REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

COVENTRY HEALTH CARE OF VIRGINIA, INC.

AS OF DECEMBER 31, 2016

Conducted from April 7, 2017

through

December June 5, 2018

By

Market Conduct Section

Life and Health
Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-1576305
NAIC: 96555

COMMONWEALTH OF VIRGINIA

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BUREAU OF INSURANCE

I, Bryan Wachter, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Coventry Health Care of Virginia, Inc. as of December 31, 2016, completed at the office of the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2019-00067 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 27th day of June 2019.

Bryan Wachter
Examiner in Charge

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I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Coventry Health Care of Virginia, Inc. (hereinafter referred to as "CHCVA" or "the Company") was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as "the Code") and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC") including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-1809, 38.2-3407.15 C, 38.2-3420, 38.2-4315, and 38.2-5808 B of the Code, as well as 14 VAC 5-90-170 A.

The period of time covered for the current examination was January 1, 2016, through December 31, 2016. The on-site examination was conducted at CHCVA's office in Harrisburg, Pennsylvania from September 11, 2017 to September 29, 2017, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on June 5, 2018. The violations cited and the comments included in this Report are the opinions of the examiners.

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

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

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations; and
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review

The examination included the following areas:

- Operations/Organization documents
- Managed Care Health Insurance Plans (MCHIPs)
- Provider Contracts
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium and Renewal Notices/Collections/Reinstatements
- Cancellations/Non-Renewals/Rescissions
- Claim Practices
- Internal Appeal and External Review

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to CHCVA during the course of the examination.

II. COMPANY HISTORY

Coventry Health Care of Virginia, Inc., (the "Partnership"), was organized on November 21,1983, by a group of physicians in the Richmond metropolitan area as Southern Health Services, L.P. The General Partner was Southern Health Management Corporation (SHMC), which was incorporated in the Commonwealth of Virginia on November 21, 1983. Southern Health Services L.P. was licensed as an HMO on March 15, 1985, under Chapter 43 of Title 38.2 of the Code and commenced business on June 1,1985.

Southern Health Services, Inc., (Southern Health) succeeded the Partnership and began operations on April 1, 1991. This occurred when the Partnership transferred its assets and liabilities to SHMC, and SHMC simultaneously transferred certain assets to Southern Health. The result was the creation of a new holding company, SHMC, and a wholly-owned subsidiary, Southern Health, which became a federally qualified HMO on June 1, 1991.

On December 1, 1994, Southern Health's parent, SHMC, was acquired by Coventry Corporation. In April of 1998, Coventry Corporation merged with Principal Health Care, Inc., forming Coventry Health Care, Inc., (CHC).

On September 1, 2001, Blue Ridge Health Alliance, Inc., (BRHA), and its fully-owned subsidiary, QualChoice of Virginia Health Plan, Inc., were acquired by CHC, and were merged with and into Southern Health. In 2002, SHMC was merged into Southern Health, resulting in Southern Health being a direct subsidiary of CHC.

On May 7, 2012, Southern Health changed its name to Coventry Health Care of Virginia, Inc, (CHCVA). On May 7, 2013, CHC was acquired by Aetna, Inc. On

January 1, 2014, CHC merged with and into Aetna Health Holdings, LLC, (AHH), a wholly-owned subsidiary of Aetna, Inc., with AHH as the surviving entity.

CHCVA is licensed only in the Commonwealth of Virginia with lines of authority as a Health Maintenance Organization (HMO) and as a Managed Care Health Insurance Plan (MCHIP).

CHCVA's service area includes the Virginia cities of Alexandria, Bedford, Bristol, Buena Vista, Charlottesville, Clifton Forge, Colonial Heights, Covington, Danville, Emporia, Fairfax, Falls Church, Fredericksburg, Galax, Hampton, Newport News, Harrisonburg, Hopewell, Lexington, Lynchburg, Manassas Park, Martinsville, Norton, Petersburg, Poquoson, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Waynesboro, Williamsburg, and Winchester.

CHCVA's service area also includes the Virginia counties of Accomack, Albemarle, Alleghany, Amelia, Appomattox, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Brunswick, Buckingham, Campbell, Caroline, Carroll, Charles City, Charlotte, Chesterfield, Clarke, Craig, Culpepper, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hanover, Henrico, Henry, Highland, Isle of Wight, James City, King & Queen, King George, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Rockingham, Russell, Shenandoah, Smyth, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Washington, Westmoreland, Wise, Wythe, and York.

Marketing efforts were carried out directly by CHCVA's sales and marketing staff, as well as through independent brokers and agents for group business. Conversion from group to individual was offered.

As of December 31, 2016, CHCVA's annual statement reported direct premiums written totaling $352,025,010, and enrollment totaled 79,378 including Medicaid. CHCVA notified the BOI that it would discontinue offering small group coverage as of July 1, 2015. In addition, CHCVA notified the BOI that it would discontinue offering individual health insurance policies as of December 31, 2016.

III. OPERATIONS/ORGANIZATION DOCUMENTS

The purpose of this review was to determine if CHCVA was operating within the scope of its basic organizational documents, 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 38.2-4304 B of the Code requires that the governing body shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (i) the establishment of advisory panels, (ii) the use of advisory referenda on major policy decisions, or (iii) the use of other mechanisms.

The review revealed that CHCVA was in substantial compliance with this section.

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 CHCVA was in substantial compliance with this section.

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 CHCVA was in substantial compliance with this section.

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 CHCVA was in substantial compliance with this section.

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 60 from a total population of 289 complaints and appeals.

TIMELINESS

The review revealed 7 instances where CHCVA failed to maintain its established complaint system, in non-compliance with CHCVA's established internal procedures and in violation of § 38.2-5804 A of the Code and 14 VAC 5-211-150 A in each instance. These instances are discussed in the following paragraphs.

CHCVA's approved complaint system requires that if CHCVA determines that it will consider an expedited appeal, the decision will be made within one working day after receipt of all information needed to make the decision. As discussed in Review Sheet

MC03J, the review revealed 1 instance in which CHCVA took longer than one working day to resolve an expedited appeal. CHCVA agreed with the examiners' observations.

CHCVA's approved complaint system requires a written response to a Level 1 post-service appeal within 30 calendar days. The review revealed 5 instances of non-compliance with CHCVA's established internal procedures. An example is discussed in Review Sheet CL02J, where CHCVA did not send the resolution letter until 55 calendar days after receipt of the appeal. CHCVA agreed with the examiners' observations.

14 VAC 5-216-40 E 1 requires that if an appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal. A health carrier may provide a second level of internal appeal for group health plans only, provided that a maximum of 15 days is allowed for a benefit determination and notification from each level of the appeal. CHCVA's approved complaint system requires a written response to a Level 1 pre-service appeal within 15 calendar days if the appeal falls under CHCVA's "Standard Process (two levels)". As discussed in Review Sheet MC20J, CHCVA took 26 days to respond to a Level 1 pre-service appeal, placing it in violation of 14 VAC 5-216-40 E 1 and in non-compliance with its established internal procedures. CHCVA agreed with the examiners' observations.

PROVIDER CONTRACTS

Section 38.2-5805 B of the Code requires that every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing. Section 38.2-5805 C of the Code requires that when the health carrier is a health maintenance organization, the contracts with providers enabling the MCHIP to provide health care services to the covered persons shall contain a "hold harmless" clause and

additional requirements. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-5805 C 1	1	MC25J
§ 38.2-5805 C 2	3	MC24J

V. PROVIDER CONTRACTS

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. Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section.

Provider Contracts

The examiners reviewed a sample of 10 from a total population of 8,811 provider contracts in force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 of the Code. The review revealed 4 instances in which CHCVA's contracts failed to contain 1 of the 11 required provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 4	1	EF05J
§ 38.2-3407.15 B 7	2	EF01J
§ 38.2-3407.15 B 9	1	EF05J

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 100 claims from a total population of 5,585 claims processed under the 10 provider contracts selected for review.

Section 38.2-3407.15 B 1 of the Code states that a carrier shall pay any clean claim within 40 days of receipt of the claim. The review revealed 5 instances where CHCVA failed to pay a clean claim within 40 days, in violation of § 38.2-3407.15 B 1 of the Code. An example is discussed in Review Sheet EFCL01J. CHCVA agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code states any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter. The review of the sample claims revealed that CHCVA failed to pay interest in 4 instances, in violation of § 38.2-3407.15 B 3 of the Code. An example is discussed in Review Sheet EFCL02J. CHCVA agreed with the examiners' observations.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

The review of the sample claims revealed that CHCVA allowed less than the amount specified in the fee schedule for the health care service provided in 2 instances, in violation of § 38.2-3407.15 B 8 of the Code. An example is discussed in Review Sheet EFCL15J. CHCVA agreed with the examiners' observations.

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. CHCVA's failure to perform the provider contract provisions required by § 38.2-3407.15 B of the Code occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 15 of the Code.

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

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

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:1 B 1	1	EF01G
§ 38.2-3407.15:1 B 2	1	EF01G
§ 38.2-3407.15:1 B 3	1	EF01G
§ 38.2-3407.15:1 B 4	1	EF01G
§ 38.2-3407.15:1 B 5	1	EF01G
§ 38.2-3407.15:1 B 6	1	EF01G
§ 38.2-3407.15:1 B 7	1	EF01G
§ 38.2-3407.15:1 B 8	1	EF01G
§ 38.2-3407.15:1 B 9	1	EF01G
§ 38.2-3407.15:1 C	1	EF01G

CARRIER CONTRACTS; REQUIRED PROVISIONS REGARDING PRIOR AUTHORIZATION

Section 38.2-3407.15:2 B of the Code requires that any provider contract between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:2 B 1	6	EF03G
§ 38.2-3407.15:2 B 2	6	EF03G
§ 38.2-3407.15:2 B 3	6	EF03G
§ 38.2-3407.15:2 B 4	6	EF03G
§ 38.2-3407.15:2 B 5	6	EF03G
§ 38.2-3407.15:2 B 6	6	EF03G
§ 38.2-3407.15:2 B 7	6	EF03G
§ 38.2-3407.15:2 B 8	6	EF03G

CARRIER AND INTERMEDIARY CONTRACTS WITH PHARMACY PROVIDERS; DISCLOSURE AND UPDATING OF MAXIMUM ALLOWABLE COST OF DRUGS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:3 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:3 B 1	1	EF09G
§ 38.2-3407.15:3 B 2	1	EF09G
§ 38.2-3407.15:3 B 3	1	EF09G
§ 38.2-3407.15:3 B 4	1	EF09G
§ 38.2-3407.15:3 C1	1	EF09G
§ 38.2-3407.15:3 C2	1	EF09G
§ 38.2-3407.15:3 C3	1	EF09G
§ 38.2-3407.15:3 C4	1	EF09G
§ 38.2-3407.15:3 C5	1	EF09G

VI. ADVERTISING

A review was conducted of CHCVA's 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)

The examiners reviewed the entire population of 11 advertisements disseminated during the examination timeframe. The review revealed that all 11 advertisements contained violations.

14 VAC 5-90-20 B states every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised. 14 VAC 5-90-170 A states that an HMO shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies disseminated in this or any other state, whether or not licensed in another state, with a notation attached to each advertisement that indicates the manner

and extent of distribution and the form number of any policy advertised. The review revealed that there is no notation physically or electronically attached to the advertisements indicating the manner and extent of distribution and the form number of the policy advertised, in violation of each of these sections.

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

> For the following reasons, we do not believe that Coventry Health Care of Virginia's advertising materials violate 14 VAC 5-90-170 A or 14 VAC 5-90-20 B. Coventry Health Care of Virginia's advertising materials are for information only and are not an offer or invitation to contract. There is a system of control in place for these advertisements. The Company apologizes that the attached documentation was mistakenly omitted from submission to the regulator. We respectfully submit the attached "Advertising/Marketing Compliance Review Top Sheet" for this advertisement which identifies the manner and extent of distribution and the form number of the advertisement. The Company uses this advertisement as an "institutional advertisement" which means its sole purpose is for the promotion of the reader's, viewers, or listener's interest in the concept of insurance, or the promotion of the insurer as a seller of insurance.

The examiners do not concur and would note that the "Advertising/Marketing Compliance Review Top Sheet" provided with CHCVA's response failed to mention the form number of the policy advertised. Additionally, this advertisement refers to "Enrollment" and is an invitation to inquire, as defined in 14 VAC 5-90-30.

VII. POLICY AND OTHER FORMS

A review of policy forms in use during the examination time frame was performed to determine if CHCVA 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.

EVIDENCE OF COVERAGE

Section 38.2-4306 A 2 of the Code states 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 CHCVA was in substantial compliance with this section.

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 CHCVA was in substantial compliance with these sections.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each HMO shall file its EOBs with the Commission for approval. These forms are subject to the requirements of

§§ 38.2-316 and 38.2-4306 of the Code, as applicable. The review revealed that CHCVA was in substantial compliance with these sections.

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 CHCVA was in substantial compliance with this section.

COPAYMENTS

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 50 from a total population of 4,840 enrollees who had met their out-of-pocket maximum during the examination time frame. The review revealed that CHCVA was in substantial compliance with this section.

VIII. 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. A sample of 50 from a total population of 852 agents and agencies during the time frame was selected for review. In addition, the writing agents or agencies designated in the 50 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 CHCVA was in substantial compliance with this section.

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. As discussed in Review Sheet AG01J, the review revealed 1 instance where CHCVA failed to appoint the agent within 30 days of the date of execution of the application, in violation of this section. CHCVA 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 AG01J, the review revealed 1 instance where CHCVA paid commission to an agent that was not appointed, in violation of this section. CHCVA 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 50 was selected from a total population of 852 agents whose appointments terminated during the examination time frame.

As discussed in Review Sheet AG01G, the review revealed that CHCVA failed to notify the agent of the termination of their appointment in 1 instance. CHCVA responded that "There is no letter for this agent/producer because she requested all her non-resident appointments to be terminated as she was no longer involved in any sales activity on any non-resident state. However, she chose to keep her resident license active." The examiners do not concur. CHCVA failed to notify the agent of the termination of her appointment.

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

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

UNDERWRITING/UNFAIR DISCRIMINATION

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

UNDERWRITING REVIEW

The examiners reviewed a sample of 100 from the total population of 16,533 individual HMO contracts issued during the examination time frame.

The review revealed no evidence of unfair discrimination and that coverage was underwritten or declined in accordance with CHCVA's 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 CHCVA was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that CHCVA calculated premium amounts in accordance with its established guidelines.

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 review revealed that the disclosure authorizations used by CHCVA in the underwriting of its group and individual contracts were in substantial compliance with this section.

X. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS

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

REINSTATEMENTS

Individual

A sample of 50 was selected from a population of 931 individual HMO contracts reinstated during the examination time frame. The review revealed that CHCVA was in substantial compliance with its established procedures for reinstatement.

Group

The examiners reviewed the entire population of 1 group HMO contract that was reinstated during the examination timeframe.

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

XI. CANCELLATIONS/NON-RENEWALS/RESCISSIONS

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

Individual

A sample of 160 from a population of 67,935 individual contracts terminated/discontinued 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 CHCVA was in substantial compliance.

Group

A sample of 15 from a population of 455 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 that CHCVA was in substantial compliance with this section.

XII. 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 60 from a total population of 289 written complaints received during the examination time frame. The review revealed that CHCVA was in substantial compliance with this section.

XIII. CLAIM PRACTICES

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

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims 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.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 250 was selected from a total population of 465,556 claims paid during the examination timeframe.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims and failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 3 instances of non-compliance with each of these sections. An example is discussed in Review Sheet CL01G. CHCVA agreed with the examiners' observations.

Mental Health & Substance Use

A sample of 90 was selected from a total population of 28,724 paid mental health and substance use claims paid during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims and failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 1 instance of non-compliance with each of these sections. As discussed in Review Sheet CL29G, a claim was received on March 17, 2015 and was not correctly adjudicated until February 1, 2016.

CHCVA disagreed with the examiners' observations, stating, in part, that:

> The Company respectfully disagrees with these observations: ...Observation B – The Company failed to act reasonably promptly upon communications with respect to this claim. The Company disagrees with this observation. The original claim was received and processed on 3/17/15 and the member was issued an EOB. Observation C – The Company failed to adopt and implement reasonable standards for the prompt investigation of this claim. The Company disagrees with this observation. The Company has policies about payment of claims and claim adjustments. Please see the attached policy and procedure, "Settling Claims" which addresses prompt payment.

The examiners do not concur. Based on the documentation provided, CHCVA took 329 calendar days to investigate this claim, affirm it, and pay it correctly.

Section 38.2-514 B of the Code states that no person shall provide to an enrollee under an HMO contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed 1 violation of each of these sections. As discussed in Review Sheet CL32G, an EOB sent to the member for a claim involving a non-participating provider stated that the member's financial responsibility to the provider was $1,300.00 when it was actually $4,300.00. CHCVA agreed with the examiners' observations.

Dental

A sample of 10 was selected from a total population of 127 dental claims paid during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Vision

A sample of 16 claims was selected from a total population of 709 vision claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Pharmacy

A sample of 100 was selected from a total population of 590,592 pharmacy claims paid during the examination time frame. The review revealed the claims were processed in accordance with the contract provisions.

INTEREST ON CLAIMS

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. The review revealed 23 violations of this section. There were 7 instances where the amount of interest due was underpaid. An example is discussed in Review Sheet CL09G, where CHCVA agreed that it underpaid the amount of statutory interest due. In 16 instances, no interest was paid. An example is discussed in CL44G, where CHCVA agreed that it failed to pay the statutory interest due.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 113 was selected from a total population of 90,981 claims denied during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims and failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 9 instances of non-compliance with each of these sections. An example is discussed in CL15G, where the medical records requested from the provider were received on June 19, 2015, but the claim was not denied until January 21, 2016. CHCVA agreed with the examiners' observations.

Section 38.2-3405 B of the Code states coordination of benefits provisions may not operate to reduce benefits because of any benefits paid, payable, or provided by any liability insurance contract or any benefits paid, payable, or provided by any medical expense or medical payments insurance provided in conjunction with liability coverage. The review revealed 3 violations of this section. An example is discussed in CL01-JB, where the claim was incorrectly denied with the message "Rej-submit to MVA carrier." CHCVA agreed with the examiners' observations.

Section 38.2-510 A 4 of the Code prohibits as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 2 instances 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 5 instances of non-compliance with this section. Section 38.2-510 A 14 of the Code prohibits as a general business, failing to provide a reasonable explanation for denial of a claim. The review revealed 5 instances of non-compliance with this section. An example of non-compliance with each of these sections is discussed in Review Sheet CL24G, where a claim involving injuries that rendered the member incapable of initiating the authorization process or communicating coverage information was incorrectly denied. Although it initially disagreed, the company later sent a revised response agreeing with the examiners' observations and providing documentation that the claims associated with this issue had been reprocessed.

Mental Health & Substance Use

A sample of 40 was selected from a total population of 5,916 mental health and substance use claims denied during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits as a general business, failing to provide a reasonable explanation for denial of a claim. The review revealed 15 instances of non-compliance with this section. An example is discussed in Review Sheet CL35G, where the member was not provided with an explanation of denial for the adjusted claim. In response, CHCVA provided the examiners with a copy of the remittance advice sent to the provider but failed to document that the member had been provided with a reasonable explanation of the denial.

Dental

A sample of 20 was selected from a total population of 263 dental claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Vision

The entire population of 3 vision claims denied during the examination time frame was reviewed. The review revealed that the claims were processed in accordance with the contract provisions.

Pharmacy

A sample of 15 was selected from a total population of 36,359 pharmacy claims denied during the examination time frame. The review revealed the claims were processed in accordance with the contract provisions.

SUMMARY

CHCVA's failure to comply with §§ 38.2-510 A 2, 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, placing CHCVA 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.

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

Of the 450 paid and 176 denied sample claims reviewed by the examiners, the review revealed 62 instances in which CHCVA 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 CL10G, where CHCVA took 121 days to affirm coverage. CHCVA agreed with the examiners' observations.

CHCVA's failure to comply with § 38.2-510 A 5 of the Code occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of this section.

THREATENED LITIGATION

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

XIV. INTERNAL APPEAL AND EXTERNAL REVIEW

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

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

The examiners reviewed the entire population of 3 external review files and a sample of 60 from a total population of 289 complaints and appeals.

Section 38.2-3559 A of the Code requires that a health carrier shall notify the covered person in writing of an adverse determination or final adverse determination and the covered person's right to request an external review. The notice of the right to request an external review shall include the following, or substantially similar, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission." The review revealed 17 violations of this section. An example is discussed in Review Sheet MC04J, where CHCVA's communication to the member incorrectly provided external review rights for benefits that

were denied, reduced, or terminated for reasons other than utilization review decisions regarding medical necessity, appropriateness, health care setting, level of care, or effectiveness.

CHCVA disagreed with the examiners' observations, stating that:

> The Company respectfully disagrees with these observations. External review rights were not offered on this appeal. We indicated this is the final decision and provided contacts for questions/concerns as required by state and federal law.

The examiners do not concur and would note that a document titled "Coventry Health Care of Virginia, INC. & Coventry Health and Life Insurance Company Your Right to Review of the Plan's Determination" provided external review rights and was included with the explanation of benefits as an insert; therefore, CHCVA incorrectly provided external review rights for an adverse benefit determination that was not an adverse determination.

XV. CORRECTIVE ACTION PLAN

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

1. 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;
2. Establish and maintain procedures to ensure that all provider contracts contain the provisions required by §§ 38.2-3407.15 B, 38.2-5805 C and 38.2-3407.15:2 B of the Code;
3. Establish and maintain procedures to ensure that the provider contracts with pharmacy providers contain the specific provisions required by §§ 38.2-3407.15:1 B, 38.2-3407.15:1 C, 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code;
4. Strengthen its procedures for compliance with the requirements of §§ 38.2-1812 A and 38.2-1833 A 1 of the Code regarding the payment of commission to agents and the appointment of agents;
5. 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;
6. Review and reopen the claims discussed in review sheets CL02G, CL03G, CL04G, CL05G, CL06G, CL09G, CL11G, CL16G, CL18G, CL19G, CL20G, CL25G, CL27G, CL28G, CL29G, CL30G, CL39G, CL41G, CL42G, CL43G, CL44G, CL46G and CL48G, and re-adjudicate them to pay 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 processed incorrectly.";

7. Review all pharmacy claims and all medical claims in which internal audits or re-processing occurred during the years of 2016, 2017, 2018 and the current year. Determine those instances where interest is owed as required by § 38.2-4306.1 B of the Code and make payments to the members/providers to whom interest is due. All checks for reimbursement should be accompanied by a letter of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that interest was due on the payment of this claim. Please accept this check for an additional payment.";

8. 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;

9. Review and reopen the claims discussed in review sheet CL01J. In addition, re-adjudicate all claims with the denial code "REJ-SUBMIT TO MVA CARRIER" to pay along with the statutory interest owed for 2016, 2017, 2018 and current year. 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. Please accept this amount as payment for this claim.";

10. Establish and maintain procedures to act reasonably promptly upon communications with respect to claims, as required by § 38.2-510 A 2 of the Code;

11. Establish and maintain procedures to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies, as required by § 38.2-510 A 3 of the Code;

12. Establish and maintain procedures to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed, as required by § 38.2-510 A 5 of the Code;

13. Establish and maintain procedures to attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear, as required by § 38.2-510 A 6 of the Code;

14. Establish and maintain procedures to provide a reasonable explanation of the basis in the insurance policy for denial of a claim, as required by § 38.2-510 A 14 of the Code; and

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

XVI. ACKNOWLEDGMENT

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

Janay Brown, MCM, Greg Lee, FLMI, CIE and Laura Klanian, HIA, PHIAS, AMCM 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, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XVII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
14 VAC 5-211-150 A, 7 violations, MC02J, MC03J, MC05J, MC06J, MC07J, MC09J, MC20J
14 VAC 5-216-40 E 1, 1 violation, MC20J
§ 38.2-5804 A, 7 violations, MC02J, MC03J, MC05J, MC06J, MC07J, MC09J, MC20J
Provider Contracts
§ 38.2-5805 C 1, 1 violation, MC25J
§ 38.2-5805 C 2, 3 violations MC24J, MC25J, MC27J
PROVIDER CONTRACTS
Ethics and Fairness – Provider Contracts
§ 38.2 3407.15 B 4, 1 violation, EF05J
§ 38.2 3407.15 B 7, 2 violations, EF01J, EF02J
§ 38.2 3407.15 B 9, 1 violation, EF05J
Ethics and Fairness – Provider Claims
§ 38.2-3407.15 B 1, 5 violations, EFCL01J, EFCL02J, EFCL04J, EFCL10J, EFCL11J
§ 38.2-3407.15 B 3, 4 violations, EFCL02J, EFCL15J, EF11G, EF12G
§ 38.2-3407.15 B 8, 2 violations, EFCL06J, EFCL15J
§ 38.2-510 A 15, 9 violations, EFCL01J, EFCL02J, EFCL04J, EFCL06, EFCL10J, EFCL11J, EF11G, EF12G, EFCL15J

Carrier contracts with pharmacy providers; required provisions; limit on termination or nonrenewal
§ 38.2 3407.15:1 B 1, 1 violation, EF01G
§ 38.2 3407.15:1 B 2, 1 violation, EF01G
§ 38.2 3407.15:1 B 3, 1 violation, EF01G
§ 38.2 3407.15:1 B 4, 1 violation, EF01G
§ 38.2 3407.15:1 B 5, 1 violation, EF01G
§ 38.2 3407.15:1 B 6, 1 violation, EF01G
§ 38.2 3407.15:1 B 7, 1 violation, EF01G
§ 38.2 3407.15:1 B 8, 1 violation, EF01G
§ 38.2 3407.15:1 B 9, 1 violation, EF01G
§ 38.2 3407.15:1 C, 1 violation, EF01G
Carrier contracts; required provisions regarding prior authorization
§ 38.2-3407.15:2 B 1, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 2, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 3, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 4, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 5, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 6, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 7, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
§ 38.2-3407.15:2 B 8, 6 violations, EF03G, EF04G, EF05G, EF06G, EF07G, EF08G
Carrier and intermediary contracts with pharmacy providers; disclosure and updating of maximum allowable cost of drugs; limit on termination or nonrenewal
§ 38.2 3407.15:3 B 1, 1 violation, EF09G
§ 38.2 3407.15:3 B 2, 1 violation, EF09G
§ 38.2 3407.15:3 B 3, 1 violation, EF09G

§ 38.2 3407.15:3 B 4, 1 violation, EF09G
§ 38.2 3407.15:3 C 1, 1 violation, EF09G
§ 38.2 3407.15:3 C 2, 1 violation, EF09G
§ 38.2 3407.15:3 C 3, 1 violation, EF09G
§ 38.2 3407.15:3 C 4, 1 violation, EF09G
§ 38.2 3407.15:3 C 5, 1 violation, EF09G
ADVERTISING
14 VAC 5-90-20 B, 1 violation (11 instances), AD01, AD02, AD03, AD04, AD05, AD06, AD07, AD08, AD09, AD10, AD11
14 VAC 5-90-170 A, 1 violation (11 instances), AD01, AD02, AD03, AD04, AD05, AD06, AD07, AD08, AD09, AD10, AD11
AGENTS
§ 38.2-1812 A, 1 violation, AG01J
§ 38.2-1833 A 1, 1 violation, AG01J
§ 38.2-1834 D, 1 violation, AG01G
CLAIM PRACTICES
§ 38.2-510 A 2, 13 violations, CL01G, CL10G, CL11G, CL29G, CL15G, CL16G, CL17G, CL18G, CL20G, CL25G, CL26G, CL27G, CL28G, CL29G
§ 38.2-510 A 3, 13 violations, CL01G, CL10G, CL11G, CL29G, CL15G, CL16G, CL17G, CL18G, CL20G, CL25G, CL26G, CL27G, CL28G, CL29G
§ 38.2-510 A 4, 2 instances of non-compliance, CL23G, CL24G
§ 38.2-510 A 5, 62 violations, CL01G, CL02G, CL06G, CL07G, CL10G, CL11G, CL13G, CL14G, CL15G, CL16G, CL17G, CL18G, CL19G, CL20G, CL21G, CL22G, CL23G, CL24G, CL25G, CL26G, CL27G, CL28G, CL29G, CL31G, CL33G, CL35G, CL37G, CL38G (35)
§ 38.2-510 A 6, 5 instances of non-compliance, CL23G, CL24G, CL01-JB (3)

§ 38.2-510 A 14, 20 violations CL23G, CL24G, CL01-JB (3), CL35G, CL38G (14)
§ 38.2-4306.1 B, 23 violations, CL02G, CL03G, CL04G, CL05G, CL06G, CL09G, CL11G, CL29G, CL30G, CL16G, CL18G, CL19G, CL20G, CL25G, CL27G, CL28G, CL39G, CL41G, CL42G, CL43G, CL44G, CL46G, CL48G
§ 38.2-514 B, 1 violation, CL32G
§ 38.2-3407.4 B, 1 violation, CL32G
§ 38.2-3405 B, 3 violations, CL01-JB (3)
INTERNAL APPEAL AND EXTERNAL REVIEW
§ 38.2-3559 A, 17 violations, MC04J, MC05J, MC06J, MC07J, MC08J, MC09J, MC10J, MC11J, MC12J, MC13J, MC14J, MC15J, MC16J, MC17J, MC19J, MC21J, MC23J

COMMONWEALTH OF VIRGINIA

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February 4, 2019

SENT VIA EMAIL

Lynn C. Quinn
Sr. Compliance Lead
Coventry Health Care of Virginia, Inc.
3033 Honeymead Road
Downingtown, PA 19335

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Quinn:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Coventry Health Care of Virginia, Inc. (CHCVA) for the period of January 1, 2016, through December 31, 2016. 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 CHCVA, 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. CHCVA 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, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
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JRF:mhh
Enclosure

cc: Julie Blauvelt
Gail Yoder

aetna®

Lynn C. Quinn, MCM
Sr. Compliance Lead
151 Farmington Avenue, REGA
Hartford, CT 06156

Phone: 215-775-5629
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March 6, 2019

Sent Via e-mail - Julie.Fairbanks@scc.virginia.gov

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157

RE: Coventry Health Care of Virginia, NAIC 96555
Market Conduct Examination Draft Report

Dear Ms. Fairbanks:

This is in response to the Coventry Health Care of Virginia (the "Company") Draft Market Conduct Examination Report. Our response is limited to the areas we have comments for or disagreement with. We have also included additional documentation as attachments to support our position where applicable.

The Company confirms there is no remaining Coventry Commercial membership in the Commonwealth of Virginia as of June 30, 2017.

Section IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)
In the "Complaint System" section found on page 8 of the draft report the Company acknowledges the noted violations of 14 VAC 5-211-150 A, 14 VAC 5-216-40 E1, and Virginia Code § 38.2-5804 A in memos MC02J, MC03J, MC05J, MC06J, MC07J, MC09J, MC20J. To be consistent with all Aetna companies and affiliates, as of November 2014 the approved Aetna Complaint system was applied to all Coventry cases.

Section V. Provider Contracts

In the "**Provider Contract**" section found on page 11 of the draft report, the Company respectfully disagrees that the provider contract associated with review sheet EF05J did not contain the contract provisions required by Virginia Code § 38.2 3407.15 B 4. Please refer to Attachment A. This provision can be found on page 16 of the Dental Group Agreement.

Section VII. Agents

In the "**Appointed Agent Review**" section found on page 21 of the draft report, the Company acknowledges the noted violation in AG01J. Aetna has published and distributed our policy and procedure guidelines to all internal sales representatives on the validation of the license and appointment records which are verified at time of quote. License and appointment records are again verified at the time the application is received and the appointments are processed prior to the case approval.

In the "**Commissions**" section found on page 21 of the draft report, the Company acknowledges the noted violation in AG01J. During the examination period, commissions were paid under the Coventry commission system which did not include a fully automated license and appointment validation. Aetna's commission system has a fully automated validation process that ensures that the license and appointment are in place before the commissions system makes a payment.

In the "**Terminated Agent Appointment Review**" section found on page 22 of the draft report, the Company acknowledges the noted violation in AG01G. Aetna will update its policy and procedure guidelines to include the notification of the termination of the appointment back to the agent when the agent has initiated the request to terminate said appointment.

Section XIII. Claim Practices

In the **"Group & Individual Medical"** section found on page 29 of the draft report, the Company respectfully disagrees with the finding in section 38.2-510 A15. The Company does not believe that an error ratio of 2.4% constitutes a general business practice.

In the "**Mental Health & Substance Use"** section found on pages 29-30 of the draft report, the Company respectfully disagrees with the findings in sections 38.2-510 A 2 and 38.2-510 A 3. The Company does not believe that an error ratio of 2.2% constitutes a general business practice.

In the **"Denied Claim Review"** section found on pages 32-33 of the draft report, the Company respectfully disagrees with the findings that the apparent violations of Virginia Code §§ 38.2-510 A 4, 38.2-510 A 6, and 38.2-510 A 14 with error ratios of 1.8%, 4.4%, and 4.4%, respectively, do not constitute a general

business practice. The Company acknowledges the noted violations of Virginia Code §§ 38.2-510 A 2 and 38.2-510 A 3.

The Company acknowledges the time and effort of the examiners and staff at the Bureau of Insurance in revising the draft report and appreciates your consideration of the above information when issuing a final draft report.

If you have any questions regarding this information or need further information, please do not hesitate to contact me. I can be reached directly at 215-775-5629 or via email at quinnl2@aetna.com. Thank you very much.

Very truly yours,

Lynn C. Quinn

Lynn C. Quinn, MCM

Enclosures

COMMONWEALTH OF VIRGINIA

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www.scc.virginia.gov/boi

May 6, 2019

VIA EMAIL

Lynn Quinn
Sr. Compliance Lead
Coventry Health Care of Virginia, Inc.
3033 Honeymead Road
Downingtown, PA 19335

RE: Coventry Health Care of Virginia, Inc. (CHCVA) Response to the Draft Examination Report

Dear Ms. Quinn:

The examiners have received and reviewed CHCVA's response to the Draft Report dated March 6, 2019. This letter will primarily address those areas of the response where CHCVA disagreed with the findings of the Report.

Section V. Provider Contracts

Regarding the findings discussed in Review Sheet EF05J, the examiners acknowledge that part of the provision required by § 38.2-3407.15 B 4 is included in the provider contract. However, several sentences from the required provision are missing, specifically the last 3 sentences of § 38.2-3407.15 B 4 a. Because these sentences are missing, CHCVA's contract with the provider does not contain the complete required provision. The Report appears correct as written.

General Business Practices

CHCVA's response raises several concerns regarding general business practices. In order to clarify the findings, the examiners would like to provide an explanation of the general business practices that were revealed during the examination. Generally, all instances of non-compliance are described in the Report; however, the examiners specifically identify those instances of non-compliance that occur with such frequency as to indicate a general business practice, as per the guidelines set forth in the NAIC's Market Regulation Handbook.

- **§ 38.2-510 A 15 of the Code:** The Provider Claims review (beginning on p. 11 of the Report) revealed 9 instances, out of 100 sample provider claims, in which

CHCVA failed to perform one or more of the provisions required by § 38.2-3407.15 of the Code; this occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 15 of the Code. (Note: this general business practice is identified on p. 13 of the Report.)

- **§ 38.2-510 A 2 of the Code:** The Denied Claims review (beginning on p. 32 of the Report) revealed 9 violations of § 38.2-510 A 2 of the Code out of 113 sample Group and Individual Medical denied claims; this occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 2 of the Code. (Note: this general business practice is identified on p. 34 of the Report.)

- **§ 38.2-510 A 3 of the Code:** The Denied Claims review (beginning on p. 32 of the Report) revealed 9 violations of § 38.2-510 A 3 of the Code out of 113 sample Group and Individual Medical denied claims; this occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 3 of the Code. (Note: this general business practice is identified on p. 34 of the Report.)

- **§ 38.2-510 A 14 of the Code:** The Denied Claims review (beginning on p. 32 of the Report) revealed 15 violations of § 38.2-510 A 14 of the Code out of 40 sample Mental Health and Substance Use denied claims; this occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 14 of the Code. (Note: this general business practice is identified on p. 34 of the Report.)

- **§ 38.2-510 A 5 of the Code:** The Time Settlement Study review (beginning on p. 34 of the Report) revealed 62 violations of § 38.2-510 A 5 of the Code out of 626 sample paid and denied claims; this occurred with such frequency as to indicate a general business practice, placing CHCVA in violation of § 38.2-510 A 5 of the Code. (Note: this general business practice is identified on p. 35 of the Report.)

CHCVA's instances of non-compliance with §§ 38.2-510 A 4 and 38.2-510 A 6 of the Code did not occur with such frequency as to indicate a general business practice. Regarding general business practices, the Report appears correct as written.

The examiners discovered several typos on pages 29, 33 and 34 of the Report that have been corrected. In addition, the examiners revised page 44 in the Area Violations Summary by Review Sheet section to state "instances of non-compliance" for §§ 38.2-510 A 4 and 38.2-510 A 6 of the Code. The examiners revised page 36 to correct a typo and to add that the entire population of 3 external review files were reviewed. A copy of the entire Report with the revised pages noted is attached, and the revised pages contain the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that CHCVA violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5,

38.2-510 A 14, 38.2-510 A 15, and 38.2-514 B of the Code, in addition to 14 VAC 5-90-20 B and 14 VAC 5-90-170 A of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that CHCVA violated §§ 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 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, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 1, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 3, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 2, 38.2-3407.15:3 C 3, 38.2-3407.15:3 C 4, 38.2-3407.15:3 C 5, 38.2-4306.1 B, 38.2-5804 A, 38.2-5805 C 1, 38.2-5805 C 2 and 38.2-3559 A of the Code, in addition to 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations and 14 VAC 5-216-40 E 1 of Rules Governing Internal Appeal and External Review.

Violations of the above sections of the Code can subject CHCVA 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

509 Progress Drive
Suite 117
Linthicum, MD 21090

15 May 2019

Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

RE: Alleged violation of Code of Virginia §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 14, 38.2-510 A 15, 38.2-514 B, 38.2-1812 A, 38.2-1833 A 1, 38.2-1834 D, 38.2-3405 B, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 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, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 1, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 3, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 2, 38.2-3407.15:3 C 3, 38.2-3407.15:3 C 4, 38.2-3407.15:3 C 5, 38.2-4306.1 B, 38.2-5804 A, 38.2-5805 C 1, 38.2-5805 C 2 and 38.2-3559 A, in addition to 14 VAC 5-90-20 B and 14 VAC 5-90-170 A of Rules Governing the Advertisement of Accident and Sickness Insurance, 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations and 14 VAC 5-216-40 E 1 of Rules Governing Internal Appeal and External Review.

Case No. INS-2019-00067

Dear Ms. Blauvelt,

This will acknowledge receipt of the Bureau of Insurance's letter dated May 10, 2019, concerning the above-referenced matter.

Coventry Health Care of Virginia, Inc. wishes to make a settlement offer for the alleged violations cited above. Further, we agree to:

1. Enclose with this letter a certified check, cashier's check or money order payable to the Treasurer of Virginia in the amount of $40,800.

2. Comply with the corrective action plan set forth in the Target Market Conduct Examination report of December 31, 2016.

3. Acknowledge Coventry Health Care of Virginia, Inc.'s right to a hearing before the State Corporation Commission in this matter and waive that right if the State Corporation Commission accepts this offer of settlement.

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,

Coventry Health Care of Virginia, Inc.

Michael Bucci

(Signed)

Michael Bucci

(Type or Print Name)

Market President

(Title)

15 May 2019

(Date)

Enclosure

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JUNE 21, 2019

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2019-00067

COVENTRY HEALTH CARE
OF VIRGINIA, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that Coventry Health Care of Virginia, 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 §§ 38.2-510 A (2), 38.2-510 A (3), 38.2-510 A (5), and 38.2-510 A (14), and 38.2-510 A (15) of the Code of Virginia ("Code") by failing to comply with claim settlement practices; § 38.2-514 B of the Code by failing to make proper disclosures on the explanation of benefits; § 38.2-1812 A of the Code by paying or sharing commissions with an unlicensed agent; § 38.2-1833 A (1) of the Code by failing to file a notice of appointment of an agent with the Commission; § 38.2-1834 D of the Code by failing to notify an agent of the termination of her appointment; § 38.2-3405 B of the Code by failing to comply with the required subrogation provisions; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth the benefits payable under the contract in the explanation of benefits; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (7), 38.2-3407.15 B (8), and 38.2-3407.15 B (9) of the Code by failing to comply with ethics and fairness requirements in carrier business practices; §§ 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 by failing to comply with contract requirements between the Defendant and pharmacy providers; §§ 38.2-3407.15:2 B (1), 38.2-3407.15:2 B (2), 38.2-3407.15:2 B (3), 38.2-3407.15:2 B (4), 38.2-3407.15:2 B (5), 38.2-3407.15:2 B (6), 38.2-3407.15:2 B (7), and 38.2-3407.15:2 B (8) of the Code by failing to comply with contract requirements between the Defendant and a participating health care provider, or its contracting agent, regarding prior authorization; §§ 38.2-3407.15:3 B (1), 38.2-3407.15:3 B (2), 38.2-3407.15:3 B (3), 38.2-3407.15:3 B (4), 38.2-3407.15:3 C (1), 38.2-3407.15:3 C (2), 38.2-3407.15:3 C (3), 38.2-3407.15:3 C (4), and 38.2-3407.15:3 C (5) of the Code by failing to comply with contract and intermediary contract requirements between the Defendant and pharmacy providers regarding disclosure and updating of maximum allowable cost of drugs; § 38.2-4306.1 B of the Code by failing to pay interest on claim proceeds; § 38.2-5804 A of the Code by failing to establish and maintain a complaint system approved by the Commission; §§ 38.2-5805 C (1) and 38.2-5805 C (2) of the Code by failing to include the proper clauses and notices in the provider contracts as required by the Commission; § 38.2-3559 A of the Code by failing to correctly notify covered persons of the right to request an external review; 14 VAC 5-90-20 B of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance ("Rules") 14 VAC 5-90-10 *et seq.*, by failing to establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies and 14 VAC 5-90-170 A of the Commission's Rules by failing to maintain all advertisements in a file for the longer of four years or until the filing of the next regular report on examination of the insurer; 14 VAC 5-211-150 A of the Commission's Rules Governing Health Maintenance Organizations by failing to maintain a complaint system and an

internal appeals procedure approved by the Commission; and 14 VAC 5-216-40 E (1) of the Commission's Rules Governing Internal Appeal and External Review by failing to comply with the required notifications for an internal appeal.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan outlined in the Bureau's Target Market Conduct Examination Report dated December 31, 2016, has tendered to Virginia the sum of Forty Thousand Eight Hundred Dollars ($40,800), 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.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Lynn Quinn, Senior Compliance Lead, Coventry Health Care of Virginia, Inc., 3033 Honeymead Road, Downingtown, Pennsylvania 19335; 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.