

REPORT ON
TARGET MARKET CONDUCT EXAMINATION
OF
MD-INDIVIDUAL PRACTICE ASSOCIATION, INC.
AS OF June 30, 2013

Conducted from January 31, 2014

through

September 15, 2015

By

Market Conduct Section

**Life and Health Market
Regulation Division**

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 52-1169135
NAIC: 96310

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
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BUREAU OF INSURANCE

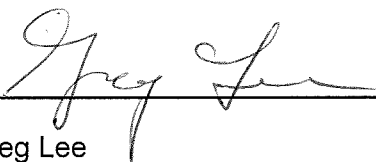


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STATE CORPORATION COMMISSION BUREAU OF INSURANCE

I, Greg Lee, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of MD-Individual Practice Association, Inc. as of June 30, 2013, conducted at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2016-00065 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 9th day of March, 2017.



Greg Lee

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of MD-Individual Practice Association, Inc. (hereinafter referred to as MDIPA), a Health Maintenance Organization (HMO), was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code, including but not necessarily limited to the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1809, 38.2-3407.15 C and 38.2-4315 of the Code of Virginia (hereinafter referred to as “the Code”) and 14 VAC 5-90-170 A.

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

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

The period of time covered for the current examination, generally, was January 1, 2013, through June 30, 2013. The examination was initiated on January 31, 2014, at the office of the State Corporation Commission’s Bureau of Insurance in Richmond, Virginia and was completed on September 15, 2015.

The violations cited and the comments included in this Report are the opinions of the examiners.

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

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

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations; and
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising
- Policy and Other Forms
- Agents
- Premium Notices/Collections/Reinstatements
- Cancellations/Nonrenewals
- Complaints

- Claim Practices
- Internal Appeal and External Review

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

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II. COMPANY HISTORY

MD-Individual Practice Association, Inc. (MDIPA) was incorporated in the Commonwealth of Virginia on December 12, 1980, and was licensed as an HMO under Chapter 43 of Title 38.2 of the Code on July 1, 1985.

MDIPA was incorporated as a non-stock, non-profit corporation on June 1, 1979, under the laws of the State of Maryland as the Montgomery County Health Maintenance Organization, Inc. On July 17, 1980, MDIPA amended its Articles of Incorporation to change its name to MD-Individual Practice Association, Inc. On December 12, 1980, MDIPA was issued a certificate of authority to operate as an HMO by the Maryland Insurance Administration (MIA).

MDIPA became federally qualified as an HMO on November 30, 1981. On December 6, 1984, MDIPA amended and restated its Articles of Incorporation to enable it to issue capital and stock and to make it a for-profit corporation. MDIPA was primarily created to provide prepaid health services to individuals and groups. MDIPA also holds licenses as an HMO in the District of Columbia and the Commonwealth of Virginia.

Until February 10, 2004, MDIPA was owned by Mid-Atlantic Medical Services, Inc. (MAMSI) at 23.3% and Physicians Health Plan of Maryland, Inc. (PHP) at 76.7%. MAMSI was an insurance holding company domiciled in the State of Maryland and PHP was a Maryland corporation and a wholly-owned subsidiary of MAMSI.

On November 3, 2003, UnitedHealth Group Incorporated (formerly known as United HealthCare Corporation "United") filed a Form A with the MIA seeking approval of the acquisition of MAMSI and its subsidiary companies, which was approved on

February 10, 2004. MU Acquisition LLC (MU), a then newly formed Delaware limited liability company and wholly-owned subsidiary of United, merged with MAMSI, with MU becoming the surviving entity. Simultaneously, MU changed its name to Mid-Atlantic Medical Services, LLC (MAMSL). As a result of the merger, the separate corporate existence of MAMSI ceased and all of its direct and indirect subsidiaries, including MDIPA, became members of the United holding company system.

On September 30, 2007, after receipt of approval from the MIA, MAMSL transferred the 23.3% of the shares it owned in MDIPA to its majority shareholder, PHP. As a result of this transfer, PHP became the sole shareholder of MDIPA owning 100% of its issued and outstanding shares.

On April 21, 2008, PHP notified the MIA that it desired to transfer all of the capital stock of MDIPA it owns to MAMSL. As a result of this transfer of common capital stock, MDIPA would become a wholly-owned subsidiary of MAMSL. On June 9, 2008, the MIA issued an Order approving the transfer of MDIPA's capital stock from PHP to MAMSL. Effective September 25, 2008, PHP transferred, by way of dividend, all of the outstanding shares of capital stock of MDIPA to MAMSL.

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

MDIPA's service area includes the Virginia cities of Alexandria, Bedford, Charlottesville, Chesapeake, Clifton Forge, Colonial Heights, Covington, Emporia, Fairfax City, Falls Church, Franklin, Fredericksburg, Hampton, Harrisonburg, Hopewell,

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

MDIPA operates solely in the group market and has no individual business. Total enrollment as of December 31, 2013, was 480 members.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

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

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. 14 VAC 5-211-150 A states that an HMO shall establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

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

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

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

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

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

The examiners reviewed the total population of 10 written complaints received during the examination time frame for compliance with MDIPA's established procedures and the requirements of the Code.

TIMELINESS

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

HANDLING

Subsection 1 of § 38.2-502 of the Code states that no person shall make, circulate, cause or knowingly allow to be made, issued or circulated any statement that misrepresents the benefits, advantages, conditions or terms of any insurance policy.

The review revealed 5 instances in which MDIPA included misinformation in its response letter to a member for whom the provider had submitted an appeal. As discussed in Review Sheets CP01-mdipa through CP05-mdipa, the response letter to the member incorrectly stated that the member was not responsible for the charges related to the service. The letter then correctly advised the member that payment for the service was included in the reimbursement to the facility and was not reimbursable separately to the individual medical provider. Although the procedure was performed in a participating facility, the services were provided by a non-participating provider, and the original Explanation of Benefits (EOB) to the member listed the entire charge amount under "Amount you owe the provider." The appeal response letter provided information that contradicted the original EOB, and these statements were incorrect and misleading. MDIPA disagreed and stated, in part, that:

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

The company further stated that:

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

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

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

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

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

The review revealed that in 38 instances, MDIPA's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular Code Section, Number of Violations, and a Review Sheet Example are referred to in the table below.

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1 b	6	EF09
§ 38.2-3407.15 B 2	6	EF06
§ 38.2-3407.15 B 5 a	6	EF03
§ 38.2-3407.15 B 8	10	EF07
§ 38.2-3407.15 B 10	10	EF04

Examples of some of the violations cited are discussed in Review Sheet EF06, where the examiners initial observations stated, in part, that:

A review of the file reveals that the Virginia Regulatory Requirements Appendix included with this Agreement does not include all of the provisions as required by § 38.2-3407.15 B of the Code of Virginia.

Section 38.2-3407.15 B 1 b of the Code requires the carrier to maintain a written or electronic record of the receipt of a claim and states that the **person submitting the claim** [emphasis added] shall be entitled to inspect such record on request. “Person submitting the claim” includes the Provider, but **Provision 8 (c)** of the Appendix entitles only the “Customer” submitting the claim to inspect such record.

Section 38.2-3407.15 B 2 of the Code requires the carrier to request required information from the **person submitting the claim** [emphasis added] and states that the carrier may not refuse to pay a claim if the carrier has failed to timely notify the **person submitting the claim** [emphasis added] of the required information. **Provision 8 (d)** in the Agreement’s Appendix excludes the Provider from this process by its use of “Customer submitting the claim.”...

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

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

MDIPA disagreed with the examiners’ observations and stated that:

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

The examiners maintained their observations and responded that:

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

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

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

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions, requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The examiners reviewed a sample of 175 claims from a population of 431 claims processed under 10 of the sample provider contracts during the examination time frame.

The review revealed that MDIPA was in substantial compliance.

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V. ADVERTISING

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

The total population of 19 advertisements distributed in Virginia during the examination time frame was reviewed. The review revealed that MDIPA was in substantial compliance.

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VI. POLICY AND OTHER FORMS

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

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

The review revealed that MDIPA was in substantial compliance.

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 MDIPA was in substantial compliance.

SCHEDULE OF CHARGES

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

The review revealed that MDIPA was in substantial compliance.

COPAYMENTS

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

MDIPA informed the examiners that no enrollee met his or her out-of-pocket or copayment maximum during the examination time frame.

VII. AGENTS

The purpose of this review was to determine compliance with Title 38.2, Chapter 18 and § 38.2-4313 of the Code. MDIPA informed the examiners that it did not issue any new business during the examination time frame. Therefore, the scope of the review was limited to terminated agent appointments.

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 15 was selected from a total population of 39 agents whose appointments terminated during the examination time frame.

The review revealed that MDIPA was in substantial compliance.

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

MDIPA informed the examiners that it did not issue any group HMO contracts during the examination time frame. Therefore, the examiners did not conduct a review of MDIPA's underwriting practices.

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IX. PREMIUM NOTICES/COLLECTIONS/REINSTATEMENTS

MDIPA's procedures for processing premium notices were reviewed for compliance with its established procedures.

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

PREMIUM NOTICES

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

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

MDIPA did not have any group whose premium increased by more than 35% during the examination time frame.

COLLECTIONS

MDIPA did not have any group that was subject to its collection procedures during the examination time frame.

REINSTATEMENTS

MDIPA informed the examiners that it did not have any group that applied for reinstatement during the examination time frame.

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X. CANCELLATIONS/NONRENEWALS

The examination included a review of MDIPA's cancellation/nonrenewal practices and procedures to determine compliance with its contract provisions, the requirements of § 38.2-508 of the Code covering unfair discrimination and the notification requirements of § 38.2-3542 of the Code and 14 VAC 5-211-230 B.

MDIPA informed the examiners that it did not have any group HMO contracts that terminated during the examination time frame.

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XI. COMPLAINTS

Section 38.2-511 of the Code requires that a complete record of complaints be maintained for all complaints received since the last examination or during the last 5 years, whichever is the more recent time period, and such records shall indicate the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A complaint is defined as “any written communication from a policyholder, subscriber, or claimant primarily expressing a grievance.”

The total population of 10 written complaints was reviewed. The review revealed that MDIPA was in substantial compliance.

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XII. CLAIM PRACTICES

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

GENERAL HANDLING STUDY

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

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

PAID CLAIM REVIEW

Group Claims

A sample of 70 was selected from a total population of 2,950 claims paid during the examination time frame.

Section 38.2-510 A 2 of the Code prohibits as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims. Section 38.2-510 A 3 of the Code prohibits as a general business practice, failing to adopt and implement reasonable standards for the prompt investigation of claims. The review revealed 2 instances of non-compliance with these sections. An example is discussed in Review Sheet CL01, where MDIPA took 431 calendar days to process a claim for emergency room physician services. MDIPA agreed with the examiners' observations.

Group Encounters

The total population of 1,795 encounters paid during the examination time frame was reviewed. The review revealed that the encounters were processed in accordance with the contract provisions.

Pharmacy Claims

A sample of 25 was selected from a total population of 3,148 pharmacy claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Interest

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment.

The review revealed 3 violations of this section. An example is discussed in Review Sheet CL05, where MDIPA took 39 days to pay a claim and failed to pay the statutory interest due. In 2 instances, (Review Sheets CL05 and CL06), no interest was paid. In 1 instance, (CL04) the amount of interest due was underpaid. MDIPA agreed with the examiners' observations in all 3 instances.

DENIED CLAIM REVIEW

Group Claims

A sample of 30 was selected from a total population of 333 claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

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

As discussed in Review Sheet CL07, the review revealed 1 violation of this section. MDIPA disagreed with the examiners' observations and stated:

The Remark code utilized explained to the enrollee that if they submit the primary care EOB, then the claim will be processed. It also explains what to do if other insurance is no longer active.

The examiners maintained their findings and responded that, "The statute prohibits an HMO from restricting or impeding the provision of covered health care services because the enrollee has other coverage. When MDIPA denied the claim and held the enrollee liable for the cost of the services provided, it failed to provide a covered health care service to the member."

Group Encounters

MDIPA informed the examiners that there was no record kept of denied encounters during the examination time frame.

Pharmacy

A sample of 15 was selected from a population of 859 pharmacy claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the terms of the contract.

TIME SETTLEMENT STUDY

The time settlement study was performed to determine compliance with § 38.2-510 A 5 of the Code, which requires that coverage of claims be affirmed or denied within a reasonable time after proof of loss statements have been completed. The normally acceptable “reasonable time” is 15 working days from the receipt of proof of loss to the date a claim is either affirmed or denied. The term “working days” does not include Saturdays, Sundays, or holidays.

MDIPA failed to provide the examiners with its instructions, procedures, etc., to document compliance with § 38.2-510 of the Code regarding Unfair Claim Settlement Practices. Therefore, the examiners applied the 30-calendar day “reasonable time” standard used in the prior examination of claims. The review revealed that MDIPA failed to affirm or deny coverage within a reasonable time in 5 instances. An example is discussed in Review Sheet CL03, where MDIPA took 80 calendar days from receipt of proof of loss to affirm a claim.

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

THREATENED LITIGATION

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

COPY

XIII. INTERNAL APPEAL AND EXTERNAL REVIEW

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

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

MDIPA informed the examiners that there were no appeals that obtained an independent external review of an adverse determination during the examination time frame; however, the 10 sample complaint files were reviewed for compliance with the notice requirements for external review. A review of the sample selected revealed that MDIPA was in substantial compliance with its established procedures and this section.

XIV. CORRECTIVE ACTION PLAN

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

1. Establish 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 complaint and appeal response letters provide complete, clear, and accurate information, as required by subsection 1 of § 38.2-502 of the Code;
3. Establish and maintain procedures to ensure that every “provider contract” as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by §§ 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 5 a, 38.2-3407.15 B 8 and 38.2-3407.15 B 10 of the Code;
4. Strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;
5. Review and consider for re-adjudication all claims paid between July 1, 2012 and December 31, 2014 that took greater than 30 calendar days to pay; 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 Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that this interest had not been paid previously.”

6. After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;
7. Immediately bring its coordination of benefits claim handling practices and EOB forms into compliance with the requirements of 14 VAC 5-211-80 B;
8. Strengthen its procedures for compliance with §§ 38.2-510 A 2, 38.2-510 A 3, and 38.2-510 A 5 of the Code; and
9. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

COPY

XV. ACKNOWLEDGMENT

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

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

Respectfully submitted,



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

COPY

XVI. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
<i>Complaint System</i>
14 VAC 5-211-150 A and § 38.2-5804 A, 1 violation, MC01
Subsection 1 of § 38.2-502, 5 violations, CP01-mdipa, CP02-mdipa, CP03-mdipa, CP04-mdipa, CP05-mdipa
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
<i>Provider Contracts</i>
§ 38.2-510 A 15, 1 violation
§ 38.2-3407.15 B 1 b, 6 violations, EF03, EF04, EF06, EF07, EF08, EF09
§ 38.2-3407.15 B 2, 6 violations, EF03, EF04, EF06, EF07, EF08, EF09
§ 38.2-3407.15 B 5 a, 6 violations, EF03, EF04, EF06, EF07, EF08, EF09
§ 38.2-3407.15 B 8, 10 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10
§ 38.2-3407.15 B 10, 10 violations, EF01, EF02, EF03, EF04, EF05, EF06, EF07, EF08, EF09, EF10
CLAIM PRACTICES
§ 38.2-4306.1 B, 3 violations, CL04, CL05, CL06
14 VAC 5-211-80 B, 1 violation, CL07
§ 38.2-510 A 2, 2 instances of non-compliance, CL01, CL04
§ 38.2-510 A 3, 2 instances of non-compliance, CL01, CL04
§ 38.2-510 A 5, 5 instances of non-compliance, CL01, CL03, CL04, CL05, CL06

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



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December 30, 2015

CERTIFIED MAIL 7014 1200 0001 3578 7989
RETURN RECEIPT REQUESTED

Mr. Joseph Stangl
4 Research Drive
5th Floor
Shelton, CT 06484

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Stangl:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of MD-Individual Practice Association, Inc. (MDIPA) for the period of January 1, 2013, through June 30, 2013. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of MDIPA, 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. MDIPA's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

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

JRF:mhh
Enclosure
cc: Althelia Battle



March 18, 2016

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

RE: MD-IPA Draft Market Conduct Examination Report as of June 30, 2013

Dear Ms. Fairbanks:

MD-Individual Practice Association, Inc. (MD-IPA) would first like to thank the Bureau for allowing us an extension in providing this response.

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

MD-IPA respectfully requests that any enclosed Exhibits be maintained as proprietary and confidential.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Stangl", with a long horizontal flourish extending to the right.

Joseph Stangl
Director, Regulatory Affairs
UnitedHealthcare
4 Research Drive
Shelton, CT 06484
203-447-4474
Joseph_stangl@uhc.com

Commonwealth of Virginia
State Corporation of Insurance, Bureau of Insurance
Market Conduct Exam of
MD-Individual Practice Association, Inc.
January 1, 2013 – June 30, 2013

Corrective Action Plan of March 18, 2016

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

1. Establish 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 14VAC 5 211 150A;

Company Response: MDIPA filed its complaint system timely in December 2011. There were numerous communications between MDIPA and the Bureau on the filing regarding requested revisions which ultimately led to the delay. MDIPA has in place a filing team responsible for State required filing such as the Virginia required complaint system. The complaint system is currently filed and approved as of April 11, 2014.

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

Company Response: MDIPA understands the discrepancy that is of concern to the Bureau and will review and update its procedures and letters accordingly.

3. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code does not contain provisions that are more burdensome upon the provider than the specific provisions required by 38.2-3407.15 B 1, 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407 .15 B 3, 38.2-3407.15 B4, 38.2-3407.15 B 4 a (i), 38.2-3407.15 B 5, 38.2-3407.15 B 5 a, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15B 9, 38.2-3407 .15 B 10 and 38.2-3407.15 B 11 of the Code.

Company Response:

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

In regard to 38.2-3407.15 B 8, MDIPA will update its Regulatory Appendix to change "provider agrees" to "provider acknowledges."

In regard to 38.2-3407.15 B 4 a (i) and 38.2-3407.15B 9, in 2010 MDIPA updated its Regulatory Appendix in 2010 which included updating the language pertaining to both these sections of the Virginia Code. A mass mailing of the Regulatory Appendix was made to all Virginia contracted providers. The updated Regulatory Appendix should have been provided to the exam team as part of the contract review; we apologize for the oversight and are attaching the 2010 Appendix herein. Please see sections 8j and 8k respectively. MDIPA would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to 38.2-3407 .15 B 10, the language requirements of 38.2-3407.15 B 10 can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8g of both Regulatory Appendices (attached). MDIPA would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

In regard to 38.2-3407.15 B 7, the language requirements of 38.2-3407.15 B 7 can be found in both the 2005 and the 2010 versions of the Regulatory Appendix (2005 version was provided as part of the exam). Please see section 8i of both Regulatory Appendices (attached). MDIPA would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed. Of additional note, the draft report indicates EF10 being in violation but EF10 does not cite 38.2-3407.15 B 7 as a concern.

In regard to 38.2-3407.15 B 1, 38.2-3407 .15 B 3, 38.2-3407.15 B4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, and 38.2-3407.15 B 11, it is unclear why the Regulatory Appendix was not included within the documentation provided within Review Sheets EF01, EF02, EF10. MDIPA apologizes for this oversight and would like to take this opportunity to confirm for the Bureau that the required language is in both the 2005 and 2010 versions of the Regulatory Appendix and to note the 2010 mass mailing of the Regulatory Appendix was done to all Virginia contracted providers. Please see sections 8b, 8e, 8f, 8h, 8i, and 8f respectively. MDIPA would disagree with the violations and we would respectfully request this be taken into consideration and the alleged violations be removed.

Please see Item 3 Exhibit.

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

Company Response: MDIPA has procedures in place and closely monitors timely acknowledgement and payment for all claims and follows strict guidelines to ensure compliance with Virginia's mandated reimbursement timeframes and interest payment requirements. The three agreed upon errors noted in the report were human processor errors and not systemic in nature. MDIPA will provide management coaching to the individuals responsible for the errors.

5. Review and consider for re-adjudication all paid claims that took greater than 30 calendar days to pay; for the years of 2011, 2012, 2013, 2014, 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 result of a target market conduct examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

Company Response: MDIPA has procedures in place and closely monitors timely acknowledgement and payment for all claims and follows strict guidelines to ensure compliance with Virginia's mandated reimbursement timeframes and interest payment requirements. The agreed upon errors noted in the report were human processor errors and not systemic in nature. The paid claim review performed by the Bureau only revealed three claims for which interest was underpaid/not paid. MDIPA believes that requesting a review of claims for a five plus year period is excessive simply based on the findings noted in the draft report. MDIPA would like to respectfully suggest for a corrective action measure, management coaching to the individuals responsible for the errors.

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

Company Response: As noted in Review Sheet CL07, MDIPA disagreed with the examiner's observation. We would like to take this opportunity to elaborate on our process. 14 VAC 5-211-80 B states in part "until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided". MDIPA maintains confirmed member benefit coordination data within its systems. In the case of the claim in question in Review Sheet CL07, the member had other coverage which had been previously confirmed as primary coverage, for the dates of service, and based on that the "benefit determination was made". MDIPA did not "restrict or impede the provision of covered health services" as the service was indeed rendered prior to the claim submission. Service was provided, the claim was submitted, benefits were determined, and it is only once that benefits were determined, that MDIPA sought to coordinate benefits. We are attaching a screen-print of the member's COB screen for reference. Please see Item 6 Exhibit.

MDIPA's procedures are in compliance with 14 VAC 5-211-80 B and the claim in question in Review Sheet CL07 was processed accordingly. MDIPA continues to disagree with the violation and respectfully requests the findings pertaining to this matter (page 26 of the draft report) as well as Recommendation 6 be removed from the report.

7. Strengthen its procedures for compliance with §§ 38.2-510 A 2, 38.2-510 A 3, and 38.2-510 A 5 of the Code.

Company Response: MDIPA has procedures in place and closely monitors timely acknowledgement and payment of all claims and follows strict guidelines to ensure

compliance with Virginia's mandated reimbursement timeframes and interest payment requirements. The five agreed upon errors noted in the report were human processor errors and not systemic in nature. MDIPA will provide management coaching to the individuals responsible for the errors.

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

Company Response: MDIPA will provide the requested documentation.

COPY

COMMONWEALTH OF VIRGINIA

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



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April 1, 2016

**CERTIFIED MAIL 7015 1520 0003 0918 9502
RETURN RECEIPT REQUESTED**

Joseph Stangl
Director, Regulatory Affairs
MD-Individual Practice Association, Inc.
4 Research Drive
Shelton, Connecticut 06484

RE: MD-Individual Practice Association, Inc.'s (MDIPA) Response to the Draft Examination Report

Dear Mr. Stangl:

The examiners have received and reviewed MDIPA's response to the Draft Report dated March 18, 2016. This response will primarily address those areas of the response where MDIPA disagreed with the findings and corrective actions of the Report or where upon further review, the examiners determined that modifications to the findings were necessary.

Corrective Action #3

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

In regards to § 38.2-3407.15 B 8 of the Code, updating the Regulatory Appendix to state that the "provider acknowledges" would not bring MDIPA's provider contracts into compliance with this section. Section 38.2-3407.15 B of the Code requires that every provider contract entered into by a carrier contain specific provisions and § 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution the fee schedule or reimbursement methodology. There is no requirement in the statute for the provider to acknowledge that the fee schedule was in fact attached at the time of execution.

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

Section 8.(g) of the Virginia Regulatory Requirements Appendixes attached to MDIPA's response refers only to the provision of policies discussed in subsection 4 {8.(f) of the Appendixes}. No changes to the Report are necessary.

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

Corrective Action #5

The examiners have reviewed the claim files and it is not conclusive that the interest violations were due solely to clerical errors. Absent a detailed description of the claim system's ability to calculate statutory interest, the examiners cannot determine the amount of clerical intervention required. There were 5 claims in the sample where interest was due and payable, and interest was either not paid or underpaid in 3 of those 5 instances, in violation of §38.2-4306.1 of the Code. As such, this corrective action is warranted and no changes to the Report are necessary.

Corrective Action #6

14 VAC 5-211-80 B states that "Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided." The EOB form that MDIPA sent to this enrollee for this denied claim clearly indicated in the "patient responsibility" column that the enrollee was liable for the entire cost of the health care services provided. The fact that "...the member had other coverage which had previously been confirmed as primary..." by MDIPA only reinforces the fact that a coordination of benefits determination could not occur until the primary carrier's EOB was received by MDIPA. The examiners have no issue with message code (SF) requesting the primary carrier's EOB. MDIPA's procedures do not comply with the requirements of this section and the Corrective Action will remain in the Report.

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

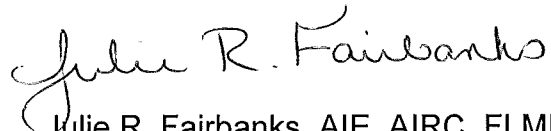
On the basis of our review of the entire file, it appears that MDIPA violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and § 38.2-510 A 15 of the Code.

It also appears that MDIPA violated §§ 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 5 a, 38.2-3407.15 B 8, 38.2-3407.15 B 10, 38.2-4306.1 B and 38.2-5804 A of the Code in addition to 14 VAC 5-211-80 B and 14 VAC 5-211-150 A of Rules Governing Health Maintenance Organizations.

Violations of the above sections of the Code can subject MDIPA 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, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

COPY

April 28, 2016

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

RE: MD-IPA Draft Market Conduct Examination Report as of June 30, 2013

Dear Ms. Fairbanks:

I write to you today in response to your review of the MD-Individual Practice Association Inc. (MD-IPA) response to the draft market conduct report. Thank you for allowing us the opportunity to further respond. The following will address your comments in the order they appear in your letter of April 1, 2016.

Corrective Action #3

In regards to 38.2-3407.15B 8, MD-IPA understands the Bureau's position and has removed "provider agrees" from provision 8 j of the Regulatory Appendix.

In regards to 38.2-3407.15 B 10, as discussed with the Bureau on April 14, 2016, OCI agreed to move the requirement to its own provision within the Regulatory Appendix. This has been completed. Being that the required language was in the Regulatory Appendix and the Bureau's concern was more so a placement issue, OCI continues to disagree a violation is warranted and we would respectfully request this be taken into consideration and the alleged violation be removed.

OCI acknowledges and thanks the Bureau for its reconsideration of the remaining items noted within Corrective Action #3.

Corrective Action #5

As noted in the draft report and as well in your letter of April 1, 2016, only three claims were found to have been not paid interest or underpaid interest. Our review of these three claims revealed that the errors were due to human intervention, and were not systematic in nature. MD-IPA remains of the opinion that a review of claims for a five plus year look back is extreme and we propose the following: All fully insured business was migrated off of MD-IPA as of December 2014. From July 2012 to December 2014 there was only one fully insured group on the MD-IPA license, the three claims of issue were from this one group. United proposes a review of this one groups claims for the period July 2012-December 2014 for any claims that took greater than 30 calendar days to pay. If it is determined interest is owed, and the amount

owed in under \$10.00, MD-IPA will remit a cumulative check to the State's unclaimed property fund.

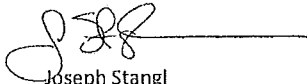
Corrective Action #6

MD-IPA maintains its position of compliance with 14 VAC5-211-80B. At your suggestion we are attaching a legal analysis we prepared to further our position on this matter. Please see Exhibit 1. We welcome any opportunity to discuss further.

MD-IPA respectfully requests that enclosed Exhibits be maintained as proprietary and confidential.

Thank you for your time and consideration.

Sincerely,



Joseph Stangl
Director, Regulatory Affairs
UnitedHealthcare
4 Research Drive
Shelton, CT 06484
203-447-4474
Joseph_stangl@uhc.com

COPY

COMMONWEALTH OF VIRGINIA

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COMMISSIONER OF INSURANCE
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August 16, 2016

**CERTIFIED MAIL 7015 1520 0003 0918 9649
RETURN RECEIPT REQUESTED**

Joseph Stangl
Director, Regulatory Affairs-Market Conduct
MD-Individual Practice Association, Inc.
4 Research Drive
5th Floor
Shelton, Connecticut 06484

RE: MD-Individual Practice Association, Inc.'s (MDIPA) Response to the Draft Examination Report

Dear Mr. Stangl:

The examiners have received and reviewed MDIPA's second response to the Draft Report dated April 28, 2016. This response will primarily address those areas of the response where MDIPA disagreed with the findings and corrective actions of the Report or where upon further review, the examiners determined that modifications to the findings were necessary.

Corrective Action #3

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

The requirements of § 38.2 3407.15 B 10 of the Code specifically refer to a carrier's provision of a policy required to be provided under subsections 8 or 9 of this section. Section 8.(g) of the Virginia Regulatory Requirements Appendix attached to MDIPA's

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

The violations of §§ 38.2-3407.15 B 8 and 38.2-3407.15 B 10 of the Code discussed in Review Sheet EF05 will remain in the Report. MDIPA's response failed to address any proposed changes to the Regulatory Appendix associated with Physical and Occupational Therapy provider contracts.

Corrective Action #5

The examiners have reviewed the claim files and it is not conclusive that the interest violations were solely attributable to manual processing interventions. Absent a detailed description of the claim system's ability to calculate statutory interest, the examiners cannot determine the amount of manual intervention required. There were 5 claims in the sample where interest was due and payable, and statutory interest was not appropriately paid in 3 of those 5 instances. As such, the corrective action is warranted. Upon further consideration, the report has been revised to limit the corrective action to all claims paid between July 1, 2012 and December 31, 2014 that took greater than 30 calendar days to pay. All interest amounts due should be paid directly to the provider or member regardless of the amount.

Corrective Action #6

The Bureau has reviewed and considered the legal analysis that was provided in response to the violations of 14 VAC 5-211-80 B noted in the draft report. While the Bureau does not object to MDIPA's process of determining coordination of benefits, the concern continues to be that MDIPA is telling the member that he is responsible for payment of the entire billed amount before the coordination of benefits determination has been made. 14 VAC 5-211-80 states as follows:

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

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

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

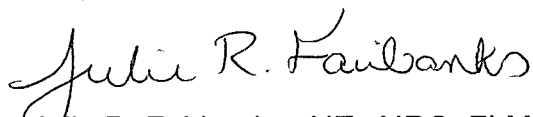
On the basis of our review of the entire file, it appears that MDIPA violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and § 38.2-510 A 15 of the Code.

It also appears that MDIPA violated §§ 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 5 a, 38.2-3407.15 B 8, 38.2-3407.15 B 10, 38.2-4306.1 B and 38.2-5804 A of the Code, in addition to 14 VAC 5-211-80 B and 14 VAC 5- 211-150 A of Rules Governing Health Maintenance Organizations.

Violations of the above sections of the Code can subject MDIPA 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, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Christopher J Mullins, CEO
MD-Individual Practice Association, Inc.
12018 Sunrise Valley Drive
Reston, Virginia 20191

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

RE: Alleged violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and § 38.2-510 A 15 of the Code, as well as §§ 38.2-3407.15 B 1 b, 38.2-3407.15 B 2, 38.2-3407.15 B 5 a, 38.2-3407.15 B 8, 38.2-3407.15 B 10, 38.2-4306.1 B and 38.2-5804 A of the Code in addition to 14 VAC 5-211-80 B and 14 VAC 5- 211-150 A of Rules Governing Health Maintenance Organizations.

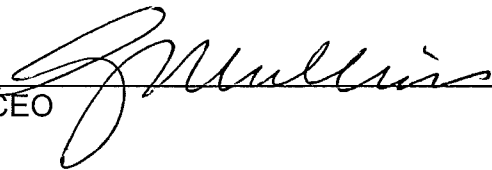
Dear Ms. Battle:

This will acknowledge receipt of your letter dated August 18, 2016, concerning the above-captioned matter.

MDIPA wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check {certified, cashier's or company) in the amount of \$10,000, payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing; and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Yours very truly,



CEO

February 2, 2017

Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

170230039

AT RICHMOND, FEBRUARY 23, 2017

SCC-CLERK'S OFFICE
DOCUMENT CONTROL CENTER

COMMONWEALTH OF VIRGINIA, *ex rel.*

2017 FEB 23 A 10: 22

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2016-00065

MD – INDIVIDUAL PRACTICE
ASSOCIATION, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that MD – Individual Practice Association, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of a health maintenance organization in the Commonwealth of Virginia ("Virginia"), violated: § 38.2-502 (1) of the Code of Virginia ("Code") by misrepresenting the benefits, advantages, conditions or terms of insurance policies; §§ 38.2-510 A (15) and 38.2-4306.1 B of the Code by failing to comply with claim settlement practices; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (5), 38.2-3407.15 B (8), and 38.2-3407.15 B (10) of the Code by failing to comply with ethics and fairness requirements for business practices; § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain an approved complaint system for each of its Managed Care Health Insurance Plans; and 14 VAC 5-211-80 B and 14 VAC 5-211-150 A of the Commission's Rules Governing Health Maintenance Organizations, 14 VAC 5-211-10 *et seq.*, by failing to follow requirements governing health maintenance organizations.

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

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to Virginia the sum of Ten Thousand Dollars (\$10,000), waived its right to a hearing, and agreed to comply with the corrective action plan contained in the target market conduct examination report as of June 30, 2013.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

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

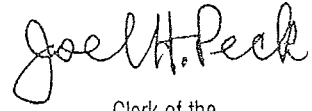
Accordingly, IT IS ORDERED THAT:

- (1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.
- (2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:
Joseph Stangl, Director Regulatory Affairs – Market Conduct, MD – Individual Practice Association, Inc., 4 Research Drive, 5th Floor, Shelton, Connecticut 06484; and a copy shall be

delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of
Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:



Clerk of the
State Corporation Commission

COPY