism during the examination timeframe. Only one quarterly meeting occurred during the 6-month examination period."

IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

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

GENERAL PROVISIONS

Section 38.2-5801 C 2 of the Code requires the filing of a certificate of quality assurance by an HMO. The review revealed that HealthKeepers was in substantial compliance.

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

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

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

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.

4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, 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 HealthKeepers 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 5-211-150 A requires an HMO to establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The examiners reviewed a sample of 65 from a population of 381 written complaints received during the examination time frame. The review revealed 6 violations of § 38.2-5804 A of the Code and 14 VAC 5-211-150 A. Examples are discussed in the following paragraphs.

TIMELINESS

HealthKeepers' Enterprise Grievances and Appeals Policy states that "Grievances are acknowledged in writing within 5 calendar days of the Health Plan receipt date". As discussed in Review Sheet MC07L, a review of the file revealed that HealthKeepers received the complaint November 23, 2015, and the acknowledgement was sent on November 30, 2015, which was 7 calendar days after receipt. This placed HealthKeepers

in non-compliance with its established internal procedures, resulting in the failure to maintain its established complaint system, as required.

HANDLING

Section 38.2-5804 A 1 of the Code requires that the record of a complaint be maintained for no less than five years. As discussed in Review Sheet MC09J, the review revealed 1 violation of this section. An email in the complaint file dated July 8, 2015 referred to a grievance that was previously discussed in the months of February and March of 2015, which was 7 months prior to HealthKeepers' recorded receipt date and resolution. The file failed to include a copy of the original grievance. Therefore, the complaint record was not complete. HealthKeepers responded that

> We respectfully disagree with this observation. This particular circumstance was logged as a grievance/major complaint in error. It should not have been included in the complaint universe. This was an inquiry which was resolved outside of the complaint process. The risk analyst offered advice on how the inquiry should be handled.

The examiners responded that HealthKeepers' definition of a grievance states that a grievance "…is a verbal or written expression of dissatisfaction regarding the plan…including…service concerns made by a member or the member's representative." A review of the emails in the complaint file clearly indicated that the written complaint met the definition of a "Grievance" as such is defined in HealthKeepers' approved complaint system.

PROVIDER AND INTERMEDIARY CONTRACTS

The examiners reviewed a sample of 25 provider contracts from a total population of 33,718 provider contracts in force during the examination time frame. The examiners also reviewed HealthKeepers' contracts negotiated with intermediary organizations for providing health care services pursuant to an MCHIP.

Section 38.2-5805 C 1 of the Code states that such contracts shall require that if the provider terminates the agreement, the provider shall give the HMO at least sixty days' advance notice of termination. As discussed in Review Sheet MC18D, the review revealed 1 violation of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 4 of the Code states that the contracts shall set forth that, in the event either the HMO or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the HMO, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the HMO. As discussed in Review Sheets MC24G and MC25G, the review revealed 2 violations of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 5 of the Code states that no provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the HMO or the intermediary organization. As discussed in Review Sheets MC24G and MC25G, the review revealed 2 violations of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 7 of the Code states that an agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination. As discussed in Review Sheets MC24G and MC25G, the review revealed 2 violations of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 8 of the Code states that an HMO and an intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract. As discussed in Review Sheets MC24G and MC25G, the review revealed 2 instances where the HMO and intermediary organization failed to provide the examiners with the complete, un-redacted copy of the executed provider contract for review and examination by the Commission, in violation of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 9 of the Code states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. An HMO may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to covered persons. The review revealed 23 violations of this section. An example is discussed in Review Sheet MC26G, where the hold harmless clause in the Agreement between HealthKeepers and its intermediary for the provision of

pharmacy services did not read essentially as set forth in § 38.2-5805 C 9 of the Code and used wording that is less favorable with respect to covered persons, in violation of this section. HealthKeepers agreed with the examiners' observations.

Section 38.2-5805 C 10 of the Code and 14 VAC 5-211-30 C state that if there is an intermediary organization between the HMO and the health care providers, the "hold harmless" clause shall be amended to include nonpayment by the plan, the HMO, and the intermediary organization and shall be included in any contract between the HMO on behalf of the MCHIP and the intermediary organization. The review revealed 2 violations of these sections. An example is discussed in Review Sheet MC26G, where the hold harmless clause in the agreement between HealthKeepers and its intermediary for the provision of pharmacy services had not been amended to include nonpayment by the plan, the HMO, and the intermediary organization, in violation of these sections. HealthKeepers agreed with the examiners' observations.

XV. INTERNAL APPEAL AND EXTERNAL REVIEW

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

The examiners reviewed the total population of 3 external reviews of final adverse decisions that occurred during the examination time frame. The review revealed that HealthKeepers was in substantial compliance.

V. PROVIDER CONTRACTS

A review of HealthKeepers' 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 33,718 provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

Professional, Facility and Ancillary

The examiners selected a sample of 23 from a population of 31,935 in force professional, facility and ancillary provider contracts.

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 7 violations of this section. An example is discussed in Review Sheet EF05D, where an amendment to the provider contract contained "Special Compensation" language that inhibited the provider's ability to ensure claims were paid in accordance with the fee schedule. The amendment stated:

> Center [provider] is responsible for reporting to HMO any discrepancy in HMO's payment within sixty (60) calendar days of such payment. If center fails to do so within this time-frame, Center shall hold HMO and members harmless from any underpayment.

HealthKeepers disagreed with the examiners' observations and stated the following:

> 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. HealthKeepers' decision to offer the provider increased compensation in the form of an Amendment would not exempt the HMO from the requirement to reimburse the provider in accordance with the negotiated fee schedule.

Pharmacy

The examiners selected a sample of 2 from a population of 1,783 in force pharmacy provider contracts.

As discussed in Review Sheets EF24G and EF25G, the review revealed that the 2 sample retail pharmacy contracts failed to contain the specific provisions required by §§ 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. HealthKeepers agreed with the examiners' observations.

SUMMARY

The review revealed 27 instances where HealthKeepers' provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. HealthKeepers' 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 HealthKeepers 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.

Additionally, HealthKeepers was in violation of the Commission's Order to cease and desist issued August 22, 2012 in Case No. INS-2012-00141. Section 12.1-33 of the Code sets forth the penalties for such violations.

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 512 claims from a population of 57,358 claims processed under the 25 provider contracts selected for review.

Section 38.2-3407.15 B 1 of the Code requires that a clean claim be paid within 40 days of receipt. The review revealed 25 instances where HealthKeepers failed to pay a clean claim within 40 days, in violation of this section. An example is discussed in Review Sheet EFCL4D, where HealthKeepers agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code states that any interest due on a claim under § 38.2-4306.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. The review revealed 27 instances where HealthKeepers failed to pay interest as required, in violation of this section. An example is discussed in Review Sheet EFCL50D, where the examiners observed that:

> On May 7, 2015, the [provider]…submitted claim #2015145BM3053 with pre-authorization code #7154187720 attached for reimbursement. HealthKeepers received this claim on May 25, 2015.
>
> HealthKeepers sent the provider a remittance on June 11, 2015 denying payment for the aforementioned claim and offering the following explanations: "The services you have performed requires a pre-authorization/referral. We are unable to pay this claim because a pre-authorization/referral was not obtained" and "Precertification/authorization/notification absent".
>
> The provider submitted claim #15159CA0414 for the same services with pre-authorization code #7154187720 attached to HealthKeepers, which received the claim on June 8, 2016. HealthKeepers sent the provider a remittance August 6, 2015 denying payment of this claim as a duplicate claim.

> On December 8, 2015 HealthKeepers sent the provider another remittance regarding the original claim. This remittance showed that an adjustment had been made to the claim allowing a payment of $5,462.51 to be made to the provider for the services rendered with no interest included.
>
> In summary, it appears HealthKeepers failed to…pay interest owing or accruing on a claim at the legal rate of interest…

HealthKeepers agreed with the examiners' observations.

Section 38.2-3407.15 B 5 of the Code states that an HMO shall pay a claim if the HMO has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit. The review revealed 6 instances where Healthkeepers denied a medically necessary covered benefit that they had previously authorized. An example is discussed in review sheet EFCL185D, where the examiners observed that:

> On August 20, 2015 [provider]…submitted claim #15243BY8224 to HealthKeepers seeking reimbursement for the service with pre-authorization code #7154140278 attached. It appears HealthKeepers denied payment for this clean and pre-authorized claim. The explanation of the denial on the provider remit stated:
>
> > The services you have performed require a pre-authorization/referral. We are unable to pay this claim because a pre-authorization/referral was not obtained. Precertification/authorization/notification absent.
>
> Documentation provided to the Bureau appears to indicate that the administration of one unit of 99601 was covered by pre-authorization code #7154140278 on August 20, 2015.

HealthKeepers agreed with the examiners' observations.

Section 38.2-3407.15 B 6 of the Code states that no HMO may impose any retroactive denial of a previously paid claim unless the HMO has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the

original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Section 38.2-3407.15 B 7 of the Code states that no HMO shall impose any retroactive denial of payment unless the HMO specifies in writing the specific claim or claims for which the retroactive denial is to be imposed. The review revealed 5 violations of these sections. An example is discussed in Review Sheet EFCL63D, where the examiners observed "…it appears HealthKeepers issued a retroactive denial of payment over 12 months after the date of the payment of the original challenged claim." HealthKeepers agreed and responded that the "…retroactive denial of payment was over 12 months of received date of original claim."

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 that HealthKeepers underpaid the fee schedule specified for the health care service provided in 3 instances in violation of this section. An example is discussed in Review Sheet EFCL02D, where the examiners observed that "It appears HealthKeepers failed to pay the contracted rates to [Emergency Medical Services

provider] for the services they rendered to a HealthKeepers member…" HealthKeepers agreed with the examiners' observations.

SUMMARY

HealthKeepers' failure to perform the provider contract provisions required by § 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 HealthKeepers establish and maintain procedures to ensure compliance with the minimum fair business standards in the processing and payment of claims, the current violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 of the Code could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties for knowing violations.

Additionally, HealthKeepers was in violation of the Commission's Order to cease and desist issued August 22, 2012 in Case No. INS-2012-00141. Section 12.1-33 of the Code sets forth the penalties for such violations.

Payment for Services by Optometrists and Ophthalmologists

Section 38.2-3407.19 B of the Code, which was effective subsequent to the examination time frame on January 1, 2016, states that no participating provider agreement shall establish the fee or rate that the optometrist or ophthalmologist is required to accept for the provision of health care materials or services, or require that an optometrist or ophthalmologist accept the reimbursement paid as payment in full, unless the health care materials and services are covered materials or covered services under the applicable vision care plan. Section 38.2-3407.19 D of the Code, which was effective

subsequent to the examination time frame on January 1, 2016, states that no vision care plan shall require an optometrist or ophthalmologist to use a particular optical laboratory, manufacturer of eyeglass frames or contact lenses, or third-party supplier as a condition of participation in a vision care plan.

A review of the sample of 1 vision provider contract revealed provisions in conflict with the requirements of §§ 38.2-3407.19 B and 38.2-3407.19 D of the Code. As discussed in Review Sheet EF21D, HealthKeepers disagreed with the examiners' observations and stated:

> Provider manual states on introduction page: "All applicable laws and regulations supersede the provisions of this manual." Further, the August 2016 Provider Manual section entitled "In-Network Savings on Additional Pairs and More" addresses state laws as follows: "Some states may prohibit eye care plans from requiring eye care providers to accept these discounts on non-covered services. If you practice in any of these states, your provider contract will reflect any exceptions."
>
> In the case of the specific provisions above, the state-specific amendment for Virginia would address statutory policies about non-covered discounts and lab usage.

The examiners responded that a general statement that "All applicable laws and regulations supersede the provisions of this manual" would not remedy the non-compliant provisions and that any Virginia amendment to the provider agreement would need to be revised to comply with §§ 38.2-3407.19 B and 38.2-3407.19 D of the Code.

Due to the fact that these Code sections went into effect after the examination time frame, no violations are being cited and no monetary penalty will be assessed. However, Healthkeepers shall take the necessary corrective actions to bring its provider contracts into compliance with this section going forward.

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 an HMO 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 an HMO and a participating pharmacy provider or its contracting agent, pursuant to which the HMO has the right or obligation to conduct audits of participating pharmacy providers, shall contain 9 specific provisions.

As discussed in Review Sheet EF26G, the review of HealthKeepers' contract with the intermediary that negotiated with pharmacies for the provision of health care services failed to contain the 9 provisions during the examination time frame, in violation of §§ 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. HealthKeepers agreed with the examiners' observations.

Section 38.2-3407.15:1 C of the Code states that any contract between an HMO and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers shall contain specific provisions that prohibit the intermediary, in the absence of fraud by the participating pharmacy provider, from terminating or failing to renew the contractual relationship with a participating pharmacy provider for invoking its rights under any contractual provision required to be contained in the contract by subsection B.

As discussed in Review Sheet EF26G, the review of HealthKeepers' contract with its intermediary revealed that it failed to contain this provision, in violation of

§ 38.2-3407.15:1 C of the Code. HealthKeepers agreed with the examiners' observations.

VII. ADVERTISING

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

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

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

A sample of 130 from a population of 549 advertisements disseminated during the examination time frame was selected for review. The review revealed that 24 of the 130 advertisements contained violations. In the aggregate, there were 34 violations, which are discussed in the following paragraphs.

14 VAC 5-90-40 states all information required to be disclosed by this chapter shall be set out conspicuously and in close conjunction with the statements to which the

information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement so as to be confusing or misleading. The review revealed 2 violations of this section. 14 VAC 5-90-50 A states that the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. 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 3 violations of this section. An example of each is discussed in Review Sheet AD63, where an invitation to inquire intermingled descriptions of the "features" and "special features" of life and disability Insurance products within an advertisement for HMO contracts without prominently disclosing the name of the underwriting insurer. HealthKeepers disagreed with the examiners' observations, but stated, "…we will remove that language from this brochure."

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 cost and complete details of the coverage, call or write your insurance agent." The review revealed 15 violations of this section. An example is discussed in Review Sheet AD52B, where the invitation to inquire failed to contain the required disclosure. HealthKeepers agreed with the examiners' observations and stated, "This disclosure will immediately be added to the flier."

14 VAC 5-90-60 A 1 states an advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of the information or use of the words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable or loss covered. The review revealed 11 violations of this section. An example is discussed in Review Sheet AD53A, where the invitation to contract contained comparative diagrams explaining different levels of in-network and out-of-network cost sharing benefits for some features of individualized plans that offer them but not for other features of the same individualized plans, where relevant cost sharing benefit differences between them existed. HealthKeepers disagreed with the examiners' observations, but responded that "…we will add a notation that specifies that the cost shares noted apply to all benefits in the chart except for Urgent and Emergency care and we will supply that benefit."

14 VAC 5-90-90 C states the source of any statistic used in an advertisement shall be identified in the advertisement. As discussed in Review Sheet AD56, the review revealed 1 violation of this section. The advertisement referred to Healthkeepers as the "Leader in Primary Care Collaboration…with over 33% of Virginia primary care physicians participating in our Enhanced Personal Healthcare program." without identifying the source of the statistic. HealthKeepers disagreed with the examiners' observations and stated that:

> The 33% of providers participating in our Enhanced Personal Health Care program is derived solely from internal Anthem knowledge. It is not otherwise recorded, published or reported in any form at this time. Accordingly, we felt that using a citation such as "according to our internal records" might not be appropriate and may cause confusion to the customer.

The examiners responded that this section requires that the source of any statistic used be identified in the advertisement.

14 VAC 5-90-160 states that an advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, age or relative position of the insurer in the insurance business. The review revealed 2 violations of this section. An example is discussed in Review Sheet AD49, where the advertisement contained the statement "…Anthem Healthkeepers has been one of Virginia's leading insurance companies for over 75 years. And we'll be there for you in 2015". Healthkeepers was incorporated April 8, 1985, thirty years prior to the examination time frame. HealthKeepers disagreed with the examiners' observations, stating that:

> Anthem Health Plans of Virginia and HealthKeepers, Inc. share the same holding company as well as the same employee, facilities, resources and advertisements. They are almost exclusively marketed under Anthem Blue Cross Blue Shield and its affiliate, Anthem HealthKeepers. This material includes a reference to this in the legal tags. We consider ourselves to have collectively served Virginias for more than 75 years.

The examiners responded that the fact that HealthKeepers may share some employees, facilities, resources, and advertisements with Anthem Health Plans of Virginia, Inc. under a common Holding Company does not make the statement any less misleading regarding the age or relative position of the HMO in the insurance business.

SUMMARY

HealthKeepers violated 14 VAC 5-90-40, 14 VAC 5-90-50 A,14 VAC 5-90-55 A, 14 VAC 5-90 60 A 1, 14 VAC 5-90-90 C and 14 VAC 5-90-160, placing it in violation of subsection 1 of § 38.2-502 and §§ 38.2-503 and 38.2-4312 A of the Code.

VIII. POLICY AND OTHER FORMS

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

Sections 38.2-4306 A 2, 38.2-316 A and 38.2-316 C 1 of the Code prohibit the use of group and individual contracts, Evidences of Coverage (EOCs), and any applicable amendments to these forms prior to filing the forms with and receiving approval from the Commission. Other forms, such as the group application, individual applications and group enrollment forms, must also be filed with the Commission for approval under §§ 38.2-316 B and 38.2-316 C 1 of the Code.

GROUP CONTRACTS

The examiners selected a sample of 50 from a population of 805 group contracts issued during the examination time frame.

As discussed in Review Sheet PF07G, the review revealed that HealthKeepers issued a group contract with policy form number ABCBS-VA-PPO-FIMC (1/14) prior to the contract being filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. HealthKeepers agreed with the examiners' observations.

EVIDENCE OF COVERAGE

Section 38.2-4306 A 2 of the Code state that no evidence of coverage (EOC), or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form has been filed with and approved by the Commission. The review revealed that HealthKeepers was in substantial compliance.

APPLICATIONS/ENROLLMENT FORMS

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

The review revealed that HealthKeepers used 2 applications/enrollment forms with policy form numbers 38400VAEENABS (1/15) and 37612VAMENABS Rev. 5/14 that had not been filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. An example is discussed in Review Sheet PF01F, where Page 2 of the Employer Enrollment Application For 2-50 Employee Small Groups Virginia 38400VAEENABS (1/15) had the specific type of medical coverage applied for handwritten into Section C of the group application. This specific coverage option was not included in the form when it was originally filed. HealthKeepers disagreed with the examiners' observations and stated:

> The customer completed an approved Employer Enrollment application that was effective January 1, 2015, SERFF Tracking #ANTY-129621351. Anthem decided to offer new medical plans effective July 1, 2015 in the Small Group market, and submitted an update to the approved January 2015 Employer Enrollment application, under SERFF Tracking #ANTY-129903112, which was approved. The customer chose to enroll with one of the new July 2015 medical products, but did not complete the most recent approved Employer application. In order to avoid customer abrasion, Anthem accepted the January 2015 approved Employer application instead of asking the customer to complete the July 2015 approved Employer application.

The examiners maintained their findings and referred HealthKeepers to 14 VAC 5-100-50 3, which requires that a form must be submitted in the final form in which it is to be issued.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each HMO shall file its EOBs with the Commission for approval. These forms are subject to the requirements of §§ 38.2-316 and 38.2-4306 of the Code, as applicable.

As discussed in Review Sheet PF03G, the form, EOB-02, sent to enrollees and providers in the processing of claims received from chiropractors was used prior to being filed with and approved by the Commission, in violation of § 38.2-3407 A of the Code. HealthKeepers responded that it "…disagrees with this finding…EOB-2 is not a form number to indicate the document is an EOB." The examiners did not concur and responded that:

> …an "Explanation of Benefits" as defined in § 38.2-3407.4 D of the Code of Virginia, includes any form provided by an HMO, which explains the amounts covered under a policy or plan or shows the amounts payable by a covered person to a health care provider. The documentation in the sample chiropractic claim files indicates that the form, EOB-2 sent to providers and members during the examination time frame had not been filed with and approved by the Commission for use by HealthKeepers.

Additionally, as discussed in Review Sheet PF04G, the EOB form ANTHPPO(9/11) used in the processing of vision claims was not filed with and approved by the Commission, in violation of § 38.2-3407.4 A of the Code. HealthKeepers agreed with the examiners' observations.

Due to the fact that in the prior Report it was recommended that HealthKeepers establish and maintain procedures to ensure that all EOBs used by HealthKeepers are filed with and approved by the Commission, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

Additionally, HealthKeepers was in violation of the Commission's Order to cease and desist issued August 22, 2012 in Case No. INS-2012-00141. Section 12.1-33 of the Code sets forth the penalties for such violations.

SCHEDULE OF CHARGES

Section 38.2-4306 B 1 of the Code prohibits the use of schedules of charges or amendments to the schedules of charges until a copy of the schedule or amendment has been filed with the Commission. The review revealed that HealthKeepers was in substantial compliance.

COST SHARING

14 VAC 5-211-90 B states that if the HMO has an established out-of-pocket maximum for cost sharing, it shall keep accurate records of each enrollee's cost sharing and notify the enrollee when his out-of-pocket maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is reached. The HMO shall not charge additional cost sharing for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all cost sharing payments charged after the out-of-pocket maximum is reached.

The examiners reviewed a sample of 100 from a total population of 25,815 enrollees who had met their out-of-pocket maximum during the examination time frame.

The examiners requested a description of HealthKeepers out-of-pocket maximum tracking procedures at the start of the examination. The description stated the following:

> Accumulators are stored in ODS and it is the source of truth…ODS stands for Operational Data Store. While there are various interpretations of this term, in general, an operational data store is a database, which supports the staging of data from the operational databases to a platform, which is

> dedicated to read access, reporting and analysis. It supports very recent transactional data, and closely, reflects the recent activities of the operational databases.
>
> The Accumulator ODS is Anthem's solution for bringing together legacy and specialty system accumulators that are 'shared' or 'commingled' into a single source of truth. Historically, this has primarily focused on medical and pharmacy sharing of an annual deductible and/or annual out-of-pocket amount.
>
> For tracking any amounts that must be shared, it is integrated with all of Anthem's legacy medical claims platforms such as ACES, CHIPS, CS90, FACETS, HealthLink, and NASCO; including two external vendors: ESI and Eyemed. The integration connections are real-time.

As discussed in Review Sheet PF01G, a review of the documentation provided by HealthKeepers indicated that it failed to notify an enrollee when his or her out-of-pocket maximum was reached in 92 instances. In the 8 instances where notification was provided, there were 3 instances where the notice was given more than 30 days after the HMO had processed sufficient claims to determine that the out-of-pocket maximum was reached. In total, the review revealed 95 violations of 14 VAC 5-211-90 B in the 100 sample files reviewed by the examiners. Additionally, the claims review indicated that when claims were adjusted to refund excess cost sharing amounts, payment was made to the participating provider, not the enrollee.

In the Review Sheet findings, the examiners requested to "…be provided with a written description of the measures implemented to resolve the issue" and "…a written description of what caused the issue to occur." HealthKeepers responded that:

> In regards to the request for an explanation of what caused the issue to occur there are 2 reasons based on claims processing platform. For WGS, it was a missed requirement when the ACA products/claims were first implemented on that platform. We discovered last year that these letters were not going out, and initiated a system project to produce those letters. That project delivered in January.

> For ACES, we had been operating under the assumption that the EOBs provided that notice. The EOBs for the products on ACES (as well as some of the products on WGS) include the member's Out of Pocket for their policy as well as how much of their out of pocket they have met. We believed that met the requirement of notifying the member that they had met their OOP. Based on the feedback from the market conduct exam where the BOI did not concur, we have initiated a system project for ACES which is expected to deliver in 1Q 2017.

The examiners' recommendations to address HealthKeepers' failure to comply with its out-of-pocket maximum tracking procedures and the requirements of 14 VAC 5-211-90 B will be addressed in the Corrective Actions section of the Report.

IX. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 and § 38.2-4313 of the Code. The 97 agents and 33 agencies designated in the sample of 180 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 HealthKeepers was in substantial compliance.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires an HMO to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent. The review revealed 4 instances where HealthKeepers failed to appoint the agent within 30 days of the date of execution of the application, in violation of this section. An example is discussed in Review Sheet AG02G. HealthKeepers 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. As discussed in Review Sheet AG02G, the review revealed 1 instance where HealthKeepers paid commission to an agent that was not appointed, in violation of this section. HealthKeepers agreed with the examiners' observations.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an HMO notify the agent within 5 calendar days and the Commission within 30 calendar days upon termination of the agent's appointment. A sample of 70 was selected from a total population of 787 agents whose appointments terminated during the examination time frame.

As discussed in Review Sheet AG01G, a review of the documentation provided by HealthKeepers indicated that HealthKeepers failed to provide notification to the agent of termination of the appointment in 51 instances. HealthKeepers responded that the "team could not locate term letter." Additionally, in 10 instances, HealthKeepers provided notification, but failed to do so within 5 calendar days. In total, there were 61 violations of § 38.2-1834 D of the Code.

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

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

UNDERWRITING/UNFAIR DISCRIMINATION

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

UNDERWRITING REVIEW

The examiners reviewed a sample of 50 from the total population of 805 group HMO contracts issued during the examination time frame. The examiners also reviewed a sample of 130 from a total population of 12,838 individual HMO contracts issued during the examination time frame.

The examiners reviewed a sample of 50 from a total population of 7,485 individual applications declined during the examination time frame. The examiners were informed by HealthKeepers 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 HealthKeepers was in substantial compliance.

MECHANICAL RATING REVIEW

The review revealed that premiums were calculated correctly.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

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

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of disclosure authorization forms to be used when collecting personal or privileged information about individuals. The reviewed revealed that the disclosure authorizations used by HealthKeepers in the underwriting of its group and individual contracts were in substantial compliance.

XI. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS

HealthKeepers' procedures for processing premium and renewal notices, collections and reinstatements were reviewed for compliance with its established procedures and certain requirements of the Patient Protection and Affordability Care Act (PPACA). HealthKeepers' practices for notifying contract holders of the intent to increase premium by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM & RENEWAL NOTICES

Individual

A sample of 40 was selected from a population of 123,251 individual HMO contracts renewed during the examination time frame.

For Exchange and Off-Exchange contracts, premium invoices are generated and mailed approximately 12 to 15 calendar days prior to the due date, which is the 1st of the month. The billing invoice displays the current due date, current charges, balance forward amount and the subsidy amount for Exchange contracts. The review revealed that HealthKeepers' premium notices were generated in accordance with its established procedures.

HealthKeepers' practices for notifying individual contract holders of the intent to increase premium by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code. The review revealed that HealthKeepers was in compliance.

Section 38.2-3407.14 B of the Code states that an HMO providing individual 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 75 days prior to the proposed renewal of individual coverage. The review revealed that HealthKeepers was in compliance with the notification requirements.

Group

A sample of 10 was selected from a population of 6,259 group HMO contracts renewed during the examination time frame.

Monthly invoices are generated within the first week of each month, regardless of the payment status of the group; however, invoices will not generate for those groups that are in pending cancellation status or on which a bill hold is in place. Premium invoices are due the first of the month, with a 31-day grace period. When a group is effective on a date other than the first of the month, the initial invoice will be for a full month from the effective date to the day before the same date in the next month. The second invoice is pro-rated for the remainder of the month after the month in which the group was effective. From the third invoice on, the standard applies. The review revealed that HealthKeepers' premium notices were generated in accordance with its established procedures.

A review of the total population of 6 groups whose premium increased by more than 35% indicated that HealthKeepers was in compliance with the notification requirements of § 38.2-3407.14 of the Code.

COLLECTIONS

Individual

Off-Exchange contract holders receive a late notice 6-10 days after the due date informing them that "Coverage only lasts for the first 31 days of your grace period' and that "your coverage will be terminated due to non-payment" within 30 days of the date on the late notice. The late notice also informs the member that "No claims will be paid after…" the expiration of the 31-day grace period. Within 5 business days of the expiration of the grace period, individual policies will be "…auto cancelled systematically."

Exchange contract holders receive a late notice 6-10 days after the due date informing the contract holder that:

> You're now in your "grace period." To give you a chance to keep your coverage, there is a three month grace period to pay. That period ends three months after your Due Date mentioned above. If we don't receive your full payment on or before that date, your plan says that your coverage will be cancelled…Coverage only lasts for the first month of your grace period. No claims will be paid after [last date of the grace period]. After the first month, your plan will be suspended and you won't have coverage.

Identical late notices are sent 6-10 days after the 1st of the month for the next 2 months. A final termination letter is sent 6-10 days after the 1st of the month at the end of the 3-month period. Reinstatement is not permitted unless there is a qualifying event as such is defined under PPACA. If there is no qualifying event, the contract holder must wait until the next open enrollment period to submit a new application. The review revealed that HealthKeepers was in compliance with its established procedures.

Group

HealthKeepers' collection procedures state that "Groups that do not pay by the end of the grace period will enter 'pending cancellation' status (also known as the

delinquency period)." This status lasts for 5 days. The group is considered "officially" cancelled for nonpayment of premium at the end of the delinquency period. Within 5 business days of the expiration of the grace period, all small group policies will be "…auto cancelled systematically."

Groups are allotted a standard grace period of 31 days to make their premium payment. Exceptions to this standard grace period for group business require separate authorization of the Plan President, or their designee. For example, if the Sales Department would request to extend the grace period to 91 days, the delay in the collection of 60 days' worth of premium dollars would need the appropriate level of authorization.

Upon expiration of the grace period, the internal sales associates and brokers associated with any unpaid large group accounts will be sent an automatic electronic notification of non-payment. The Sales Department has 5 days to respond to Finance Operations by either identifying the Company's errors leading to this incorrect billing or pursuing the collection of the outstanding premium. After 5 days without a response, the system will auto cancel the large group and provide the customer termination letters, as well as electronic notification to the Sales Department and brokers of the termination.

For small and large groups, claims are automatically pended upon expiration of the grace period. Claims with dates of service after the grace period expiration date are pended and members will not receive an EOB statement. The review revealed that HealthKeepers was in compliance with its established procedures.

REINSTATEMENTS

Individual

A sample of 80 was selected from a population of 3,363 individual HMO contracts reinstated during the examination time frame.

HealthKeepers' procedures state that "On-Exchange policies are excluded from the Administrative Decision Process, with the exception of requests to review for an Anthem error. Anthem will reinstate if there is proof of an Anthem error. We must notify the Exchange of the reinstatement."

The procedures for Off Exchange and Legacy individual contracts state that "If it is determined that Anthem did not make a mistake, the requestor will be notified and she/he will communicate with applicant/member/broker." The Enrollment and Billing Department's Special Review or Underwriting team will determine what qualifies as an Anthem error and what corrections/adjustments are to be made. A letter is sent to the member advising of HealthKeeper's decision and his/her right to appeal, if denied.

The review revealed that HealthKeepers was in compliance with its established procedures for reinstatement.

Group

A sample of 15 was selected from a population of 149 group HMO contracts reinstated during the examination time frame.

Once a group has terminated, Finance Operations oversees the collection process for all cancelled accounts. Accordingly, Finance Operations has the responsibility to administer the reinstatement of any terminated group. A terminated group is eligible for reinstatement if the following criteria are met:

1. The reinstatement request is made within 30 calendar days of the terminated date as documented by the system transaction date.
2. There have been no more than two previous reinstatements of coverage in the past twelve months.
3. All Underwriting guidelines have been met.
4. There have been no more than two NSF (in-sufficient funds) returned checks in the most recent rolling twelve months.
5. Payment in full for past and current month premiums is required prior to reinstatement action.
6. Where Accounts Receivable oversees the collection process and where allowed by contract, a reinstatement fee will be charged. Waiver of this fee must be authorized by the Manager of the Accounts Receivable & Collections department.
7. The Plan President may choose not to offer the option for reinstatement of terminated groups in their state or business segment upon notification to Accounts Receivable. This decision will apply to the entire state or business segment.

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

The review revealed that HealthKeepers was in compliance with its established procedures for reinstatement.

XII. CANCELLATIONS/NON-RENEWALS/RESCISSIONS

The examination included a review of HealthKeepers' cancellation/non-renewal practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; and the notification requirements of 14 VAC 5-211-230 B, 14 VAC 5-211-230 C and § 38.2-3542 of the Code. The examiners were informed by HealthKeepers that no rescissions of coverage occurred during the examination time frame.

Individual

A sample of 100 from a population of 34,228 individual contracts terminated during the examination time frame was selected for review.

14 VAC 5-211-230 B 1 states that an HMO shall not terminate coverage for services provided under a contract without giving the subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that, for termination due to nonpayment of premium, the grace period as required in 14 VAC 5-211-210 B 16 shall apply. The review revealed that HealthKeepers was in substantial compliance.

Group

A sample of 52 from a population of 444 groups terminated during the examination time frame was selected for review.

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 HMO 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 15 violations of this section. An example is discussed in Review Sheet CN04G, where in 12 instances, HealthKeepers failed to send the required notice. HealthKeepers disagreed with the examiners' observations and stated:

> HealthKeepers complies with the requirement under § 38.2-3542 C by including the required Notice to the employer/policyholder with the monthly bill, which is sent on the 10th of the preceding month, in advance of the premium payment due date. This notice on the invoice includes the date the premiums must be received by and the termination date as required under the statute.

The examiners responded that "…a termination notice on a monthly billing invoice sent prior to the start of the grace period and prior to the premium being overdue would not satisfy the notification requirements of this section."

XIII. COMPLAINTS

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

The examiners reviewed a sample of 65 from a total population of 381 written complaints received during the examination time frame. The review revealed that HealthKeepers was in substantial compliance.

XIV. CLAIM PRACTICES

The purpose of the examination was to review the claim practices for compliance with §§ 38.2-510 and 38.2-4306.1 of the Code, as well as 14 VAC 5-211-10 et seq., Rules Governing Health Maintenance Organizations. In addition, sample claims were reviewed for compliance with 14 VAC 5-211-90 B related to out-of-pocket amounts and cost sharing.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims and encounters. Claims are defined as submissions for negotiated fee-for-service, per diem and per case payments for health care services provided by inpatient and outpatient physicians and facilities. The encounters reviewed were periodic capitated payments made to providers of laboratory services.

HealthKeepers has contracted with intermediaries for the processing of its claims for chiropractic and pharmacy services. American Specialty Health Networks, Inc. (ASH) processes chiropractic claims and Express Scripts, Inc. (ESI) processes pharmacy claims.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 590 was selected from a total population of 1,473,967 claims paid during the examination timeframe.

The review revealed 4 instances where HealthKeepers failed to comply with the provisions of the EOC. An example is discussed in Review Sheet CL15M, where the allowable amount of $77.87 for an office visit was applied to the member's deductible.

The Schedule of Benefits stated, in part, "Primary Care Physician/Provider (PCP)/Specialty Care Physician/Provider (SCP) In-Network $25 Copayment per visit No Deductible for the first 3 visits, or 30% Coinsurance after Deductible for subsequent visits." The claim history indicated it was the first office visit for the member. Therefore, the $25 copayment should have been applied to this claim. HealthKeepers disagreed with the examiners' observations and stated that:

> Per member's EOC member has a 25.00 co pay for the first 3 visits. After 3 visits deductible and coinsurance apply. This is a PCP driven plan. If member needs to see a Specialist, they have to contact their PCP to get a referral as noted on page 29 of the EOC. This member does not have a referral for this specialist and the claim is paying at low tier.

The examiners maintained their findings and responded that "The claim was corrected on August 9, 2016 reversing the amount applied to the deductible and applying the $25 copayment. The Claim Text noted that the system incorrectly applied the benefit at non-par and should have paid at par since the provider is par."

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. Section 38.2-514 B of the Code states that no person shall provide to a claimant, subscriber or enrollee under a 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. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable. The review revealed 1 violation of each of these sections. As discussed in Review Sheet CL48J, an EOB from a non-participating provider indicated that the Member was not liable

for the difference between the allowable amount and the billed charges. HealthKeepers disagreed with the examiners' observations and stated that:

> Claim was adjusted on 02/02/2016 per Inquiry Tracking 2016028071015, dated 01/28/2016 to pay as par due to services being a medical emergency. Per emergent services member is not responsible for charges billed above what is reasonable and customary.

The examiners maintained their findings and would note that in this instance there was no executed contract in place between the HMO and the provider containing the "hold harmless" provision required by § 38.2-5805 C of the Code. Although the claim was adjusted to pay at the in-network level of benefits in accordance with the EOC, the provider was not contractually obligated to accept as payment the amount that HealthKeepers determined to be reasonable and customary.

Sections 38.2-510 A 2 of the Code prohibits, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims. The review revealed 3 instances of non-compliance with this section. Section 38.2-510 A 3 of the Code prohibits, as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 30 instances of non-compliance with this section. An example of noncompliance with both of these sections is discussed in Review Sheet CL11J, where a claim for Magnetic Resonate Imaging (MRI) services at an outpatient hospital received on August 11, 2015 was incorrectly denied for the failure to obtain prior authorization. Inquiry notes dated August 26, 2015 indicated that HealthKeepers was aware that an authorization was on file, yet the claim was not adjusted and affirmed until October 2, 2015. HealthKeepers agreed with the examiners' observations and stated that "…due to an individual manual

error made by our claims associate the claim was initially incorrectly denied. The claim was corrected, but that adjustment was not timely."

Section 38.2-510 A 4 of the Code prohibits, as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 1 instance of non-compliance with this section. As discussed in Review Sheet CL82M, a claim was denied in error as requiring pre-certification. HealthKeepers agreed with the examiners' observations.

Section 38.2-510 A 6 of the Code prohibits as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 9 instances of non-compliance with this section. An example is discussed in Review Sheet CL44J, where HealthKeepers incorrectly calculated its payment to an air ambulance provider. HealthKeepers agreed with the examiners' observations. Consequently, the examiners requested additional information in CLMEM01J regarding air ambulance payments. HealthKeepers performed an internal audit of ambulance and air ambulance 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.

14 VAC 5-211-80 B states that an HMO shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other health care plans. In the event that benefits are provided by another health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The HMO shall be required to provide or arrange for the service first and then, at its option, seek coordination

of benefits with any other health insurance or health care benefits or services that are provided by other policies, contracts, or plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided. The review revealed 1 violation of this section. As discussed in Review Sheet CL80M, HealthKeepers denied a claim for coordination of benefits information and held the enrollee liable for the cost of the covered services provided. HealthKeepers agreed with the examiners' observations.

14 VAC 5-211-90 B states that if the HMO has an established out-of-pocket maximum for cost sharing, it shall keep accurate records of each enrollee's cost sharing and notify the enrollee when his out-of-pocket maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is reached. The HMO shall not charge additional cost sharing for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all cost sharing payments charged after the out-of-pocket maximum is reached. The review revealed 7 violations of this section. An example is discussed in Review Sheet CL06J, where HealthKeepers failed to notify an enrollee within 30 days when his or her out-of-pocket maximum was reached. HealthKeepers agreed with the examiners' observations.

Mental Health & Substance Use

A sample of 158 was selected from a total population of 63,584 mental health and substance abuse 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. Section 38.2-514 B of the Code states that no person shall provide to a claimant, subscriber or enrollee under a 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. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable. The review revealed 2 violations of each of these sections. An example is discussed in Review Sheet CL28J, where the EOB failed to indicate that the member was responsible for the difference between the allowable charge and the amount billed by the non-participating provider. HealthKeepers agreed with the examiners' observations.

Section 38.2-510 A 3 of the Code prohibits, as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 13 instances of non-compliance with this section. An example of noncompliance with this section is discussed in Review Sheet CL28M, where the allowable amount on a claim was incorrectly applied to the deductible on September 26, 2015. Although no new information was received, the claim was subsequently re-adjudicated on October 29, 2015 to reflect the correct member cost sharing of 20% coinsurance. HealthKeepers agreed with the examiners' observations.

Section 38.2-510 A 6 of the Code prohibits as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 1 instance of non-compliance with this section. As discussed in Review Sheet CL83M, a claim was

denied in error and the reason given was that the date of service occurred after the cancellation date of coverage. HealthKeepers agreed with the examiners' observations.

14 VAC 5-211-90 B states that if the HMO has an established out-of-pocket maximum for cost sharing, it shall keep accurate records of each enrollee's cost sharing and notify the enrollee when his out-of-pocket maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is reached. The HMO shall not charge additional cost sharing for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all cost sharing payments charged after the out-of-pocket maximum is reached. The review revealed 1 violation of this section. An example is discussed in Review Sheet CL54M, where HealthKeepers failed to notify an enrollee within 30 days when his or her out-of-pocket maximum was reached. HealthKeepers disagreed with the examiners' observations, stating that the "…OOP maximum information was reflected on the EOB." The examiners responded that, although the EOB provided dollar amounts, it did not provide a notification to the enrollee that the out-of-pocket maximum was reached.

Chiropractic

A sample of 20 was selected from a total population of 7,377 chiropractic claims paid during the examination time frame.

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

services provided to the enrollee. The review revealed 2 violations of this section. An example is discussed in Review Sheet CL04G, where HealthKeepers calculated the coinsurance amount payable by an enrollee on an amount that exceeded the total amount actually paid or payable to the provider of such services. HealthKeepers disagreed with the examiners' observations and stated:

> ASH disagrees with the finding that the member cost share was greater than the amount paid or payable. ASH allowed $35.00 for the services rendered. A 20% coinsurance was applied resulting in $7.00 of member responsibility. A $2.24 administrative fee assessed to the provider and a $.28 EFT bonus was paid to the provider for a total paid amount to the provider of $26.04.

The examiners responded that:

> The enrollee's coinsurance amount of $7.00 was not based upon the amount that was actually paid to the provider. The $26.04 payment to the provider, which per the evidence of coverage would be 80% of the total amount paid or payable, would indicate an allowed amount of $32.55. Therefore, the enrollee's 20% coinsurance amount should have been $6.51.

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

Vision

A sample of 60 claims was selected from a total population of 26,323 vision claim paid during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis for denial of a claim. The review revealed 3 instances of non-compliance with this section. An example is discussed in Review Sheet CL115J, where, although some services on the claim were paid, the reason given

on the EOB for a denied service stated that the "Benefit maximum for this time period or occurrence has been reached." However, the review revealed that the service was denied because it was not a covered service, not because the benefit maximum had been reached. HealthKeepers agreed with the examiners' observations and responded that it "…is currently working with [its] vision claims administrator to determine a more accurate Remark Code to be used in such scenarios."

Pharmacy

A sample of 165 was selected from a total population of 2,068,410 pharmacy claims paid during the examination time frame.

Section 38.2-3407.3 A of the Code states that an HMO that issues a contract pursuant to which the enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the enrollee. The review revealed 1 violation of this section. As discussed in Review Sheet CL46G, HealthKeepers calculated the coinsurance amount payable by an enrollee on an amount that exceeded the total amount actually paid or payable to the provider of such services. HealthKeepers disagreed with the examiners' observations and stated:

> We respectfully submit that we are in compliance with Section 38.2-3407.3 of the Code of Virginia. Our Pharmacy Benefit Manager (PBM) is the provider of the prescription drugs as detailed in the member certificates, either directly (through mail order) or through their network of contract pharmacies. While we identify the network of pharmacies for the member to use, that network is not a network that is developed by Anthem. It is a network that is contracted by and controlled by our PBM and used not just for Anthem business but other non-Anthem business as well. We have no contractual obligation of payment to these network pharmacies and no insight into what our PBM's payments are.

> Our certificates describe how the Maximum Allowed Amount for prescription drugs is determined. It states that for prescription drug benefits administered under the pharmacy benefit, the Maximum Allowed Amount and the resulting cost share to the member is determined by using prescription drug cost information provided by the PBM. As the provider of prescription drugs through access to its networks, our PBM provides cost information for what it charges Anthem. On that basis, the cost share amounts are calculated in accordance with VA statutory requirements.

The examiners responded that:

> Section 38.2-3407.3 of the Code of Virginia states that an insurer or HMO that issues an accident and sickness insurance policy or contract pursuant to which the insured or enrollee is required to pay a specified percentage of the cost of covered services*, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the insured or enrollee.*
>
> In this instance, the retail pharmacy and licensed pharmacists and technicians employed there would appear to be the provider of services to the enrollee, not the Pharmacy Benefits Manager.

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

Dental

A sample of 70 was selected from a total population of 10,315 dental claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Laboratory Encounters

A sample of 50 was selected from a total population of 167,808 laboratory encounters paid during the examination time frame.

Section 38.2-3407.3 A of the Code states that an HMO that issues a contract pursuant to which the enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the enrollee. The review revealed 10 violations of this section. As discussed in Review Sheet CL01G, HealthKeepers calculated the coinsurance amount payable by an enrollee on an amount that exceeded the total amount actually paid or payable to the provider of such services. HealthKeepers agreed with the examiners' observations.

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

INTEREST ON CLAIMS

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. The review revealed 13 violations of this section.

There were 5 instances where the amount of interest due was underpaid (Review Sheets CL33J, CL43J, CL47J, CL56J and CL20M). An example is discussed in Review Sheet CL20M, where HealthKeepers agreed that it underpaid the amount of interest due by $0.11. In 2 instances, no interest was paid, (Review Sheets CL21J and CL54M). All but one of the of the 7 violations discussed above occurred on the WellPoint Group System (WGS) claims processing platform.

As discussed in Review Sheets CL33G, CL34G, CL35G, CL38G, CL39G and CL45G, the review revealed 6 instances where interest was due on claims for pharmacy services and none was paid. HealthKeepers agreed with the examiners' observations.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 376 was selected from a total population of 214,438 claims denied during the examination time frame.

Sections 38.2-510 A 2 of the Code prohibits, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims. The review revealed 13 instances of non-compliance with this section. Section 38.2-510 A 3 of the Code prohibits, as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 44 instances of non-compliance with this section. An example of noncompliance with both of these sections is discussed in Review Sheet CL33M, where a claim received on December 30, 2014 was not denied until October 13, 2015. HealthKeepers agreed with the examiners' observations and stated that it "…acknowledges claim was not processed timely due to provider data issue. Issue impacting claims processing was resolved and claims was processed on 10/13/15."

Section 38.2-510 A 4 of the Code prohibits, as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 4 instances of non-compliance with this section. An example is discussed in Review Sheet CL39J, where certain procedures codes on a claim were denied in error as requiring prior authorization. HealthKeepers agreed with the examiners' observations.

Section 38.2-510 A 6 of the Code prohibits as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 3 instances of non-compliance with this section. An example is discussed in Review Sheet CL44M, where a claim for evaluation and management services was denied with a message on the EOB stating, "Laboratory procedures must be performed by the participating Laboratory Provider and is not the member's responsibility." HealthKeepers agreed with the examiners' observations and responded that "…due to an individual manual error by our claims associate the benefits were not paid per the EOC. The member's claim is being adjusted to match the EOC."

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis for denial of a claim. The review revealed 19 instances of non-compliance with this section. An example is discussed in Review Sheet CL76J, where a claim for covered telemedicine services was denied. The explanation on the EOB stated erroneously that, "This is not a covered expense of the patient's plan." HealthKeepers agreed with the examiners' observations and indicated that the "Claim will be adjusted to correct." Additionally, HealthKeepers' actions in this instance constituted 1 violation of § 38.2-3451 A of the Code, which requires that an HMO providing individual or small group coverage shall provide that such coverage includes the Essential Health Benefits (EHBs) as required by § 1302 (a) of the PPACA (Patient Protection and Affordability Care Act). Telemedicine services are a required EHB under the PPACA.

14 VAC 5-211-80 B states that an HMO shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other health care plans. In the event that benefits are provided by another health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The HMO shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are provided by other policies, contracts, or plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided.

The review revealed 1 violation of this section. As discussed in Review Sheet CL106J, Healthkeepers denied a claim for coordination of benefits information and held the enrollee liable for the cost of the covered services provided. HealthKeepers disagreed with the examiners' observations and stated that "The member received their services; HealthKeepers did not prevent the member from receiving the covered services." The examiners maintained their findings and responded that:

> 14 VAC 5-211-80 B states, in part, "…Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided." The Explanation of Benefits shows a $200 member responsibility and in addition states that the $200 is "Non-Covered". HealthKeepers has held the enrollee liable for the cost of the covered services before the coordination of benefits was determined, thereby placing HealthKeepers in violation of this regulation.

Mental Health & Substance Use

A sample of 54 was selected from a total population of 14,736 mental health and substance abuse claims denied during the examination time frame.

Section 38.2-510 A 3 of the Code prohibits, as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 2 instances of non-compliance with this section. An example of noncompliance with this section is discussed in Review Sheet CL50M, where a claim was received on May 5, 2015 and denied in error on June 3, 2015. The claim was not paid until August 1, 2015, after an internal review. HealthKeepers disagreed with the examiners' observations and stated that "The proof of loss was received 05/15/2015 and (payment/denial) remitted on 06/03/2015 for timely filing." The examiners would respond that the claim was denied in error as requiring complete medical records, and, although no new information was received, the claim was not paid until August 1, 2015, after an internal review.

Section 38.2-510 A 4 of the Code prohibits, as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 1 instance of non-compliance with this section. Section 38.2-510 A 6 of the Code prohibits as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 1 instance of non-compliance with this section. Review Sheet CL92J discusses the instance of noncompliance with both of these sections. A claim for neuropsychological testing was denied for pre-authorization/referral although the EOC indicated that none was required. HealthKeepers agreed with the examiners' observations and stated, "Claim will be adjusted to correct."

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis for denial of a claim. The review revealed

17 instances of non-compliance with this section. An example is discussed in Review Sheet CL95J, where the explanation on the EOB for the denied claim stated that "You can learn more about the services listed by calling the customer service phone number on the back of your ID card. We can tell you the diagnosis and the treatment codes included on your claim, along with the descriptions for those codes." However, documentation from internal claim notes indicated that the claim was denied because the "services performed require a pre-authorization/referral." HealthKeepers agreed with the examiners' observations.

Chiropractic

A sample of 10 was selected from a population of 3,231 chiropractic claims denied during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis for denial of a claim. The review revealed 4 instances of non-compliance with this section. An example is discussed in Review Sheet CL23G, where a review of the file indicated that no EOB was sent to the enrollee for a claim denied for medical necessity review. HealthKeepers agreed with the examiners' observations and stated that "Anthem and ASH are working together to obtain a BOI approved EOB template that can be sent for all paid and denied claims."

Vision

A sample of 15 was selected from a total population of 2,406 vision claims denied during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis for denial of a claim. The review revealed

7 instances of non-compliance with this section. An example is discussed in Review Sheet CL113J, where the denial on the EOB stated that "Benefit maximum for this time period or occurrence has been reached." However, the review revealed that the services were denied because they were non-covered services, not because the benefit maximum had been reached. HealthKeepers agreed with the examiners' observations and responded that it "…will revise the…denial code…for the service…and assign the denial code '96' which states Non-Covered charges."

Pharmacy

A sample of 100 was selected from a population of 943,066 pharmacy claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Dental

A sample of 30 was selected from a total population of 6,754 dental claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

SUMMARY

HealthKeepers' failure to comply with §§ 38.2-510 A 3 and 38.2-510 A 14 of the Code occurred with such frequency as to indicate a general business practice and placed HealthKeepers in violation of these sections.

TIME SETTLEMENT STUDY

The time settlement study was performed to determine compliance with § 38.2-510 A 5 of the Code, which requires that coverage of claims be affirmed or denied

within a reasonable time after proof of loss statements have been completed. The normally acceptable "reasonable time" is 15 working days from the receipt of proof of loss to the date a claim is either affirmed or denied. The term "working days" does not include Saturdays, Sundays, or holidays.

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

Of the 1,063 paid and 585 denied sample claims reviewed by the examiners, the review revealed 115 instances in which HealthKeepers failed to affirm or deny coverage within a reasonable time, in non-compliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL58J, where HealthKeepers took 114 calendar days to affirm a claim. HealthKeepers agreed with the examiners' observations.

HealthKeepers' failure to comply with § 38.2-510 A 5 of the Code did not occur with such frequency as to indicate a general business practice.

THREATENED LITIGATION

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

XVI. CORRECTIVE ACTION PLAN

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

1. Maintain its established enrollee participation mechanism as required by § 38.2-4304 B of the Code;
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 and 14 VAC 5-211-150 A;
3. Review and strengthen its procedures for maintaining a complete record of complaints, as required by §§ 38.2-511 and 38.2-5804 A 1 of the Code;
4. Establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the provider terminates the agreement, the provider shall give the HMO at least sixty days' advance notice of termination, as required by § 38.2-5805 C 1 of the Code;
5. Establish and maintain procedures to ensure that its contracts with providers state that the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the HMO, as required by § 38.2-5805 C 4 of the Code;
6. Establish and maintain procedures to ensure that its contracts with providers state that no provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the HMO or the intermediary organization, as required by § 38.2-5805 C 5 of the Code;

7. Establish and maintain procedures to ensure that contracts between HealthKeepers' intermediary organizations and providers require the health care providers to give sixty days' advance notice of termination of the contract to the intermediary organization, as required by § 38.2-5805 C 7 of the Code;

8. Establish and maintain procedures to ensure that the HMO and any applicable intermediary organization maintain its executed contracts for a period of five years after the expiration of any such contract, as required by § 38.2-5805 C 8 of the Code;

9. As recommended in the prior Report, review and revise its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in § 38.2-5805 C 9 of the Code;

10. Establish and maintain procedures to ensure that the "hold harmless" clause in contracts between the HMO on behalf of the MCHIP and the intermediary organization is amended to include non-payment by the plan, the HMO and the intermediary organization, and is included in any contract between the intermediary organization and health care providers and in any contract between the HMO on behalf of the MCHIP and the intermediary organization, as required by § 38.2-5805 C 10 of the Code and14 VAC 5-211-30 C;

11. As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;

12. Establish and maintain procedures to ensure that the provider contracts with retail pharmacies contain the specific provisions required by §§ 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;

13. Amend all direct contracts between the HMO and a provider containing the "Special Compensation" amendment to remove the language inhibiting the provider's ability to ensure that claims are paid in accordance with the fee schedule, as required by § 38.2-3407.15 B 8 of the Code;

14. As recommended in the prior Report, establish and maintain procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;

15. Review and reopen the claims discussed in review sheets EFCL430D, EFCL16D, EFCL53D, EFCL188D, EFCL252D and re-adjudicate them to pay along with statutory interest owed. 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 denied in error." After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

16. Review and reopen the claims discussed in review sheets EFCL4D, EFCL15D, EFCL50D, EFCL57D, EFCL185D, EFCL204D. Re-adjudicate these claims to pay along with the statutory interest owed. 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 denied for no pre-authorization in error. Please accept this amount as payment for this claim.” After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

17. Review and reopen the claims discussed in review sheets EFCL20D, EFCL63D, EFCL154D, EFCL255D, EFCL267D. Retract the retroactive denials and pay the claims along with the statutory interest owed. 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 a retroactive denial of payment occurred in error during the adjudication of this claim.” After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

18. Adjust the claims discussed in EFCL02D, EFCL03D and EFCL116D and pay them at the contract rate for all services rendered along with statutory interest owed on the underpaid portion. 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 underpaid.” After which, furnish the examiners with documentation that the required amounts have been refunded within 90 days of this Report being finalized;

19. Amend all provider contracts with optometrists and ophthalmologists to comply with the requirements of §§ 38.2-3407.19 B and 38.2-3407.19 D of the Code;

20. 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 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 and 38.2-3407.15:1 C of the Code;

21. Establish and maintain procedures to ensure that all information required to be disclosed by 14 VAC 5-90-10 et seq. is set out conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement as to be confusing or misleading, as required by 14 VAC 5-90-40;

22. Establish and maintain procedures to ensure that the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive, as required by 14 VAC 5-90-50 A;

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

24. Establish and maintain procedures to ensure that an advertisement does not omit information or use words, phrases, statements or illustrations if the omission of the

information or the use of the words, phrases, statements or illustrations has the capacity or tendency to mislead prospective purchasers as to the nature and extent of any policy benefit payable or loss covered, as required by 14 VAC 5-90-60 A 1;

25. Establish 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;

26. Establish and maintain procedures to ensure that advertisements do not contain statements which are untrue in fact, or by implication misleading, with respect to the corporate structure, age or relative position of the HMO in the insurance business, as required by 14 VAC 5-90-160;

27. Establish and maintain procedures to ensure that the small group contracts filed with the Commission on behalf of its affiliate insurance company are not issued to small group HMO contract holders, in order to maintain compliance with §§ 38.2-316 A and 38.2-316 C 1 of the Code;

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

29. As recommended in the prior Report, establish and maintain procedures to ensure that all EOBs used by HealthKeepers are filed with and approved by the Commission, in their final form, as required by § 38.2-3407.4 A of the Code;

30. Establish and maintain procedures and claim system processes to ensure that an accurate record of each enrollee's out-of-pocket maximum is kept, as required by 14 VAC 5-211-90 B;

31. Establish and maintain procedures and claim system processes to ensure that each enrollee is notified when his or her out-of-pocket maximum is met and that notification is given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is met, as required by 14 VAC 5-211-90 B;

32. Establish and maintain procedures and claim system processes to ensure that the HMO does not charge additional cost-sharing for the remainder of the contract or calendar year, as appropriate, and that the HMO promptly refunds to the enrollee, not to the provider, all cost-sharing payments charged after the out-of-pocket maximum is reached, in order to maintain compliance with 14 VAC 5-211-90 B;

33. Review and reopen all claims for all enrollees who exceeded his or her out-of-pocket maximum during the years of 2015, 2016, 2017, 2018, 2019 and the current year and promptly refund to the enrollee all cost-sharing payments charged to the enrollee after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee, not to the provider. 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 within 90 days of this Report being finalized;

34. 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;

35. 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;

36. Establish and maintain procedures to ensure that in the event the coverage is terminated due to nonpayment of premium by the employer, that the HMO 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;

37. As recommended in the prior Report, establish and maintain procedures, and revise existing practices, to ensure that all EOBs clearly and accurately set forth the benefits payable under the contract, as required by § 38.2-3407.4 B of the Code;

38. 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;

39. Review all capitated laboratory encounters, and paid chiropractic claims from 2015, 2016, 2017, 2018, 2019 and the current year and reimburse enrollees directly for all excess coinsurance amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send

a letter or statement on the EOB with each payment stating that "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you." After which, furnish the examiners documentation that the required amounts have been refunded within 90 days of the Report being finalized.

40. Establish and maintain procedures to ensure that telemedicine services, an Essential Health Benefit (EHB) under PPACA is covered under all non-grandfathered individual and small group HMO contracts, in order to maintain compliance with § 38.2-3451 A of the Code;

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

42. Review and consider for re-adjudication all claims paid on the Wellpoint Group System (WGS) that required any manual processing and took longer than 30 calendar days to pay and all paid pharmacy claims that took greater than 30 calendar 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 § 38.2-4306.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which,

furnish the examiners with documentation that the required interest has been paid within 90 days of this Report being finalized;

43. 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 CLMEM01J;

44. Review and consider for re-adjudication all claims denied for the years of 2015, 2016, 2017, 2018 and the current year because an authorization was not on file. If the claim was later paid and it is determined that an authorization was on file when the claim was denied, reprocess the claim to pay interest, as required by § 38.2-4306.1 B of the Code, based upon when proof of loss was received. If the claim was never paid but there is an authorization on file, reprocess and pay the claim and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. If no authorization should have been required but the claim was later paid, reprocess the claim to pay interest, as required by § 38.2-4306.1 B of the Code, based upon when proof of loss was received. If no authorization should have been required but the claim was never paid, reprocess and pay the claim and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. Send checks for the additional payments and interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an error was made during the processing of this claim. Please accept this additional payment." After which,

furnish the examiners with documentation that the required payments and interest has been paid;

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

46. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code;

47. Within 90 days of this report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XVII. ACKNOWLEDGMENT

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

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

Respectfully submitted,

Julie R. Fairbanks

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

XVIII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

OPERATIONS/ORGANIZATION DOCUMENT
Enrollee Participation
§ 38.2-4304 B, 1 violation, OP01G
MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaints/Appeals
§ 38.2-5804 A and 14 VAC 5-211-150 A, 6 violations, MC07L, MC08L, MC09L, MC09J, MC10J, MC11J
§ 38.2-5804 A 1, **1 violation**, MC09J
Provider and Intermediary Contracts
§ 38.2-5805 C 1, 1 violation, MC18D
§ 38.2-5805 C 4, 2 violations, MC24G, MC25G
§ 38.2-5805 C 5, 2 violations, MC24G, MC25G
§ 38.2-5805 C 7, 2 violations, MC24G, MC25G
§ 38.2-5805 C 8, 2 violations, MC24G, MC25G
§ 38.2-5805 C 9, 23 violations, MC01D, MC02D, MC03D, MC04D, MC05D, MC06D, MC07D, MC08D, MC09D, MC10D, MC11D, MC12D, MC13D, MC14D, MC15D, MC16D, MC17D, MC18D, MC19D, MC20D, MC21D, MC26G, MC27G
§ 38.2-5805 C 10 & 14 VAC 5-211-30 C, 2 violations, MC26G, MC27G
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 2, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 3, 2 violations, EF24G, EF25G

§ 38.2-3407.15 B 4, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 5, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 6, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 7, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 8, 9 violations, EF05D, EF06D, EF08D, EF14D, EF17D, EF19D, EF20D, EF24G, EF25G
§ 38.2-3407.15 B 9, 2 violations, EF24G, EF25G
§ 38.2-3407.15 B 10, 2 violations, EF24G, EF25G
Provider Claims
§ 38.2-3407.15 B 1, 25 violations, EFCL4D, EFCL15D, EFCL16D, EFCL20D, EFCL47D, EFCL48D, EFCL49D, EFCL50D, EFCL53D, EFCL55D, EFCL56D, EFCL57D, EFCL59D, EFCL61D, EFCL119D, EFCL128D, EFCL182D, EFCL185D, EFCL188D, EFCL204D, EFCL240D, EFCL252D, EFCL255D, EFCL334D, EFCL430D
§ 38.2-3407.15 B 3, 27 violations, EFCL01, EF50G, EFCL4D, EFCL16D, EFCL20D, EFCL48D, EFCL50D, EFCL53D, EFCL55D, EFCL57D, EFCL59D, EFCL61D, EFCL63D, EFCL116D, EFCL119D, EFCL128D, EFCL147D, EFCL152D, EFCL182D, EFCL185D, EFCL188D, EFCL189D, EFCL204D, EFCL252D, EFCL255D, EFCL334D, EFCL430D
§ 38.2-3407.15 B 5, 6 violations, EFCL4D, EFCL15D, EFCL50D, EFCL57D, EFCL185D, EFCL204D
§ 38.2-3407.15 B 6, 5 violations, EFCL20D, EFCL63D, EFCL154D, EFCL255D, EFCL267D
§ 38.2-3407.15 B 7, 5 violations, EFCL20D, EFCL63D, EFCL154D, EFCL255D, EFCL267D
§ 38.2-3407.15 B 8, 3 violations, , EFCL02D, EFCL03D, EFCL116D

REQUIRED PROVISIONS IN CARRIER CONTRACTS WITH PHARMACY PROVIDERS
§§ 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 and 38.2-3407.15:1 C, 1 violation, each section, EF26G
ADVERTISING
14 VAC 5-90-40, 2 violations, AD58, AD63
14 VAC 5-90-50 A, 3 violations, AD58, AD62, AD63
14 VAC 5-90-55 A, 15 violations, AD30, AD31, AD32, AD33, AD39, AD42, AD43, AD44, AD45, AD46, AD47, AD48, AD49, AD50, AD52B
14 VAC 5-90-60 A 1, 11 violations, AD62, AD35 (2), AD38B, AD41A, AD41B, AD41C, AD52A, AD53A, AD53C, AD53D
14 VAC 5-90-90 C, 1 violation, AD56
14 VAC 5-90-160, 2 violations, AD17A, AD49
POLICY AND OTHER FORMS
§ 38.2-316 A, 1violation, PF07G, PF02F, PF03F, PF04F, PF05F
§ 38.2-316 B, 2 violations, PF01F, PF08G
§ 38.2-316 C 1, 3, violations, PF07G , PF01F, PF02F, PF03F, PF04F, PF05F, PF08G
§ 38.2-3407.4 A, 2 violations, PF03G, PF04G
14 VAC 5-211-90 B, 95 violations, PF01G
AGENTS
§ 38.2-1833 A 1, 4 violations, AG02G, AD03G, AD06G, AD07G
§ 38.2-1812 A, 1 violation, AG02G
§ 38.2-1834 D, 61 violations, AG01G

CANCELLATIONS/NON-RENEWALS/RESCISSIONS
§ 38.2-3542 C, 15 violations, CN01G, CN02G, CN03G, CN04G (12)
CLAIM PRACTICES
§ 38.2-510 A 1, 3 instances of non-compliance, CL25J, CL28J, CL48J
§ 38.2-510 A 2, 16 instances of non-compliance, CL11J, CL13J, CL21J, CL29J, CL30J, CL31J, CL39J, CL51J, CL52J, CL56J, CL30M, CL33M, CL35M, CL37M, CL38M, CL39M
§ 38.2-510 A 3, 89 violations, CL01J, CL02J, CL03J, CL04J, CL05J, CL08J, CL11J, CL13J, CL16J, CL19J, CL20J, CL21J, CL22J, CL23J, CL24J, CL26J, CL27J, CL29J, CL30J, CL31J, CL32J, CL33J, CL34J, CL35J, CL36J, CL37J, CL39J, CL40J, CL41J, CL42J, CL43J, CL44J, CL45J, CL47J, CL51J, CL52J, CL56J, CL57J, CL58J, CL59J, CL60J, CL61J, CL62J, CL63J, CL64J, CL69J, CL71J, CL73J, CL74J, CL77J, CL83J, CL104J, CL105J, CL107J, CL01M, CL02M, CL03M, CL04M, CL05M, CL06M, CL07M, CL11M, CL18M, CL19M, CL20M, CL28M, CL30M, CL33M, CL34M, CL35M, CL37M, CL38M, CL39M, CL40M, CL41M, CL42M, CL46M, CL48M, CL50M, CL54M, CL68M, CL69M, CL70M, CL71M, CL73M, CL77M, CL81M, CL82M, CL83M
§ 38.2-510 A 4, 6 instances of non-compliance, CL39J, CL92J, CL102J, CL35M, CL44M, CL82M
§ 38.2-510 A 5, 115 instances of non-compliance, CL01J, CL02J, CL03J, CL04J, CL05J, CL08J, CL11J, CL13J, CL16J, CL19J, CL20J, CL21J, CL22J, CL23J, CL24J, CL26J, CL27J, CL29J, CL30J, CL31J, CL32J, CL33J, CL34J, CL35J, CL36J, CL37J, CL39J, CL40J, CL41J, CL42J, CL43J, CL44J, CL45J, CL47J, CL51J, CL52J, CL56J, CL57J, CL58J, CL59J, CL60J, CL61J, CL62J, CL63J, CL64J, CL69J, CL71J, CL73J, CL74J, CL77J, CL83J, CL104J, CL105J, CL107J, CL01M, CL02M, CL03M, CL04M, CL05M, CL06M, CL07M, CL11M, CL18M, CL19M, CL20M, CL28M, CL30M, CL33M, CL34M, CL35M, CL37M, CL38M, CL39M, CL40M, CL41M, CL42M, CL46M, CL48M,

CL50M, CL54M, CL68M, CL69M, CL70M, CL71M, CL73M, CL75M, CL77M, CL80M, CL81M, CL82M, CL83M, CL02G, CL03G, CL04G, CL05G, CL06G, CL07G, CL08G, CL09G, CL10G, CL11G, CL12G, CL13G, CL14G, CL15G, CL16G, CL17G, CL18G, CL19G, CL20G, CL21G, CL22G, CL23G, CL24G, CL25G
§ 38.2-510 A 6, 14 instances of non-compliance, CL21J, CL44J, CL45J, CL46J, CL49J, CL92J, CL102J, CL06M, CL15M, CL35M, CL44M, CL80M, CL82M, CL83M
§ 38.2-510 A 14, 50 violations, CL55J, CL65J, CL66J, CL67J, CL68J, CL70J, CL72J, CL76J, CL78J, CL79J, CL80J, CL81J, CL82J, CL83J, CL84J, CL85J, CL86J, CL87J, CL88J, CL89J, CL90J, CL91J, CL92J, CL93J, CL94J, CL95J, CL96J, CL97J, CL98J, CL109J, CL110J, CL111J, CL112J, CL113J, CL114J, CL115J, CL116J, CL117J, CL118J, CL35M, CL37M, CL38M, CL39M, CL44M, CL55M, CL59M, CL22G, CL23G, CL24G, CL25G
§ 38.2-514 B, 3 violations, CL25J, CL28J, CL48J
§ 38.2-3407.3 A, 13 violations, CL01G (10), CL04G, CL17G, CL46G
§ 38.2-3407.4 B, 3 violations, CL25J, CL28J, CL48J
§ 38.2-3451 A, 1 violation, CL76J
§ 38.2-4306.1 B, 13 violations, CL21J, CL33J, CL43J, CL47J, CL56J, CL20M, CL54M, CL33G, CL34G, CL35G, CL38G, CL39G, CL45G
14 VAC 5-211-80 B, 2 violations, CL106J, CL80M
14 VAC 5-211-90 B, 8 violations, CL01J, CL06J, CL10J, CL09M, CL32M, CL54M, CL62M, CL63M

COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
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August 19, 2019

SENT VIA E-MAIL

Kimberly J. Stevens
Regulatory Compliance Director – VA
HealthKeepers, 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 HealthKeepers, 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 HealthKeepers, 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. HealthKeepers, 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

Anthem HealthKeepers
Offered by HealthKeepers, Inc.
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: HealthKeepers, Inc., Exposure Draft Report

Dear Ms. Fairbanks,

Enclosed you will find HealthKeepers, 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 remediated if necessary.

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

Sincerely,

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

Enclosures

Target Market Conduct Examination
Response to Recommendations
HealthKeepers Inc.

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

1. Maintain its established enrollee participation mechanism as required by § 38.2-4304 B of the Code;

   HealthKeepers has an enrollee participation mechanism in place as required by § 38.2-4304 B of the Code. However, during the Exam it was alleged that the Virginia Quality Assurance Advisory Committee (the Committee), which includes participation of a person covered by a HealthKeepers plan, did not meet with enough frequency to demonstrate compliance. As a result, the Committee Charter was revised in November 2016 to include the expectation of holding quarterly meetings.

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 and 14 VAC 5-211-150 A;

   The examination identified variances between HealthKeepers 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.

3. Review and strengthen its procedures for maintaining a complete record of complaints, as required by §§ 38.2-511 and 38.2-5804 A 1 of the Code;

   HealthKeepers has procedures in place for maintaining a complete record of complaints, as required by §§ 38.2-511 and 38.2-5804 A 1 of the Code. We have determined that the cited violation (Review Sheet MC09J) was a one-time variance which has been appropriately addressed with the individual associate.

4. Establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the provider terminates the agreement, the provider shall give the HMO at least sixty days' advance notice of termination, as required by § 38.2-5805 C 1 of the Code;

   This issue, outlined in Review Sheet MC18D, was isolated to EyeMed's Eye Care Professional agreement. The Company worked with EyeMed to ensure their Professional Agreement was updated. As a result, the language below was added to their Eye Care Professional Agreement on June 28, 2016, fully remediating this issue.

   "Termination Date. We may terminate this ***agreement***, as provided below, to any ***one*** or more ***affiliated eye care professionals*** or to all ***affiliated eye care professionals*** and ***you*** covered under this ***agreement***. This agreement may be terminated as follows……

5.2.2 By either ***party*** upon 60 days prior written notice to the other ***party*** for any reason or no reason."

5. Establish and maintain procedures to ensure that its contracts with providers state that the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the HMO, as required by § 38.2-5805 C 4 of the Code;

   This issue was isolated to Express Scripts, the PBM at the time of the Exam. Express Scripts revised its provider contracts November 4, 2016, to state that the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the HMO, as required by § 38.2-5805 C 4 as shown below, which fully remediates this issue. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

   "2. Hold Harmless. **In the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier.** No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization."

6. Establish and maintain procedures to ensure that its contracts with providers state that no provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the HMO or the intermediary organization, as required by § 38.2-5805 C 5 of the Code

   This issue was isolated to Express Scripts, the PBM at the time of the Exam. Express Scripts revised its provider contracts November 4, 2016, to state that no provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the HMO or the intermediary organization, as required by § 38.2-5805 C 5 of the Code as shown below, which fully remediates this issue. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

   "2. Hold Harmless. In the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier. **No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization.** An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.

Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization."

7. Establish and maintain procedures to ensure that contracts between HealthKeepers' intermediary organizations and providers require the health care providers to give sixty days' advance notice of termination of the contract to the intermediary organization, as required by § 38.2-5805 C 7 of the Code;

   This issue was isolated to Express Scripts, the PBM at the time of the Exam. Express Scripts revised its provider contracts November 4, 2016, to require providers to give sixty days' advance notice of termination of the contract to the intermediary organization, as required by § 38.2-5805 C 7 of the Code as shown below, which fully remediates this issue. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

   "2. Hold Harmless. In the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization. **An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.** Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract. If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization."

8. Establish and maintain procedures to ensure that the HMO and any applicable intermediary organization maintain its executed contracts for a period of five years after the expiration of any such contract, as required by § 38.2-5805 C 8 of the Code;

   This issue was isolated to Express Scripts, the PBM at the time of the Exam. Express Scripts revised its provider contracts November 4, 2016, to include a statement that it will maintain its executed contracts for a period of five years after the expiration of any such contract, as required by § 38.2-5805 C 8 of the Code as shown below, which fully remediates this issue. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

   "2. Hold Harmless. In the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or

the health carrier. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization. An agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. **These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.** If there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization."

9. As recommended in the prior Report, review and revise its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in § 38.2-5805 C 9 of the Code;

   HealthKeepers revised its provider contracts on January 1, 2017, as shown below, which fully remediates this issue.

   "Provider hereby agrees that in no event, including but not limited to, nonpayment by the Plan, insolvency of the Plan or breach of this Provider Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than the Plan for services provided pursuant to this Provider Agreement. This section shall not prohibit collection of any applicable Cost Shares billed in accordance with the terms of the Health Benefit Plan for the Plan.

   The Provider further agrees that (1), this section shall survive the termination of this Provider Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Members, and (2), this section supersedes any oral or written agreement to the contrary now existing or hereafter entered into between the Provider and the Member or persons acting on the Member's behalf."

10. Establish and maintain procedures to ensure that the "hold harmless" clause in contracts between the HMO on behalf of the MCHIP and the intermediary organization is amended to include non-payment by the plan, the HMO and the intermediary organization, and is included in any contract between the intermediary organization and health care providers and in any contract between the HMO on behalf of the MCHIP and the intermediary organization, as required by § 38.2-5805 C 10 of the Code and14 VAC 5-211-30 C 3;

    This issue was isolated to Express Scripts, the PBM at the time of the Exam. Express Scripts revised its hold harmless clause November 4, 2016, as shown below, which fully remediates this issue. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

    "2. Hold Harmless. In the event either the health carrier or the intermediary organization fails to pay for health care services as set forth in the contracts between the intermediary organization and its providers, or in the contract between the intermediary organization and the health carrier, the covered person shall not be liable to the provider for any sums owed by either the intermediary organization or the health carrier. No provider party to such a contract, or agent, trustee or assignee thereof, may maintain any action at law against a covered person to collect sums owed by the health carrier or the intermediary organization. An agreement to provide health care services between an intermediary

organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination. Each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract. If there is an intermediary organization between the health carrier and the health care providers, **the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization**."

11. As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;

    HealthKeepers is compliant with the substantive provisions of § 38.2-3407.15 B of the Code but acknowledges that all of our provider contracts did not include updates to the provisions included in § 38.2-3407.15 B of the Code. The company will put procedures in place to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code.

12. Establish and maintain procedures to ensure that the provider contracts with retail pharmacies contain the specific provisions required by §§ 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;

    Express Scripts distributed a Virginia Regulatory Addendum as an update to the Provider Manual on November 4, 2016, that incorporated all of provisions required by § 38.2-3407.15 B, which completely remediated this issue.

13. Amend all direct contracts between the HMO and a provider containing the "Special Compensation" amendment to remove the language inhibiting the provider's ability to ensure that claims are paid in accordance with the fee schedule, as required by § 38.2-3407.15 B 8 of the Code;

    HealthKeepers will amend its direct contracts between the HMO and a provider 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:

    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 HealthKeepers, Inc., rate.

14. As recommended in the prior Report, establish and maintain procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;

    HealthKeepers has reviewed its procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code. The issues noted during the exam were limited to episodes of human error and/or isolated incidents and were not caused by any systemic issue and were in conflict with our established procedures.

15. Review and reopen the claims discussed in review sheets EFCL430D, EFCL16D, EFCL53D, EFCL188D, EFCL252D and re-adjudicate them to pay along with statutory interest owed. 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 denied in error.” After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

    HealthKeepers will reopen and adjust claims as requested.

16. Review and reopen the claims discussed in review sheets EFCL4D, EFCL15D, EFCL50D, EFCL57D, EFCL185D, EFCL204D. Re-adjudicate these claims to pay along with the statutory interest owed. 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 denied for no pre-authorization in error. Please accept this amount as payment for this claim.” After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

    HealthKeepers will reopen and adjust claims as requested.

17. Review and reopen the claims discussed in review sheets EFCL20D, EFCL63D, EFCL154D, EFCL255D, EFCL267D. Retract the retroactive denials and pay the claims along with the statutory interest owed. 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 a retroactive denial of payment occurred in error during the adjudication of this claim.” After which, furnish the examiners with documentation that the required amounts have been paid within 90 days of this Report being finalized;

    HealthKeepers will reopen and adjust claims as requested.

18. Adjust the claims discussed in EFCL02D, EFCL03D and EFCL116D and pay them at the contract rate for all services rendered along with statutory interest owed on the underpaid portion. 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 underpaid.” After which, furnish the examiners with documentation that the required amounts have been refunded within 90 days of this Report being finalized;

    HealthKeepers will reopen and adjust claims as requested.

19. Amend all provider contracts with optometrists and ophthalmologists to comply with the requirements of §§ 38.2-3407.19 B and 38.2-3407.19 D of the Code;

    HealthKeepers worked with EyeMed to ensure their provider contracts with optometrists and ophthalmologists were revised to comply with requirements of §§ 38.2-3407.19 B and 38.2-3407.19 D of the Code as shown below effective January 1, 2016, which fully remediates this issue.

    - § 38.2-3407.19 B

      “Article IV, Section 4.4, **Non-Covered Services**, is hereby amended to comply with Virginia Insurance Law, Section 38.2-3407.19, to add the following as a second paragraph for contracts that are entered into, amended, extended or renewed on or after January 1, 2016:

We shall not establish a fee or rate that ***you*** are required to accept for the provision of materials or services, or require ***you*** to accept the reimbursement paid as payment in full, unless the materials and services are ***covered materials*** or ***covered services***. ***EyeMed*** reserves the right to notify ***its members*** that ***you*** may not accept all discounts."

- "Article VIII, **Miscellaneous**, is hereby amended to comply with Virginia Insurance Law, Section 38.2- 3407.19, to include the following as a new paragraph for contracts that are entered into, amended, extended or renewed on or after January 1, 2016:

  8.16 **Lab Network**. ***We*** will not restrict or limit, either directly or indirectly, ***your*** choice of sources and suppliers of services or materials or use of optical labs in ***your*** practice. In the event ***you*** choose to use ***your*** own labs, all references in this ***agreement*** to labs and Optical Procurement Services LLC ("Supplier") shall not apply."

20. 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 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 and 38.2-3407.15:1 C of the Code;

    The Company will 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 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 and 38.2-3407.15:1 C of the Code.

21. Establish and maintain procedures to ensure that all information required to be disclosed by 14 VAC 5-90-10 et seq. is set out conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisement as to be confusing or misleading, as required by 14 VAC 5-90-40;

    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.

22. Establish and maintain procedures to ensure that the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive, as required by 14 VAC 5-90-50 A;

    HealthKeepers 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.

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

    HealthKeepers 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.

24. Establish and maintain procedures to ensure that an advertisement does not omit information or use words, phrases, statements or illustrations if the omission of the information or the use of the words, phrases, statements or illustrations has the capacity or tendency to mislead prospective purchasers as to the nature and extent of any policy benefit payable or loss covered, as required by 14 VAC 5-90-60 A 1;

    The Company has made significant progress in ensuring that our advertisements are compliant with 14 VAC 5-90-60 A 1 and has provided additional training and coaching. Additionally, there are tools that are easily accessible which outline requirements. The Company will also take additional steps to further ensure compliance.

25. Establish 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;

    HealthKeepers 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 all sources even if data is specific to the Company's statistics. Further, all advertisements will be reviewed to ensure any statistic is identified.

26. Establish and maintain procedures to ensure that advertisements do not contain statements which are untrue in fact, or by implication misleading, with respect to the corporate structure, age or relative position of the HMO in the insurance business, as required by 14 VAC 5-90-160;

    HealthKeepers has reviewed its procedures to ensure that advertisements do not contain statements which are untrue in fact, or by implication misleading, with respect to the corporate structure, age or relative position of the HMO in the insurance business, as required by 14 VAC 5-90-160. Further, all advertisements will be reviewed to ensure they do not contain any misleading information with respect to corporate structure, age or relative position of the HMO in the insurance business.

27. Establish and maintain procedures to ensure that the small group contracts filed with the Commission on behalf of its affiliate insurance company are not issued to small group HMO contract holders, in order to maintain compliance with §§ 38.2-316 A and 38.2-316 C 1 of the Code;

    HealthKeepers has reviewed and updated its procedures and controls to ensure that the small group contracts filed with the Commission on behalf of its affiliate insurance company are not issued to small group HMO contract holders, in order to maintain compliance with §§ 38.2-316 A and 38.2-316 C 1 of the Code. The Company issued correct contracts to affected small groups as of November 24, 2017, fully remediating this issue. Further, we have found no downstream effects as a result of this issue.

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

    HealthKeepers has procedures in place to ensure that all application and enrollment forms are filed with and approved by the Commission, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code. The two violations noted were a result of associate error and not a result of inadequate procedures. The associates were coached accordingly.

29. As recommended in the prior Report, establish and maintain procedures to ensure that all EOBs used by HealthKeepers are filed with and approved by the Commission, in their final form, as required by § 38.2-3407.4 A of the Code;

HealthKeepers has made significant progress in ensuring that all EOBs used by the Company are filled with an approved by the Commission and will look at ways to further enhance its procedures.

30. Establish and maintain procedures and claim system processes to ensure that an accurate record of each enrollee's out-of-pocket maximum is kept, as required by14 VAC 5-211-90 B;

    HealthKeepers was aware that it had issues with its accumulator tracking system at the time of the exam and was working to ensure that an accurate record of each enrollee's out-of-pocket maximum was kept, as required by 14 VAC 5-211-90 B. The system was enhanced effective September 17, 2018 fully remediating this issue.

31. Establish and maintain procedures and claim system processes to ensure that each enrollee is notified when his or her out-of-pocket maximum is met and that notification is given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is met, as required by 14 VAC 5-211-90 B;

    HealthKeepers has enhanced its system to produce new member communications to ensure that each enrollee is notified when his or her out-of-pocket maximum is met as required by 14 VAC 5-211-90 B effective November 9, 2016, which fully remediates this issue.

32. Establish and maintain procedures and claim system processes to ensure that the HMO does not charge additional cost-sharing for the remainder of the contract or calendar year, as appropriate, and that the HMO promptly refunds to the enrollee, not to the provider, all cost-sharing payments charged after the out-of-pocket maximum is reached, in order to maintain compliance with 14 VAC 5-211-90 B;

    HealthKeepers has enhanced its procedures and the claim system to ensure compliance with 14 VAC 5-211-90 B. The system changes were implemented effective September 17, 2018 which fully remediates this issue.

33. Review and reopen all claims for all enrollees who exceeded his or her out-of-pocket maximum during the years of 2015, 2016, 2017, 2018 and the current year and promptly refund to the enrollee all cost-sharing payments charged to the enrollee after the out-of-pocket maximum was reached. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee, not to the provider. 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 within 90 days of this Report being finalized;

    As of the implementation of the system project on September 17, 2018, HealthKeepers is refunding all cost-sharing payments charged in excess of an enrollee's out-of-pocket maximum to the enrollee as required by 14 VAC 5-211-90 B. However, we acknowledge during the timeframe under review that in some cases we were refunding the excess to the party that submitted the claim including when this was the provider.

    We respectfully request that the Bureau reconsider its request that HealthKeepers adjust affected claims back to 2015 to refund the enrollee. As a general business practice, if a provider receives payment in excess of an enrollee's out-of-pocket maximum, they will reimburse the member. As such, affected members have already been made whole. Adjusting claims now would result in member and provider confusion and abrasion.

34. 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;

    HealthKeepers 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.

35. 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 HealthKeepers 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.

36. Establish and maintain procedures to ensure that in the event the coverage is terminated due to nonpayment of premium by the employer, that the HMO 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;

    HealthKeepers 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, as of January 17, 2019, we enhanced our procedures and implemented a new termination letter to ensure that in the event the coverage is terminated due to nonpayment of premium by the employer, the HMO 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.

37. As recommended in the prior Report, establish and maintain procedures, and revise existing practices, to ensure that all EOBs clearly and accurately set forth the benefits payable under the contract, as required by § 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.

38. Review all capitated laboratory encounters, paid chiropractic and paid pharmacy claims from 2015, 2016, 2017, 2018 and the current year and reimburse enrollees directly for all excess coinsurance amounts collected for claims that were processed in violation of the calculation of cost-sharing provisions of § 38.2-3407.3 A of the Code, as required by § 38.2-218 D 1 c of the Code. Send a letter or statement on the EOB with each payment stating that “As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that an error was made in the calculation of your cost-sharing amount. Please accept this refund due to you.” After which, furnish the examiners documentation that the required amounts have been refunded within 90 days of the Report being finalized.

HealthKeepers has enclosed a legal opinion for the pharmacy portion of this corrective action. This issue is separate and distinct from the noted capitated laboratory and chiropractic issues. Please see Appendix A.

The capitated laboratory findings were a result of a benefit set up issue that was sent for resolution on April 4, 2017. The Company will determine if further remediation is needed. In addition, the Company will further review the findings for the chiropractic claims.

39. Establish and maintain procedures to ensure that telemedicine services, an Essential Health Benefit (EHB) under PPACA is covered under all non-grandfathered individual and small group HMO contracts, in order to maintain compliance with § 38.2-3451 A of the Code;

    The Company has ensured that telemedicine services are covered under non-grandfathered individual and small group HMO contracts. This was a singular product set up issue which has been corrected.

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

    HealthKeepers has taken significant steps to strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of 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.

41. Review and consider for re-adjudication all claims paid on the Wellpoint Group System (WGS) and all paid pharmacy claims that took greater than 30 calendar days to pay for the years of 2015, 2016, 2017 and the current year and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that “As a result of a Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that this interest had not been paid previously.” After which, furnish the examiners with documentation that the required interest has been paid within 90 days of this Report being finalized;

    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. As noted in #40, the Company has taken significant steps to strengthen its procedures for the payment of required interest. We respectfully request that the Bureau reconsider its request that the Company re-adjudicate all claims paid on WGS to ensure required interest was paid 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.

    The Company reviewed all of the findings associated with pharmacy claims and agrees that interest had not been paid by Express Scripts as required by § 38.2-4306.1 B of the Code. Express Scripts 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. HealthKeepers has terminated its relationship with Express Scripts since the Exam.

42. 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 CLMEM01J;

    HealthKeepers 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 CLMEM01J.

43. Review and consider for re-adjudication all claims denied for the years of 2015, 2016, 2017, 2018 and the current year because an authorization was not on file. If the claim was later paid and it is determined that an authorization was on file when the claim was denied, reprocess the claim to pay interest, as required by § 38.2-4306.1 B of the Code, based upon when proof of loss was received. If the claim was never paid but there is an authorization on file, reprocess and pay the claim and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. If no authorization should have been required but the claim was later paid, reprocess the claim to pay interest, as required by § 38.2-4306.1 B of the Code, based upon when proof of loss was received. If no authorization should have been required but the claim was never paid, reprocess and pay the claim and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. Send checks for the additional payments and interest along with a letter of explanation or statement on the EOB that “As a result of a Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that an error was made during the processing of this claim. Please accept this additional payment.” After which, furnish the examiners with documentation that the required payments and interest has been paid;

    HealthKeepers will re-adjudicate claims and furnish the examiners with documentation requested.

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

    HealthKeepers implemented system code changes to bring EOBs into compliance with the requirements of 14 VAC 5-211-80 B on November 10, 2017, which fully remediated this issue.

45. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code;

    HealthKeepers has comprehensive procedures in place to ensure compliance with §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code 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.

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

March 13, 2020

SENT VIA EMAIL

Kimberly Stevens
Regulatory Compliance Director
HealthKeepers, Inc.
2015 Staples Mill Road
Richmond, VA 23230

RE: HealthKeepers, Inc. (HealthKeepers) Response to the Draft Examination Report

Dear Ms. Stevens:

The examiners have received and reviewed HealthKeepers' response to the Draft Report dated October 18, 2019. This letter will primarily address those areas of the response where HealthKeepers 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 HealthKeepers 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.

Corrective Action #5, #6, #7, #8 and #10

The examiners acknowledge that HealthKeepers has terminated its relationship with Express Scripts since the Exam time frame. However, HealthKeepers will be required to provide documentation demonstrating that HealthKeepers' contracts with its current PBM and pharmacy providers include the language required by §§ 38.2-5805 C 4, 38.2-5805 C 5, 38.2-5805 C 7, 38.2-5805 C 8, and 38.2-5805 C 10 of the Code and 14 VAC 5-211-30 C 3. The Report appears correct as written.

Corrective Action #13

HealthKeepers' 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 HealthKeepers' 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 #33

The examiners acknowledge that in some cases during the timeframe under review, HealthKeepers may have refunded the out-of-pocket maximum excess to the party that submitted the claim including when this was the provider. 14 VAC 5-211 90 B requires that an HMO shall promptly refund excess copayments to the enrollee. HealthKeepers' business decision to place responsibility on the **provider** to refund excess copayments does not relieve HealthKeepers of its responsibility to comply with Code. HealthKeepers will be required to document that all claims where the enrollees exceeded the copayment maximum during the years of 2015, 2016, 2017, 2018, 2019 and the current year have been reviewed and that all necessary refunds have been made by HealthKeepers to the enrollee, or that HealthKeepers has verified that refunds have been made by the provider to the enrollee, within 90 days of the Report being finalized. This CAP item has been revised to include the year 2019.

Corrective Action #38

As discussed in the Bureau's letter to HealthKeepers dated January 16, 2020, the examiners have considered HealthKeepers' response, and the findings citing a violation of § 38.2-3407.3 of the Code will remain in the Report; however, no monetary forfeiture will be assessed for the pharmacy claim violation. The CAP has been revised to require that HeathKeepers comply with the requirements of § 38.2-3407.3 of the Code going forward for pharmacy claims. CAP item #38 has also been revised to include the year 2019. In addition, the examiners acknowledge that the requirements of § 38.2-3407.3 of the Code may have changed for certain capitated laboratory encounters effective July 1, 2017.

Corrective Action #40

The examiners acknowledge that HealthKeepers has terminated its relationship with Express Scripts since the examination time frame. HealthKeepers will be required to provide documentation demonstrating that HealthKeepers and its current PBM have procedures in place to comply with the payment of interest as required by § 38.2-4306.1 B of the Code. The Report appears correct as written.

Corrective Action #41

The corrective action item requires that HealthKeepers **review** the specified claims and consider them for re-adjudication, and only those claims requiring adjustment would need to be re-adjudicated. The examiners acknowledge that HealthKeepers 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 HealthKeepers review and consider for re-adjudication all claims paid on the WGS system **that required any manual processing** and that took longer than 30 calendar days to pay and all paid pharmacy claims that took longer than 30 calendar 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 § 38.2-4306.1 of the Code. This CAP item has also been revised to include the year 2019.

Corrective Action #43

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

A typo when referencing 14 VAC 5-211-30 C has been corrected on pages 14, 68, and 78 of the Report.

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 HealthKeepers violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 3, 38.2-510 A 14 and 38.2-514 B of the Code, in addition to 14 VAC 5-90-40, 14 VAC 5-90-50 A, 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1, 14 VAC 5-90-90 C and 14 VAC 5-90-160 of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that HealthKeepers violated §§ 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, 38.2-3407.3 A, 38.2- 3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2- 3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15:1 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, 38.2-3451 A, 38.2-3542 C, 38.2-4304 B, 38.2-4306.1 B, 38.2-5804 A, 38.2-5804 A 1, 38.2-5805 C 1, 38.2-5805 C 4, 38.2- 5805 C 5, 38.2-5805 C 7, 38.2-5805 C 8, 38.2-5805 C 9 and 38.2-5805 C 10 of the Code, in addition to 14 VAC 5-211-30 C, 14 VAC 5-211-80 B, 14 VAC 5-211-90 B, and 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations.

Violations of the above sections of the Code can subject HealthKeepers 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

Anthem HealthKeepers
Offered by HealthKeepers, Inc.
P.O. Box 27401
Richmond, VA 23279

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

Re: Alleged Violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-510 A 3, 38.2-510 A 14, 38.2-514 B, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3407.3 A, 38.2- 3407.4, 38.2-3407.4 B, 38.2-3407 .15 B 1, 38.2-3407. 15 B 2, 38.2-3407. 15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15:1 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, 38.2-3451 A, 38.2-3542 C, 38.2-4304 B, 8.2-4306. 1 B, 38.2-5804 A, 38.2-5804 A 1, 38.2-5805 C 1, 38.2-5805 C 4, 38.2- 5805 C 5, 38.2-5805 C 7, 38.2-5805 C 8, 38.2-5805 C 9 and 38.2-5805 C 10 of the Code, in addition to, 14 VAC 5-90-40, 14 VAC 5-90-50 A, 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1, 14 VAC 5-90-90 C, 14 VAC 5-90-160 of Rules Governing the Advertisement of Accident and Sickness Insurance, 14 VAC 5-211-30 C, 14 VAC 5-211-80 B, 14 VAC 5-211-90 B, and 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations
Case No. INS-2020-00046

Dear Ms. Blauvelt,

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

HealthKeepers 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 $161,400 separately.

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

3. Acknowledge HealthKeepers 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.

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,

HealthKeepers, Inc.

Jeff Ricketts

(Signed)

Jeff Ricketts

(Type or Print Name)

Plan President, Virginia

(Title)

March 31, 2020

(Date)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, APRIL 14, 2020

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COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2020-00046

HEALTHKEEPERS, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that HealthKeepers, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code of Virginia ("Code") by failing to use insurance policies or forms on file and approved by the Commission; § 38.2-510 A 3 of the Code by failing to adopt and implement reasonable standards for the prompt investigation of claims; § 38.2-510 A 14 of the Code by failing to promptly provide a reasonable explanation of the basis for denial of a claim; § 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; § 38.2-3407.3 A of the Code by failing to calculate coinsurance on the amount paid or payable to the provider; § 38.2-3407.4 A of the Code by failing to file explanation of benefit forms for approval by the Commission; § 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; §§ 38.2-3407.15 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; § 38.2-3451 A of the Code by failing to provide an essential health benefit; § 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; § 38.2-4304 B of the Code by failing to establish a mechanism to provide enrollees an opportunity to participate in matters of policy and operation; § 38.2-4306.1 B of the Code by failing to pay interest on claim proceeds; §§ 38.2-5804 A and 38.2-5804 A 1 of the Code by failing to maintain a complaint system approved by the Commission and by failing to maintain a record of the complaints for a period of no less than five years; §§ 38.2-5805 C 1, 38.2-5805 C 4, 38.2-5805 C 5, 38.2-5805 C 7, 38.2-5805 C 8, 38.2-5805 C 9, and 38.2-5805 C 10 of the Code by failing to include required provisions in provider contracts; 14 VAC 5-90-40 of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* ("Rules"), by failing to conspicuously

set out all information required to be disclosed; 14 VAC 5-90-50 A of the Commission's Rules by using potentially misleading or deceptive advertisements, 14 VAC 5-90-55 A of the Commission's Rules by failing to include the required disclosure regarding the exclusions and limitations of the policy, 14 VAC 5-90-60 A 1 of the Commission's Rules by making misleading statements in the advertisements of covered benefits; 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 5-90-160 of the Commission's Rules by using statements in advertisements that are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, age or relative position of the company; as well as 14 VAC 5-211-30 C of the Commission's Rules Governing Health Maintenance Organizations, 14 VAC 5-211-10 *et seq.*, by failing to include the required hold harmless clause in provider contracts; 14 VAC 5-211-80 B of the Commission's Rules by failing to provide or arrange for service prior to seeking coordination of benefits; 14 VAC 5-211-90 B of the Commission's Rules by failing to properly provide notice to an enrollee when his out-of-pocket maximum has been reached; and 14 VAC 5-211-150 A of the Commission's Rules by failing to establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The Commission is authorized by §§ 38.2-218, 38.2-219, 38.2-4316 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 Sixty-One Thousand Four Hundred Dollars ($161,400); and has waived the right to a hearing.

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, HealthKeepers, 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.