REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.

AS OF DECEMBER 31, 2016

COPY

Conducted from July 10, 2017

Through

March 18, 2019

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

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NAIC: 53007

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I, Mel Gerachis, Principal Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Group Hospitalization and Medical Services, Inc. as of December 31, 2016, completed 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-2019-00199 finalizing the Report.

IN WITNESS WHEREOF, I have
hereunto set my hand and affixed
the official seal of the Bureau at
the City of Richmond, Virginia,
this 6th day of July, 2020.

Mel Gerachis
Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Group Hospitalization and Medical Services, Inc. (hereinafter referred to as "GHMSI"), a Health Service Plan licensed under Chapter 42 of Title 38.2 of the Code of Virginia (hereinafter referred to as "the Code") was conducted under the authority of §§ 38.2-1317 and 38.2-4234 of the Code of Virginia (hereinafter referred to as "the Code"). The examination included a detailed review of GHMSI's fully-insured individual, small group and large group comprehensive major medical, dental, and vision insurance coverage for the period beginning July 1, 2016 through December 31, 2016. The on-site examination was conducted from July 10, 2017, through October 20, 2017, at GHMSI's offices in Baltimore, Maryland and Columbia, Maryland, and completed at the office of the Commission's Bureau of Insurance in Richmond, Virginia on March 18, 2019.

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

A previous Target Market Conduct Examination covering the period of January 1, 2009, through March 31, 2009, was concluded on April 21, 2010. As a result of that examination, GHMSI made a monetary settlement offer, which was accepted by the State Corporation Commission (hereafter referred to as "the Commission) on February 22, 2012, in Case No. INS-2011-00047, in which GHMSI agreed to the entry by the Commission of an order to cease and desist from any conduct that constitutes a violation of

certain sections of the Code and agreed to comply with the Corrective Action Plan contained in the Report.

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

The examiners may not have discovered all non-compliant practices that the company may have been engaged in during the examination time frame. Failure to identify or comment on specific company practices in the Commonwealth of Virginia or other jurisdictions does not constitute acceptance of such practices. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to GHMSI during the course of the examination.

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II. EXECUTIVE SUMMARY

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

There are 120 violations and instances of non-compliance noted in this Report. The policy form review revealed 3 instances where group contracts had been altered or changed from forms previously filed with and approved by the Commission, in violation of §§ 38.2-316 A 1 and 38.2-316 C 1 of the Code. The violations of § 38.2-316 C 1 of the Code could be construed as knowing as GHMSI was also cited for violations of this section during the previous exam. GHMSI failed to provide evidence of timely notice of termination of appointment to agents in 9 of 25 sample files reviewed, in violation of § 38.2-1834 D of the Code.

Of the 120 violations and instances of non-compliance noted in this Report, 68 were identified during the Claims review. Overall, the Unfair Claims Settlement Practices review of GHMSI's claims revealed smaller percentages of noncompliance than during the previous exam. However, GHMSI's failure to comply with §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code did occur with such frequency as to indicate a general business practice, placing GHMSI in violation of each of these sections. The exam revealed 3 violations of § 38.2-3418.17 A of the Code and 1 violation of § 38.2-3418.17 D of the Code for failure to handle claims for the treatment of autism spectrum disorder in accordance with these 2 sections.

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The claims review also revealed 2 violations for failure to pay interest in accordance with § 38.2-3407.1 B of the Code.

A corrective action plan (CAP) that must be implemented by GHMSI was established as a result of these issues and others discussed in the Report.

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III. COMPANY HISTORY

GHMSI, a health service plan domiciled in the District of Columbia, was founded on March 13, 1934, as Group Hospitalization, Inc. (GHI). After GHI had conducted business for several years, the District of Columbia's Department of Insurance, Securities and Banking ordered GHI to reorganize into a stock or mutual insurance company. In response, GHI sought Congressional action to maintain its not-for-profit status. On August 11, 1939, Congress authorized GHI to operate only for the benefit of its subscribers and to be a not-for-profit institution. GHI was incorporated as of that date. In 1942, GHI was sanctioned to use the Blue Cross service mark and in 1951, GHI became a fully participating member of the Blue Cross system.

Medical Service of the District of Columbia (MSDC) was founded and began operation in 1948 and was authorized to use the Blue Shield service mark in 1952. GHI and MSDC merged in 1985, and GHMSI became the successor entity. At that time, GHMSI adopted the trade name Blue Cross and Blue Shield of the National Capital Area (BCBSNCA).

On April 8, 1986, a court order was issued outlining the territorial boundary of exclusivity between Blue Cross Blue Shield of Virginia (now Anthem Health Plans of Virginia, Inc.) and BCBSNCA. The boundary approximated Virginia State Route 123.

As of January 16, 1998, GHMSI was purchased by CareFirst of Maryland, Inc. (CFMI) which operates under a newly incorporated, not-for-profit company, CareFirst, Inc. GHMSI filed to operate as CareFirst BlueCross BlueShield on January 5, 1999. In 2001, CareFirst announced its intentions to convert to for-profit status and be acquired by WellPoint Health Networks; however, this plan was later rejected. GHMSI currently operates in Maryland, the District of Columbia, and Virginia as a not-for-profit health service plan.

GHMSI markets group, individual, and Medicare supplement policies through internal and external brokers and direct marketing in the cities of Fairfax and Alexandria, the Town of Vienna, Arlington County, and the areas of Fairfax and Prince William Counties lying east of Route 123.

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As of December 31, 2016, GHMSI's annual statement reported Virginia direct premiums written totaled $475,778,954. Enrollment for health products at the end of 2016 totaled 229,552 members.

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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 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.

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 GHMSI was in substantial compliance.

COMPLAINT SYSTEM

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

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benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than the timeframes established in subdivisions 1 and 2 of this subsection: 1. If an internal appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal. 2. If an internal appeal involves a post-service claim review request, the health carrier shall notify the covered person of its decision within 60 days after receipt of the appeal.

Although the examiners selected a sample of 100 from a population of 1,612 written complaints and appeals received during the examination time frame, 21 sample files were later determined to be files that were outside the examination time frame and were not reviewed. The examiners reviewed the remaining 79 sample files. The review revealed 2 violations of § 38.2-5804 A of the Code and 3 violations of 14 VAC 5-216-40 E 2. An example of each is discussed in Review Sheet CP03J-GH, where GHMSI advised the member that the Plan's vendor, Magellan, would provide notice of their decision within 90 days from the date of the submission of the appeal to Magellan. As the health carrier is required to notify the covered person of its decision within 60 days after receipt of the post-service appeal, GHMSI failed to notify the covered person within 60 days of receipt of the appeal. GHMSI also failed to provide the benefit determination letter in the sample file. GHMSI agreed with the examiners' observations and explained that the appeals workflow had been updated to ensure all appeals to Magellan are resolved within 60 days.

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PROVIDER AND INTERMEDIARY CONTRACTS

The examiners reviewed a sample of 23 from a population of 10,354 provider contracts in force during the examination time frame. The examiners also reviewed GHMSI's

contracts negotiated with intermediary organizations for providing health care services pursuant to an MCHIP.

Section 38.2-5805 B of the Code states that every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing. GHMSI contracted with an intermediary, Davis Vision, Inc. (Davis Vision), to process vision claims and negotiate contracts with vision providers. As discussed in Review Sheet MC01M-GH, GHMSI indicated that a participating vision provider did not have a direct written agreement with Davis Vision, in violation of § 38.2-5805 B of the Code.

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V. INTERNAL APPEAL AND EXTERNAL REVIEW

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

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

The examiners reviewed a sample of 10 from a population of 17 external reviews of final adverse determinations that occurred during the examination time frame. In addition, the 79 sample files of complaints and appeals were reviewed for compliance with the notice requirements for external review.

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 8 violations of this section. Section 38.2-3559 D of the Code states that the health carrier shall include the standard and expedited external review procedures and

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any forms with the notice of the right to an external review. The review revealed 7 violations of this section. 14 VAC 5-216-30 B states that as part of each health carrier's health benefit plan and any adverse benefit determination, each health carrier shall provide notice of its available internal appeals procedures (including urgent care appeals), including timeframes for submission of an appeal, the health carrier's review and response. Such notice shall also include the name, address, and telephone number of the person or organizational unit designated to coordinate the review of the appeal for the health carrier, and contact information for the Bureau of Insurance. If the plan is a managed care health insurance plan (MCHIP), the mailing address, telephone number, and email address for the Office of the Managed Care Ombudsman shall also be included. The review revealed 1 violation of this section. 14 VAC 216-40 D 2 states a full and fair review shall also provide for, upon request to the health carrier, the covered person to have reasonable access to and free of charge copies of all documents, records, and other information relevant to the covered person's request for benefits. This information shall be provided to the covered person as soon as practicable. The review revealed 1 violation of this section.

An example of GHMSI's non-compliance with each of these 4 sections is discussed in Review Sheet CP10J-GH, where GHMSI incorrectly provided external review rights and a link to download external review forms for an adverse benefit determination. GHMSI disagreed with the examiners' observations explaining that it was in the process of implementing changes as the result of a Bureau of Insurance (Bureau) External Review Inquiry. The Bureau discussed the application of each of these sections during the examination timeframe and recognized that the system changes were in process, so no monetary penalty will be assessed at this time.

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VI. PROVIDER CONTRACTS

A review of a GHMSI's provider contracts was conducted to determine compliance with §§ 38.2-3407.15 B, 38.2-3407.15:1 B and 38.2-3407.15:1 C, 38.2-3407.15:2 B, 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code. Each section sets forth specific provisions that contracts between carriers and providers shall contain.

ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 B 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.

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Provider Contracts

The examiners reviewed a sample of 23 from a population of 10,354 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 3 instances in which GHMSI'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	EF02M-GH
§ 38.2-3407.15 B 9	1	EF02M-GH
§ 38.2-3407.15 B 11	1	EF02M-GH

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. GHMSI's failure to amend its provider contracts to comply with § 38.2-3407.15 B of the Code did not occur with such frequency as to indicate a general business practice.

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 298 from a population of 7,253 claims processed under the 23 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 2 instances where GHMSI failed to pay a clean claim within 40 days, in violation of this section. An example is discussed in Review Sheet EFCL07D. GHMSI agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code requires that any interest owing or accruing on a claim under § 38.2-3407.1 of the Code, shall be paid at the time the claim is paid or within 60 days thereafter. As discussed in Review Sheet EFCL06D, the review revealed 1 instance

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where GHMSI failed to pay interest as required, in violation of § 38.2-3407.15 B 3 of the Code. GHMSI agreed with the examiners' observations.

Section 38.2-3407.15 B 6 of the Code states that no carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Section 38.2-3407.15 B 7 of the Code of Virginia states notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted. The review revealed 1 violation of each of these sections. As discussed in Review Sheet EFCL03D, GHMSI issued a retroactive denial of payment over 12 months after the date of the payment of the original claim and failed to specify in writing the specific claim for which the retroactive denial was being imposed along with an explanation of why the claim was being retroactively adjusted. GHMSI agreed with the examiners' observations.

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Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis. The review revealed 1 violation of this section. An example is discussed in Review Sheet EFCL03M, where GHMSI underpaid the fee schedule specified for the health care service provided. GHMSI disagreed with the examiners' observations and provided screenshots reflecting an allowable amount of $102.67 for procedure code 99203 and $93.48 for procedure code 46600. The examiners responded, in part, that although GHMSI provided the examiners with screen shots noting the allowable amounts, the examiners were not provided with documentation that the provider contract standard fee schedule for this provider had been amended with the lower allowable amounts.

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. GHMSI's failure to perform the provider contract provisions required by § 38.2-3407.15 B of the Code did not occur with such frequency as to indicate a general business practice.

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

Section 38.2-3407.15:1 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has

the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions.

The examiners reviewed 2 sample provider contracts that were subject to this section of the Code. The review revealed that GHMSI was in substantial compliance.

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 regarding prior authorizations. The examiners reviewed 23 sample provider contracts that were subject to this Code section. 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	1	EF03M-GH
§ 38.2-3407.15:2 B 2	1	EF03M-GH
§ 38.2-3407.15:2 B 3	1	EF03M-GH
§ 38.2-3407.15:2 B 4	1	EF03M-GH
§ 38.2-3407.15:2 B 5	1	EF03M-GH
§ 38.2-3407.15:2 B 6	1	EF03M-GH
§ 38.2-3407.15:2 B 7	1	EF03M-GH
§ 38.2-3407.15:2 B 8	1	EF03M-GH

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.

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The examiners reviewed 2 sample provider contracts that were subject to this section of the Code. The review revealed that GHMSI was in substantial compliance.

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VII. ADVERTISING

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

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of 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)

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

A sample of 20 from a population of 150 advertisements disseminated during the examination time frame was selected for review. The review revealed that 3 of the 20 advertisements contained violations. In the aggregate, there were 3 violations, which are discussed in the following paragraph.

14 VAC 5-90-50 A states the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or

tendency to mislead or deceive shall be determined by the Commission from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. The review revealed 1 violation of this section. As discussed in Review Sheet AD01H-GH, GHMSI's Summary of Benefits and Coverage incorrectly stated that the Mental Health Substance Use Disorder deductible applied to both in-network and out-of-network providers. GHMSI agreed with the examiners' observations.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has exclusions, limitations, reduction of benefits, terms under which the policy may be continued in force or discontinued. For cost and complete details of the coverage, call or write your insurance agent." The review revealed 2 violations of this section. An example is discussed in Review Sheet AD01M-GH, where the invitation to inquire failed to contain the required disclosure. GHMSI agreed with the examiners' observations.

SUMMARY

GHMSI violated 14 VAC 5-90-50 A and 14 VAC 5-90-55 A which placed it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

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VIII. POLICY AND OTHER FORMS

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

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

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

GROUP CONTRACTS

The examiners reviewed the entire population of 6 group contracts issued during the examination time frame.

The review revealed that, in 3 instances, GHMSI issued a group contract that had been altered or changed from forms previously filed with the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. An example is discussed in Review Sheet PF02M-GH, where GHMSI issued a group contract with the policy form number VA/CF/HB/DOCS (1/13) that had been altered or changed without being filed with and approved by the Commission. GHMSI disagreed with the examiners' observations and stated that:

> Although there are discrepancies between form VA/CF/HB/DOCS (1/13) and the EOV, the form was filed and approved by the VBOI on 1/3/14. Nonetheless,

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a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that this form is no longer in production and we have, and continue to implement process improvements to advance version control and QA reviews for accurate contract creation following form approvals.

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

Due to the fact that the violations of § 38.2-316 C 1 of the Code were discussed in the prior Report, the current violations of could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

INDIVIDUAL CONTRACTS

The examiners reviewed a sample of 50 from a population of 1,558 individual contracts issued during the examination time frame.

The review revealed that the individual contracts were filed and approved as required.

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 GHMSI was in substantial compliance.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that a corporation issuing subscription contracts file its EOBs with the Commission for approval. The review revealed that GHMSI was in substantial compliance with this section.

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SCHEDULE OF BENEFITS

Sections 38.2-316 A and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of the schedule of benefits prior to use. The review revealed that GHMSI was in substantial compliance with this section.

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IX. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 and § 38.2-4224 of the Code. A sample of 25 from a population of 533 agents and agencies appointed during the time frame was selected for review. In addition, the writing agents or agencies designated in the 56 new business files were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A and 38.2-4224 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 GHMSI was in substantial compliance.

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APPOINTED AGENT REVIEW

Section 38.2-1833 A 2 of the Code requires a Health Service Plan to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, provide the agent with verification that the appointment has been filed with the Commission. The review revealed 1 violation of this section. As discussed in Review Sheet AG01M-GH, GHMSI failed to provide verification to the agent that the appointment had been filed with the Commission. GHMSI agreed with the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commissions or other valuable consideration to an agent or agency that was not appointed or that was not licensed at the time of the transaction. The review revealed that GHMSI was in substantial compliance with this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that a Health Services Plan notify the agent within 5 calendar days and the Commission within 30 calendar days upon termination of the agent's appointment. A sample of 25 was selected from a population of 145 agents whose appointments terminated during the examination time frame.

The review revealed 9 violations of this section. An example is discussed in Review Sheet AG06M-CF, where GHMSI failed to provide notification to the agent of the termination of the appointment. GHMSI agreed with the examiners' observations.

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

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

UNDERWRITING/UNFAIR DISCRIMINATION

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

UNDERWRITING REVIEW

The examiners reviewed a sample of 50 from a population of 1,558 individual contracts issued during the examination time frame. The examiners also reviewed the entire population of 6 group contracts issued during the examination time frame.

The examiners reviewed a sample of 50 from a population of 425 individual applications declined during the examination time frame. The examiners were informed by GHMSI that no group applications were declined during the examination time frame.

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

UNDERWRITING PRACTICES – AIDS

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

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

MECHANICAL RATING REVIEW

The review revealed that premiums were calculated correctly.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

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

DISCLOSURE AUTHORIZATION FORMS

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

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that, in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

Administrative Letter 2015-07 provides life and health insurers with a prototype AUD notice. An AUD notice containing wording substantially similar to the wording in the prototype notice is deemed to be approved for use in Virginia.

A sample of 50 from a population of 425 individual applications declined was selected by the examiners for review.

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Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that, in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code. The review revealed 5 violations of each of these sections. An example is discussed in Review Sheet UN01M-GH, where GHMSI failed to provide a written notice of the AUD decision when it closed the application after the applicant failed to respond to GHMSI's request for additional information that was missing from the application. GHMSI agreed with the examiners' observations.

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XI. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS

GHMSI 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). GHMSI'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 & RENEWAL NOTICES

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

Individual

A sample of 25 was selected from a population of 2,358 individual policies whose premiums increased by more than 35%, and a sample of 25 was selected from a population

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of 5,861 individual policies renewed during the examination time frame. The review revealed that GHMSI was in substantial compliance.

Group

A review of the total population of 14 groups whose premium increased by more than 35% indicated that GHMSI was in substantial compliance.

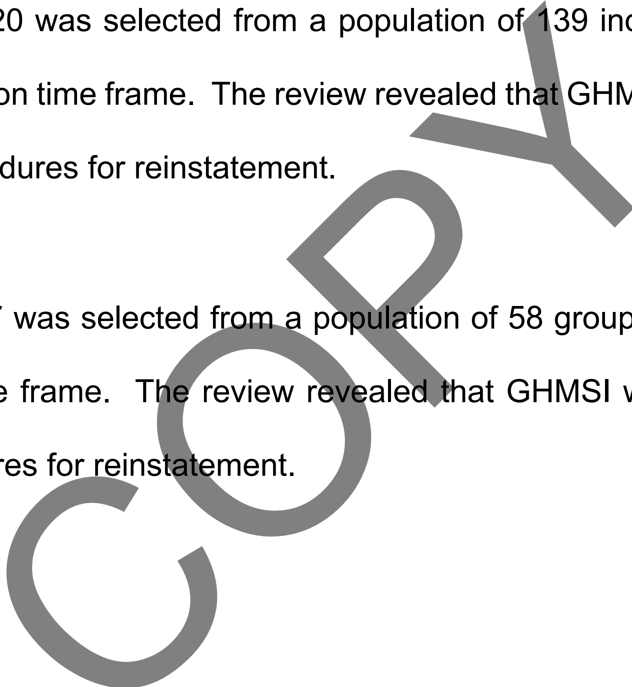
REINSTATEMENTS

Individual

A sample of 20 was selected from a population of 139 individual policies reinstated during the examination time frame. The review revealed that GHMSI was in compliance with its established procedures for reinstatement.

Group

A sample of 7 was selected from a population of 58 group policies reinstated during the examination time frame. The review revealed that GHMSI was in compliance with its established procedures for reinstatement.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XII. CANCELLATIONS/NON-RENEWALS/RESCISSIONS

The examination included a review of GHMSI'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 § 38.2-3542 of the Code. The examiners were informed by GHMSI that no rescissions of coverage occurred during the examination time frame.

Individual

A sample of 60 from a population of 4,633 individual policies terminated during the examination time frame was selected for review. The review revealed that GHMSI was in substantial compliance.

Group

A sample of 15 from a population of 68 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 insurer until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. The review revealed that GHMSI was in substantial compliance.

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XIII. COMPLAINTS

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

The examiners reviewed a sample of 79 from a population of 1,612 written complaints received during the examination time frame. The review revealed that GHMSI was in substantial compliance with this section.

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XIV. CLAIM PRACTICES

The examination included a review of GHMSI's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code.

GENERAL HANDLING STUDY

The review consisted of a sampling of group and individual medical, mental health and substance use disorder, dental, vision and pharmacy claims. GHMSI has contracted with intermediaries for the processing of its claims for vision and pharmacy services. Davis Vision, Inc. (Davis Vision) processes vision claims and CaremarkPCS Health, LLC (Caremark) processes pharmacy claims.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 150 was selected from a population of 501,171 claims paid during the examination timeframe.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that GHMSI was in non-compliance with this section in 3 instances. 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 that GHMSI was in violation of this section in 2 instances. An example of GHMSI's non-compliance with these 2 sections is discussed in Review Sheet CL21D, where GHMSI failed to include a reasonable explanation on the EOB for the denial of the claim. GHMSI agreed with the examiners' observations.

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Section 38.2-3442 A of the Code states that notwithstanding any provision of § 38.2-3406.1, 38.2-3411.1, or any other section of this title to the contrary, a health carrier shall provide coverage for all of the following items and services, and shall not impose any cost-sharing requirements such as a copayment, coinsurance, or deductible with respect to the following items and services: 1. Evidence-based items or services that have in effect a rating of A or B in the recommendations of the U.S. Preventive Services Task Force, with respect to the individual involved. The review revealed that GHMSI was in violation of this section in 1 instance. As discussed in Review Sheet CL10D, GHMSI applied cost sharing requirements to a service that contained a B rating from the U.S. Preventive Services Task Force. GHMSI agreed with the examiners' observations.

Mental Health & Substance Use Disorder

A sample of 60 was selected from a population of 34,121 paid mental health and substance use disorder claims paid during the examination time frame.

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 settlement of claims in which liability has become reasonably clear. The review revealed that GHMSI was in non-compliance with this section in 1 instance. Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed that GHMSI was in non-compliance with this section in 1 instance. 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 that GHMSI was in violation of this section in 1 instance. As discussed in Review Sheet CL29D, GHMSI assessed a $15 copay for procedure code 90837 and a $15

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copay on procedure code 99051, for a total copay amount of $30. However, GHMSI's EOC indicates that a $15 per visit copay is required for an outpatient office visit. GHMSI disagreed with the examiners' observation and explained that the provider billed for both mental health and medical services and when GHMSI is billed for mixed services (medical and mental health), the member has the higher copay responsibility. The examiners responded that the provider submitting this claim billed GHMSI for three claim lines; 90837 (psychotherapy 60 minutes with patient), 99051 (service provided in office during regularly scheduled evening, weekend, or holiday hours), and 90785 (Interactive Complexity). GHMSI assessed a $15 copayment each for procedure codes 90837 and 99051. These procedure codes were billed for and related to the treatment of adjustment disorder with mixed anxiety and depressed mood. Since GHMSI failed to provide documentation that would indicate that this provider rendered both mental health and medical treatment to this member separately, the examiners maintained their findings.

Dental

A sample of 10 was selected from a population of 5,304 dental claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Vision

A sample of 30 claims was selected from a population of 5,156 vision claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that GHMSI was in non-compliance with this section in 1 instance.

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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 settlement of claims in which liability has become reasonably clear. The review revealed that GHMSI was in non-compliance with this section in 1 instance. In addition, the review revealed that GHMSI was in non-compliance with its EOC in 1 instance. As discussed in Review Sheet CL08M, GHMSI assessed a $50 copay instead of the $0 copay required in the EOC. GHMSI disagreed with the examiners' observations stating:

> Davis Vision has this member enrolled in Subgroup A5P Plan 101 which has a $50.00 exam copayment. CareFirst's partner, Davis Vision, acted in good faith, without misrepresentations, and processed the members' claims, which complied with their benefit contracts.

The examiners maintained their findings and responded that "The EOC provided by GHMSI states that there is no copayment or coinsurance for an eye examination. Since GHMSI did not provide documentation to support the $50 copayment for the eye exam, GHMSI misrepresented policy provisions relating to coverages at issue, has failed to make a fair and equitable settlement, and is in non-compliance with the EOC."

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Pharmacy

A sample of 50 was selected from a population of 497,121 pharmacy claims paid during the examination time frame. The review revealed the claims were processed in accordance with the contract provisions.

INTEREST

Section 38.2-3407.1 B of the Code sets forth the requirement that interest on claims proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of the claim payment. The review revealed 2 violations of this section. An example is discussed in Review Sheet CL06D, where

GHMSI took 34 days to pay a claim and failed to pay the statutory interest due. GHMSI agreed with the examiners' observations.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 90 was selected from a population of 95,067 claims denied during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that GHMSI was in non-compliance with this section in 1 instance. Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed that GHMSI was in non-compliance with this section in 1 instance. 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 settlement of claims in which liability has become reasonably clear. The review revealed that GHMSI was in non-compliance with this section in 2 instances. Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed that GHMSI was in non-compliance with this section in 3 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the

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benefits payable under the contract. The review revealed that GHMSI was in violation of this section in 2 instances. An example of non-compliance with each of these sections is discussed in Review Sheet CL16D, where GHMSI denied a claim for surgery from a preferred provider and held the member liable for the cost of the covered services provided, stating on the EOB, “Benefits for this charge are not available as claims must be submitted within a specified time period. Please refer to your benefit book.” GHMSI disagreed with the examiners' observations stating:

> The member's group contract that was effective for the date of service in the audit, 3/30/2016, allowed for claim submission within 180 days of that date. As stated on the EOB, benefits cannot be provided if the claim is not submitted within that timeframe. Please refer to the member's contract under General Provisions/7.2/B, which is included below:
> B. Proof of Loss.
> For Covered Services provided by Preferred Providers, Preferred and Participating Dentists, Contracting Vision Providers, and Contracting Pharmacies, Members are not required to submit claims in order to obtain benefits.
> For Covered Services provided by Non-Preferred Providers, Non-Participating Dentists, Non-Contracting Vision Providers, and Non-Contracting Pharmacies, Members must furnish written proof of loss, or have the provider submit proof of loss, to CareFirst within one-hundred and eighty (180) days after the date of the loss. The Member is also responsible for providing information requested by CareFirst, including, but not limited to, medical records.
> Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

The examiners responded that the claim file indicated that the provider of these services was a preferred provider and GHMSI did not provide documentation that the member should have been held liable for the charges on this claim.

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Mental Health & Substance Use Disorder

A sample of 30 was selected from a population of 4,475 mental health and substance use disorder claims denied during the examination time frame.

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 settlement of claims in which liability has become reasonably clear. The review revealed that GHMSI was in non-compliance with this section in 4 instances. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed that GHMSI was in non-compliance with this section in 5 instances. Section 38.2-3418.17 A of the Code states that notwithstanding the provisions of § 38.2-3419 and any other provision of law, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder, in individuals (i) from January 1, 2012, until January 1, 2016, from age two years through age six years and (ii) from and after January 1, 2016, from age two years through age 10 years, subject to the annual maximum benefit limitation set forth in subsection K and to provisions of subsection G. If an individual who is being treated for autism spectrum disorder becomes older than the applicable maximum age set forth in the preceding sentence and continues to need treatment, this section does not preclude coverage of treatment and services. In addition to the requirements imposed on

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health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage or refuse to deliver, issue, amend, adjust, or renew coverage of an individual solely because the individual is diagnosed with autism spectrum disorder or has received treatment for autism spectrum disorder. The review revealed that GHMSI was in violation of this section in 3 instances. Section 38.2-3418.17 D of the Code states that coverage under this section will not be subject to any visit limits, and shall be neither different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors. The review revealed that GHMSI was in violation of this section in 1 instance. An example of GHMSI's non-compliance with these 4 sections is discussed in Review Sheet CL06D. GHMSI initially denied a claim on September 9, 2016, with the first two lines denied with the explanation "The member's age is not within the guidelines for these services" and the third line denied with the explanation "This service exceeds the maximum number allowable per procedure". The claim was reprocessed on October 14, 2016, with the first two lines paid and the third line denied with the explanation "This service exceeds the maximum number allowable per procedure". Therefore, GHMSI failed to make a fair and equitable settlement of this claim and failed to provide a reasonable explanation for the denial of a claim. In denying coverage for the treatment of autism spectrum disorder rendered to an eight-year-old member, on the first iteration of this claim, GHMSI was in violation of the provisions of § 38.2-3418.17 A of the Code; and in denying the third line on both iterations of the claim for exceeding visit limits, GHMSI was in violation of the provisions of § 38.2-3418.17 D of the Code. GHMSI agreed with the examiners' observations.

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Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed that GHMSI was in non-compliance with this section in 2 instances. Section 38.2-3407.4 B of the Code states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. The review revealed that GHMSI was in violation of this section in 2 instances. An example of GHMSI's non-compliance with these 2 sections is discussed in Review Sheet CL19D, where GHMSI denied the claim on September 30, 2016, with a service date of October 6, 2014, for not submitting the claim within a specified time period. The claim was reprocessed on November 14, 2016, as paid with the member responsible for a $130 deductible. The claim was reprocessed again on November 29, 2016, to reflect a decrease in member liability to a coinsurance amount of $26 and no deductible. GHMSI's internal notes for the third adjudication of the claim indicate that the adjustment was made due to a "manual processing error" on the second adjudication of the claim. Therefore, GHMSI failed to accurately and clearly set forth the benefits payable under the contract on the explanation of benefits sent to the member and failed to adopt and implement reasonable standards for the prompt investigation of this claim. GHMSI agreed with the examiners' observations.

<u>Dental</u>

A sample of 10 was selected from a population of 2,771 dental claims denied during the examination time frame.

Section 38.2-510 A 14 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to promptly provide a reasonable explanation

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of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The review revealed that GHMSI was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL04M, GHMSI denied a claim for a preventive oral examination with the explanation "The member's contract limits the benefit of this service to once in a three-year period." However, the EOC for this member allows coverage for 2 preventive oral examinations per benefit year. GHMSI disagreed with the examiners' observations and explained that the original claim was paid on February 3, 2016, and the same claim was resubmitted on August 1, 2016. Although the claim was correctly denied as a duplicate, the denial reason was incorrectly stated. The examiners maintained their findings that GHMSI failed to provide a reasonable explanation of the basis in relation to the facts for the denial of the claim.

Vision

A sample of 22 was selected from a population of 213 vision claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Pharmacy

A sample of 30 was selected from a population of 110,760 pharmacy claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

SUMMARY

GHMSI's failure to comply with §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code occurred with such frequency as to indicate a general business practice, placing GHMSI in violation of these sections.

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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.

The review revealed that of the 300 sample paid claims and 182 sample denied claims reviewed, GHMSI failed to affirm or deny coverage within a reasonable time in 28 instances, in non-compliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL04D, where GHMSI took 87 working days to affirm a claim. GHMSI agreed with the examiners' observation.

GHMSI's failure to affirm or deny coverage within 15 working days of receipt of complete proof of loss did not occur with such frequency as to indicate a general business practice.

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OUT-OF-POCKET MAXIMUM

The examiners reviewed a sample of 30 from a population of 986 insureds who had met their out-of-pocket maximum during the examination time frame. The review revealed that GHMSI was in substantial compliance with the policy provisions.

THREATENED LITIGATION

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

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XV. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, GHMSI will be required to implement the following corrective actions. GHMSI 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;
2. Review and strengthen its procedures to ensure timely response to post-service appeals, as required by 14 VAC 5-216-40 E 2;
3. Establish and maintain procedures to ensure every contract with a provider of health care services enabling an MCHIP to provide health care services shall be in writing, as required by § 38.2-5805 B of the Code;
4. As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;
5. Review and strengthen procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;
6. Review and reopen the claim discussed in review sheet EFCL03M and re-adjudicate it to pay along with statutory interest owed. Include with the 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 under paid.";

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7. Establish and maintain procedures to ensure that all contracts between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions regarding prior authorization, as required by §§ 38.2-3407.15:2 B and 38.2-3407.15:2 C of the Code;
8. Strengthen and maintain procedures to ensure that the content of each Summary of Benefits and Coverage shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive, as required by 14 VAC 5-90-50 A;
9. Strengthen and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A;
10. As recommended in the prior Report, establish and maintain procedures to ensure that all policy and application forms are filed with and approved by the Commission, as required by §§ 38.2-316 A and 38.2-316 C 1 of the Code;
11. Establish and maintain procedures for compliance with §§ 38.2-1833 A 2 and 38.2-1834 D of the Code concerning the appointment and appointment termination of its agents and agencies;
12. Establish and maintain procedures to ensure that the AUD notice required by §§ 38.2-610 A 1 and 38.2-610 A 2 of the Code is provided to applicants in accordance with the guidelines established by Administrative Letter 2015-07;
13. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 1, 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5, 38.2-510 A 6, and 38.2-510 A 14 of the Code;

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14. Review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, as required by§ 38.2-3407.4 B of the Code. This shall include clearly and accurately indicating member liability, allowable amounts, deductibles, coinsurance, and copayments on its EOBs;
15. Review and strengthen its procedures to ensure that all claims are adjudicated in accordance with the EOC;
16. Review and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 B of the Code;
17. Review all auto-adjudicated mental health and substance use disorder claims with a procedure code of 99051 for the years for the years 2016, 2017, 2018, and 2019. Determine those instances where the claim had been assessed a medical copay in error and send checks for the proper contractual benefits, plus any interest as required by § 38.2-3407.1 B of the Code to the member/provider to whom benefits and interest are due. 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 revealed that an error in the payment of this claim was found. Please accept this check for an additional payment." After which, furnish the examiners with documentation that the required amounts have been paid;
18. Establish and maintain procedures for the adjudication of autism spectrum disorder claims to ensure compliance with §§ 38.2-3417.18 A and 38.2-3417.18 D of the Code;
19. Review all claims processed in 2016, 2017, 2018 and 2019 with an autism spectrum disorder diagnosis and identify any claims that were not processed in accordance with

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§ 38.2-3417.18 of the Code. Re-adjudicate any claims that were not paid in accordance with these sections and make interest payments where necessary, as required by § 38.2-3407.1 B of the Code. Include with each check an explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly." After which, furnish the examiners with documentation that the required amounts have been paid;

20. Review and strengthen its procedures for the adjudication of claims with procedure codes that have a rating of A or B in the recommendations of the U. S. Preventive Services Task Force, as required by § 38.2-3442 A of the Code; and

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

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XVI. ACKNOWLEDGMENT

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

Mel Gerachis, FLMI, AIRC, AMCM, Janay Brown, MCM, Heather Webb, MCM, and Daniel Abbondanzo of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

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

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XVII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
§ 38.2-5804 A, **2 violations**, CP03J-GH, CP07J-GH
14 VAC 5-216-40 E 2, 3 violations, CP03J-GH, CP07J-GH, CP08J-GH
Provider Contracts
§ 38.2-5805 B, **1 violation**, MC01M-GH
PROVIDER CONTRACTS
Ethics and Fairness – Provider Contracts
§ 38.2-3407.15 B 4, 1 violation, EF02M-GH
§ 38.2-3407.15 B 9, 1 violation, EF02M-GH
§ 38.2-3407.15 B 11, 1 violation, EF02M-GH
Ethics and Fairness – Provider Claims
§ 38.2-3407.15 B 1, 2 violations, EFCL07D, EFCL16M
§ 38.2-3407.15 B 3, 1 violation, EFCL06D
§ 38.2-3407.15 B 6, 1 violation, EFCL03D
§ 38.2-3407.15 B 7, 1 violation, EFCL03D
§ 38.2-3407.15 B 8, 1 violation, EFCL03M
Carrier contracts; required provisions regarding prior authorization
§ 38.2-3407.15:2 B 1, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 2, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 3, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 4, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 5, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 6, 1 violation, EF03M-GH

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§ 38.2-3407.15:2 B 7, 1 violation, EF03M-GH
§ 38.2-3407.15:2 B 8, 1 violation, EF03M-GH
ADVERTISING
14 VAC 5-90-50 A, 1 violation, AD01H-GH
14 VAC 5-90-55 A, 2 violations, AD01M-GH, AD04M-GH
POLICY AND OTHER FORMS
§ 38.2-316 A, 3 violations, PF02M-GH, PF03M-GH, PF04M-GH,
§ 38.2-316 C 1, 3 violations, PF02M-GH, PF03M-GH, PF04M-GH
AGENTS
§ 38.2-1833 A 2, 1 violation, AG01M-GH
§ 38.2-1834 D, 9 violations, AG03M-GH, AG04M-GH (8)
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-610 A 1, 5 violations, UN01M-GH, UN02M-GH, UN03M-GH, UN04M-GH, UN05M-GH
§ 38.2-610 A 2, 5 violations, UN01M-GH, UN02M-GH, UN03M-GH, UN04M-GH, UN05M-GH
CLAIM PRACTICES
§ 38.2-510 A 1, 2 instances of non-compliance, CL16D, CL08M
§ 38.2-510 A 3, 3 instances of non-compliance, CL16D, CL18D, CL19D
§ 38.2-510 A 5, 28 instances of non-compliance, CL04D, CL05D, CL33D, CL05M, CL06M, CL14M, CL16M (22)

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§ 38.2-510 A 6, 8 violations, CL06D, CL07D, CL08D, CL14D, CL16D, CL18D, CL29D, CL08M
§ 38.2-510 A 14, 13 violations, CL02D, CL06D, CL07D, CL08D, CL14D, CL16D, CL18D, CL19D, CL21D, CL23D, CL29D, CL31D, CL04M
§ 38.2-3407.1 B, 2 violations, CL04D, CL06D
§ 38.2-3407.4 B, 7 violations, CL14D, CL16D, CL18D, CL19D, CL21D, CL23D, CL29D
§ 38.2-3418.17 A, 3 violations, CL06D, CL07D, CL08D
§ 38.2-3418.17 D, 1 violation, CL06D
§ 38.2-3442 A, 1 violation, CL10D

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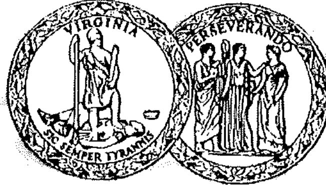
COMMONWEALTH OF VIRGINIA



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July 25, 2019

SENT VIA EMAIL

Ms. Jenene Lyn Williams
Director, External Audit Coordination
Group Hospitalization and Medical Services, Inc.
1501 South Clinton Street
Room 10147
Baltimore, MD 21224

RE: Market Conduct Examination Report
Exposure Draft - Group Hospitalization and Medical Services, Inc.

Dear Ms. Williams:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Group Hospitalization and Medical Services, Inc. (GHMSI) for the period of July 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 GHMSI, 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. GHMSI's response(s) to the draft Report will be attached to and become part of the final Report.

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

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks

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

COPY

Jenene L. Williams, Sr. Director, External Audit Coordination
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224
Tel. 410.528.5796
Fax 410.505-6787

October 4, 2019

Ms. Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
1300 E. Main Street
Richmond, Virginia 23219

RE: Market Conduct Examination Report
Exposure Draft – Group Hospitalization and Medical Services, Inc.

COPY

Dear Ms. Fairbanks:

Thank you for the exposure draft of the market conduct examination of Group Hospitalization and Medical Services, Inc. ("GHMSI") for the period of July 1, 2016 through December 31, 2016. GHMSI has received the exposure draft and this letter will serve as its response. Unless noted, GHMSI has not commented on those sections of the examination in which the Virginia Bureau of Insurance found substantial compliance.

Kindly note that GHMSI placed its corrective action measures within the body of its response.

Section II. EXECUTIVE SUMMARY

In the development and implementation of its business policies and day-to-day practices, GHMSI exercises its best intent and good faith efforts to comply with all applicable state and federal law, including Virginia law. GHMSI objects to the assertions that the company knowingly violates Virginia law or engages in general business practices that fail to comply with it.

Section IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

Complaint System

The Plan is committed to maintaining a compliant complaint system where responses are timely and consistent with policies and procedures agreed and approved by the Commission.

CP07J-GH: Regarding the violations associated with § 38.2-5804 A 1 of the Code of Virginia, GHMSI conducted a root cause analysis. Upon completion, GHMSI conducted refresher training on 8/27/19. The company enhanced its current inventory reporting measures. The enhancement enables identification of cases prior to them aging past the timeframe set forth by the VBOI. The new reporting, effective 9/9/19, will be issued to the management staff daily, thus ensuring that aged cases are addressed in a timely manner.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

CP08J-GH and CP07J-GH: Regarding the violations associated with 14 VAC 5-216-40 E 2, GHMSI conducted a root cause analysis. Upon completion, GHMSI conducted refresher training on 8/27/19. GHMSI also conducts monthly quality audits to ensure associates are properly and timely handling appeals A supervisor also monitors the inventory daily for timeliness.

Provider and Intermediary Contracts.

MC01M-GH: GHMSI disagrees with the examiner's findings. Attached is a screenshot from the online provider directory for GHMSI for the Davis Vision network of providers, as well as a screenshot form Davis Vision's internal system listing for the JC Penney Optical location #11147, (Attachment MC01M-GH).

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Section VI. PROVIDER CONTRACTS

Ethics and Fairness in Carrier Business Practices – Provider Contracts

EF02M-GH: GHMSI conducted a root cause analysis regarding this finding. To address the gap, GHMSI will revise all dental provider contracts to include provisions required by sections 38.2-3407.15 B 4, B9, and B11 of the Code of Virginia. This will be completed by April 2020. GHMSI is conducting monthly meetings to review, revise and monitor through implementation.

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL06D: With regards to § 38.2-3407-15 B l, GHMSI respectfully disagrees this sample claim represents a violation. While the adjudication of the claim was rejected in error, GHMSI received it on 7/18/16 and finalized it on 7/29/16.

With regards to § 38.2-3407.15 B 3, GHMSI acknowledges it did not properly process the original claim received 7/18/16. The provider resubmitted the charges 11/21/16 with payment being made 12/2/16 for out of network benefits. Interest is applicable for this date of service as of the receipt date of 7/18/16. Interest of $.61 was processed and paid on 12/2/16.

EFCL07D-GH: GHMSI agrees that there was a delay in paying the claim due to the fact that the copay was initially processed incorrectly. There was a benefit update made to the file on 10/5/16. The claim was then adjusted to reflect the correct copay. Steps have been taken to ensure ongoing compliance.

EFCL16M: GHMSI will continue to review and strengthen its front end and back end procedures to ensure that claims are adjudicated in accordance with the evidence of coverage and in compliance with regulatory requirements going forward.

EFCL03D: GHMSI has reviewed its standard operating procedure to ensure it clearly describes the manual process of generating a recoupment letter. The department completed the review of desktop procedures in 2018. Training reviews of this procedure were completed with the VBOI examiner to ensure that there is a comprehensive process for GHMSI to film all recoupment letters and correspondence sent to providers.

CL30D: GHMSI respectfully disagrees with the finding. The sample claim was received 1/6/16 and paid to the provider 1/13/16. The claim (6006P7222500) was adjusted on 6/26/16 removing member liability and paid interest. GHMSI received and paid a subsequent claim for the same services, claim (600617222501). The company retracted this duplicate payment within 6 months of payment on 12/1/16. The claim has been corrected and reprocessed on 2/28/17 (6006P7222501) to accurately identify the correct member liability. The reprocessed explanation of benefits was sent to the member. The sample claim was self-identified and corrected and reprocessed with interest before the VBOI audit commenced. Therefore, GHMSI respectfully requests that the VBOI reconsider and remove the violations for this sample.

EFCL01M: GHMSI respectfully disagrees with this finding. GHMSI's provider contracting rate shows the allowable amount of $47.18 per unit for CPT 77331 with modifier 26. Please see Attachment EFCL01M that were previously provided for this claim. GHMSI respectfully requests that the VBOI review again and reconsider this sample.

Carrier Contracts: Required Provisions Regarding Prior Authorization

EF03M-GH: GHMSI conducted a root cause analysis. To address the gap, GHMSI will revise all dental provider contracts to include provisions required by § 38.2-3407.15:2 B 1 through B 8 of the Code of Virginia. This will be done by April 2020. GHMSI is conducting monthly meetings to review, revise and monitor through implementation.

Section VII. ADVERTISING

AD01H-GH: GHMSI agrees, in part, with the findings. GHMSI acknowledges that the SBC incorrectly notes that a deductible applies to both in-network and out-of-network mental health substance use disorder services. GHMSI further notes that the SBC further provides the following:

> "This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or sample plan document at content.GHMSI.com/sbc/contracts/APPVBN7CRXNVBN7L.pdf or by logging into My Account."

The sample plan document linked within the SBC at the web address provided correctly states that the deductible only applies to out-of-network mental health substance use disorder services.

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GHMSI, therefore, agrees with the VBOI's observation with respect to this specific in-network benefit on this individual SBC. GHMSI updated the SBC and loaded it to the content server in August 2019.

AD04M-GH: GHMSI agrees this sample broadly invites recipients to inquire "about accident and sickness insurance." GHMSI has discontinued the postcard that is the subject of this audit sample.

As for AD04M-GH and AD01M-GH, beginning June 2018 (when GHMSI's review violation agreement response was acknowledged by the VBOI), GHMSI added the following statement to all invitations to inquire:

> "The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or GHMSI. "

To ensure that all GHMSI advertisements and marketing materials are accurate, error-free and compliant, GHMSI's product managers, product specialists and marketing project managers review all materials before they are shared publicly. During this review process, product managers and product specialists compare all plan and benefit information to the contract and plan design guide, which is formally reviewed each year during roundtable quality assurance sessions. Additionally, all marketing materials are reviewed by GHMSI's legal team to ensure compliance and accuracy. This was the review process in 2016 and it continues to date.

Section VIII. POLICY AND OTHER FORMS

PF02M-GH: Regarding § 38.2 316 A and § 38.2 316 C, although there are discrepancies between form VA/CF/HB/DOCS (1/13) and the Explanation of Variance (EOV), the form was filed and approved by the VBOI on 1/3/14. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that this form is no longer in production and GHMSI has and continues to implement process improvements to advance version control and QA reviews for accurate contract creation following form approvals. The form terminated from production 7/31/16.

PF03M-GH: Regarding § 38.2 316 A and § 38.2 316 C, although there are discrepancies between form VA/CF/LG/2015 GC AMEND (1/15) and the EOV, the form was filed and approved by the VBOI on 12/11/14. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that this form is no longer in production as of 12/31/18 and GHMSI

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has and continues to implement process improvements to advance version control and quality assurance reviews for accurate contract creation following form approvals.

PF04M-GH: Regarding violations § 38.2 316 A and § 38.2 316 C, please see SERFF Tracking CFBC-130245944 where form VA/CF/LG/INCENT (R. 1/16) was approved on 10/26/15. Per our cover letter, form VA/CF/LG/INCENT (R. 1/16) is to replace VA/CF/PPO/INCENT (1/15). Additionally, form VA/CF/PPO/INCENT (R. 1/16) was removed from production and termed on 12/31/16.

PF05M-GH, PF06M-GH, PF08M-GH: Regarding violations § 38.2 316 A and § 38.2 316 C, this is a CFBC form that is only used with CFBC products and written solely on CFBC paper. Therefore, GHMSI disagrees with the findings under GHMSI and request that these findings be removed from the GHSMI exam. GHMSI should not be cited twice for the same forms given this CFBC form is not used in any GHMSI products.

PF07M-GH and PF10M-GH: Regarding violations § 38.2 316 A and § 38.2 316 C, this is a CFBC form that is only used with CFBC products and written solely on CFBC paper. Therefore, GHMSI disagrees with the findings under GHMSI and request that these findings be removed from the GHSMI Audit. Given this CFBC form is not used with any GHMSI. Additionally, the form was removed from production and terminated 7/31/16.

PF09M-GH: This is a CFBC form that is only used with CFBC products and written solely on CFBC paper. Therefore, GHMSI disagrees with the findings under GHMSI and request that these findings be removed from the GHSMI Audit. GHMSI should not be cited twice for the same forms given this CFBC form is not used in any GHMSI products. Please note that GHMSI has been cited under the CFBC findings (review sheet PF08M-CF). GHMSI terminated the form and removed the it from production on 12/31/16.

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Section IX. AGENTS

Appointed Agent Review

GHMSI conducted a root cause analysis regarding this finding. To address the gap, on 4/2/18 GHMSI updated procedures and conducted training that included: a) timeline of reviewing and approving agent agreements; b) procedures for processing appointments for Virginia licenses; c) log all appointments with the correct appointment date in a shared database; d) appointment log is checked daily; and e) monthly 100% audit of appointment log by validating against the appointment/termination website to ensure compliance

Terminated Agent Appointment Review

AG03M-GH and AG04M-GH: GHMSI conducted a root cause analysis regarding this finding. To address the gap, on 4/2/18 GHMSI updated procedures and conducted training that included: a) timeline and requirements for processing termination requests; b) timeline and

requirements for sending the appointment termination notification letter directly to the agent and/or agency; c) timeline and requirements for sending termination notification to Commission and agent; and d) updated audit procedures to include source of termination request, timeline requirements and document retention to ensure compliance.

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

Adverse Underwriting Decision (AUD)

UN01 M-GH through UN05M-GH: GHMSI acknowledges the findings and has developed Adverse Underwriting Decision letters to comply with § 38.2-610 A 1 and § 38.2-610 A 2 of the Code of Virginia and Administrative Letter 2015-07. GHMSI will deploy these letters no later than 12/31/19.

Section XIV. CLAIM PRACTICES

CL16D and CL18D: Within 30 days GHMSI will adjust the claims to revise the member liability for cost-share only. The company will provide the VBOI a copy of the updated EOB.

At the time these claims were processed, the members' contractual timely filing period of 180 days was applied. GHMSI made a subsequent business decision to increase the members' filing limit from 180 days to 1 year. In April 2017, GHMSI corrected the member contracts to include the appropriate timely filing period. The new contracts have been validated as including the 1 year filing limit.

CL08M: GHMSI acknowledges the examiner's findings that the members were incorrectly charged copayment for routine vison exams. GHMSI identified this error in 2018. In February 2018, GHMSI and Davis Vision refunded payment plus applicable interest to affected members. GHMSI will provide documentation that the members listed in the review sheet received refunded payment including applicable interest.

CL13M: GHMSI disagrees with the examiner's findings. Attachment CL13M, screenshots from the member's benefit file, indicates that the member has a $20 copayment for Spectacle Lenses.

CL19D: Steps have been taken to ensure ongoing compliance. GHMSI installed system enhancements to the accumulator records and the error is no longer an issue for claims processed after 1/1/2017.

CL30D: GHMSI respectfully disagrees with the finding. The sample claim was received

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1/6/16 and paid to the provider on 1/13/16. The claim (6006P7222500) was adjusted on 6/26/16 removing member liability and paid interest. GHMSI received and paid a subsequent claim for the same services (600617222501). The company retracted this duplicate payment within 6 months of payment on 12/1/16. The claim has been corrected and reprocessed on 2/28/17 (006P7222501) to accurately identify the correct member liability. GHMSI sent the reprocessed EOB to the member. The sample claim was self-identified and corrected and reprocessed with interest before the VBOI audit commenced. Therefore, GHMSI respectfully requests reconsideration and removal of the violations for this sample.

CL04D: With respect to § 38.2-510 A 5, GHMSI failed to affirm or deny coverage of this claim within a reasonable time after proof of loss statement was completed.

CareFirst respectfully disagrees that it is in violation of Section 38.2-3407.1B. Section 38.2-3407.1 F provides that Virginia interest shall not apply in the event that the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. Because the out-of-area provider was paid by the local plan (Florida Blue), the laws governing the interest paid on claims would fall within that jurisdiction. Florida has an interest penalty law. Specifically, Sections 641.3155 and 627.613 of the Florida Insurance Code provide for the payment of interest for claims not paid within the timely manner prescribed by the statute.

CL05D: With respect to § 38.2-510 A 5, GHMSI failed to affirm or deny coverage of this claim within a reasonable time after proof of loss statement was completed.

CL20D: GHMSI disagrees with the findings. The group electronically terminated the policy on 11/16/16 with an 11/05/16 termination date. On 12/14/16, the GHMSI Enrollment and Billing team processed a request to reinstate the policy without a break in coverage. GHMSI reprocessed the claim due to a retroactive enrollment change. Therefore, no interest is due. GHMSI respectfully requests that the VBOI review this violation again.

CL26D: GHMSI respectfully disagrees that it is in violation of § 38.2-3407.1B. § 38.2-3407.1 F provides that Virginia interest shall not apply in the event that the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. Because the out-of-area provider was paid by the local plan, BlueCross BlueShield of Michigan, the laws governing the interest paid on claims would fall within that jurisdiction. Michigan has an interest penalty law. Specifically, § 550.1403 and § 500.2006 of the Michigan Insurance Code provide for the payment of interest for claims not paid within the timely manner prescribed by the statute.

CL32D: This sample claim should not have been part of the GHMSI sample. GHMSI has confirmed that the sample is a BlueChoice claim, not a GHMSI claim. Attachments CL32D,

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Explanation of Benefits and member contract, prove that this sample claim was under BlueChoice. Consequently, GHMSI properly paid the claim within 30 days as required for HMO products under Virginia law. The claim was received on 07/15/16 and paid in network 08/11/16 under an HMO product. The claim was 27 days old on the paid date and per Virginia law interest was not required.

CL33D: GHMSI respectfully disagrees with the finding. GHMSI received the out-of-network claim on 08/29/16 and fully processed it on 09/22/16. 100% of the allowed amount was applied to the member's out-of-network deductible. There was no payment to which GHMSI could apply interest.

CL04M, CL05M and CL06M: GHMSI will continue to review and strengthen its front end and back end procedures to ensure that claims are adjudicated in accordance with the evidence of coverage and in compliance with regulatory requirements going forward.

CL14M and CL16M: GHMSI acknowledges the examiner's findings. As of March 2019, GHMSI has established a workgroup to implement Explanation of Benefits that will be filed with the VBOI for approval. Requirements were established for Davis Vision to implement on July 2019. Discussions are taking place between Davis Vision and GHMSI to finalize expectations and requirements. GHMSI expects to file the EOBs for approval with the VBOI by Q1, 2020.

Once the VBOI approves the EOBs, Davis Vision will implement notification of explanation of benefits. GHMSI will establish a monitoring process to confirm ongoing compliance. The timeframe will be dependent upon the approval date from the VBOI.

CL01D: With respect to § 38.2-510 A 14 and § 38.2-510 A 6, GHMSI respectfully disagrees with the examiner's finding of violations. While the group name indicates that this is a gastrointestinal specialist, the rendering provider is listed with a provider specialty of 05, Anesthesiology. A valid rejection of "This service is not a covered benefit under the member's contract for the type of provider performing this service. Please refer to your employee benefit booklet or contract for additional information" was used appropriately for this claim. A provider with this type of specialty would not perform a surgical procedure. The provider resubmitted a new claim and GHMSI received it on 2/8/17. With this submission, a valid provider specialty of 11, internal medicine, was used. The claim was finalized on 2/24/17, with no member liability indicated.

CL02D: With respect to § 38.2-510 A 14, GHMSI agrees procedure code A4630 (replacement batteries medically necessary TENS owned by patient) was erroneously adjudicated as experimental and investigational. The service is not a covered benefit. Procedure code A4595 (electrical stimulator supplies, 2 leads), however, is payable following GHMSI Medical Policy 1.01.010, Durable Medical Equipment (page 4). GHMSI adjusted the claim for a statistical

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correction and finalized it on 5/9/18. GHMSI corrected the system on 12/22/17. The company completed an impact report which revealed that 8 claims including the sample claim were affected during the audit period. There was no monetary impact.

CL06D): With respect to § 38.2-3418.17, GHMSI acknowledges that the claim was incorrectly processed. Procedure code 0360T (obser behave assessment excluded inpatient) was incorrectly denied. GHMSI adjusted and finalized the claim 2/23/18 with a total payment of $11.67 interest. GHMSI corrected its system on 9/28/16. An impact report revealed there were no other affected claims.

With respect to § 38.2-510 A 6, GHMSI acknowledges the examiner's finding.

With respect to § 38.2-510 A 14, GHMSI acknowledges the examiner's finding.

With respect to § 38.2-3418.17 D, GHMSI acknowledges the examiner's finding.

With respect to §38-2-3407.1 B, GHMSI adjudicated the claim and made an additional payment of $108.00 on 2/23/18. With this adjustment complete, a total of $11.67 interest was issued.

CL07D: With respect to § 38.2-3418.17, GHMSI acknowledges that the claim was incorrectly processed. Procedure code H2033 (multisystemic therapy for juveniles) was incorrectly denied. GHMSI corrected the system on 12/20/17. An impact report was completed and reflected 25 affected claims including the sample claims for CL07D and CL08D. All claims were for the same member. GHMSI adjusted all 25 claims on 2/23/18 with the outcome of a total combined additional payment of $3,121.71, which the company sent directly to the provider of service.

With respect to § 38.2-510 A 6, GHMSI acknowledges the examiner's finding.

With respect to § 38.2-510 A 14, GHMSI acknowledges the examiner's finding.

With respect to § 38.2-3407.4 B (but noted on the preliminary exam findings as § 38.2- 3407.1 B), GHMSI acknowledges the examiner's finding.

CL08D: With respect to § 38.2-3418.17, GHMSI acknowledges that the claim was incorrectly processed. Procedure code H2033 (multisystemic therapy for juveniles) was incorrectly denied. GHMSI corrected its system on 12/20/17. The company prepared an impact report and identified 25 affected claims including the sample claims for CL08D and CL07D. All claims were for the same member. The adjustments occurred on 2/23/18 and the the total combined amount was $3,121.71, which GHMSI sent directly to the provider.

With respect to § 38.2-510 A 6, Care First acknowledges the examiner's findings.

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With respect to § 38.2-510 A 14, GHMSI acknowledges the examiner's findings.

With respect to § 38.2-3407.4 B (but noted on the preliminary exam findings as § 38.2- 3407.1 B), GHMSI acknowledges due to incorrect denial, the company did not accurately and clearly set forth the benefits payable under the contract.

CL14D, CL21D, CL23D: GHMSI acknowledges the findings. Steps have been taken to ensure ongoing compliance.

CL29D: GHMSI disagrees with the violations. The claim at issue was for services rendered by a participating provider with a Blue Plan in another state (Host Plan). The provider billed for both mental health and medical services. The copay for mental health office visit is $15.00 per day per provider. The copay for a medical office visit is $30.00 per day per provider. The medical procedure code has the higher copay for a specialist of $30. However, the allowance from the Host Plan for the medical services was less than the $30 copay, so the remaining copay was taken on the mental health line of the claim of $15. When GHMSI is billed for mixed services (medical and mental health), the member has the higher copay responsibility. GHMSI, of course, would not have exceeded the $30 copay. Please refer to the member contract/Benefits/Page 15/Mental Health Substance Abuse that was previously provided. GHMSI respectfully requests that the VBOI review the matter again.

CL31D: Regarding § 38.2-510 A14 of the Code of Virginia, the GHMSI claims processing system produces an EOB that does not contain a message code explanation when an internal message code 1002 (provider not eligible to reimburse for service per provider contract) with zero pricing occurs. GHMSI corrected its claims processing system as of May, 2016.

Regarding § 38.2-3407.1 B of the Code of Virginia, GHMSI disagrees that its processing represents a violation. The Host Plan processed this claim that included an out-of-area provider. A state in which the provider resides has a timely filing requirement that includes paying interest if the claim is not timely paid. The Host Plan must ensure compliance with all applicable laws when paying claims. It is our understanding that the Host Plan pays interest on host claims when interest is owed.

CL10D: With respect to § 38.2-3442 A, GHMSI acknowledges that the claim was incorrectly processed. Procedure code G0444 (annual depression screening) was incorrectly applied to the patient's deductible because diagnosis code Z1389 (encounter for screening for other disorder) was incorrectly processed as medical instead of routine. GHMSI corrected its system on 12/22/17. An impact report revealed 26 affected claims including the sample claim and the total underpayment amount of $425.82.

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Ms. Fairbanks, on behalf of GHMSI I thank you for the opportunity to respond to this market conduct examination draft report.

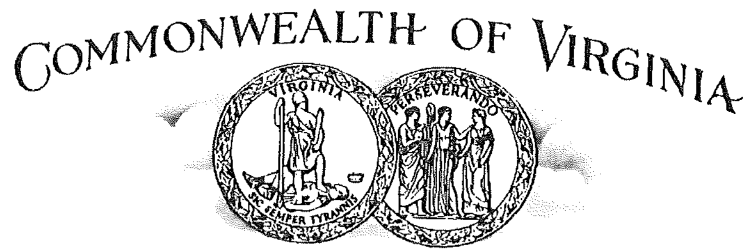
Sincerely,

Jenene Lyn Williams

Attachments (6)

COPY

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



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December 17, 2019

VIA EMAIL

Jenene Williams
Sr. Director, External Audit Coordination
CareFirst BlueCross BlueShield
1501 South Clinton Street
Room 10147
Baltimore, MD 21224

RE: Response to the Draft Examination Report
Group Hospitalization and Medical Services, Inc. (GHMSI)

Dear Ms. Williams:

The examiners have received and reviewed GHMSI's response to the Draft Report dated October 4, 2019. This letter will address GHMSI's concerns in the same order as presented in your response. Since GHMSI's response will also be attached to the final Report, this response does not address those issues where GHMSI indicated agreement and/or action taken as a result of the Report. GHMSI should note that upon finalization of this exam, GHMSI will be given approximately 90 days to document compliance with all of the corrective actions in the Report.

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Section II. Executive Summary

GHMSI's response raised concerns regarding assertions in the Report that GHMSI engages in general business practices that do not comply with Virginia law. 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 6 of the Code:** The Denied Claims review (beginning on p. 36 of the Report) revealed 4 violations of § 38.2-510 A 6 of the Code of Virginia (the Code) out of a sample of 30 Group and Individual Mental Health and Substance Use denied claims; this occurred with such frequency as to indicate a general business practice,

placing GHMSI in violation of § 38.2-510 A 6 of the Code. (Note: this general business practice is identified on p. 41 of the Report.)

- **§ 38.2-510 A 14 of the Code:** The Denied Claims review (beginning on p. 36 of the Report) revealed 5 violations of § 38.2-510 A 14 of the Code out of a sample of 30 Mental Health and Substance Use denied claims; this occurred with such frequency as to indicate a general business practice, placing GHMSI in violation of § 38.2-510 A 14 of the Code. (Note: this general business practice is identified on p. 41 of the Report.)

GHMSI's instances of non-compliance with §§ 38.2-510 A 1, 38.2-510 A 3 and 38.2-510 A 5 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.

GHMSI's response also raised concerns regarding assertions in the Report that GHMSI knowingly violated Virginia laws. GHMSI was cited for violating §§ 38.2-316 C 1, 38.2-510 A 6, and 38.2-3407.1 of the Code in both the current and prior Reports, therefore these violations could be considered knowing. The Report appears correct as written.

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Section IV. Managed Care Health Insurance Plans (MCHIPS)

Provider and Intermediary Contracts:

MC01M-GH: GHMSI provided the examiners with screenshots from GHMSI's online provider directory for the Davis Vision network of providers and from Davis Vision's internal system listing for the JC Penney Optical location #11147. GHMSI also explained that Davis Vision, Inc., GHMSI's intermediary, entered into a Master Agreement (Agreement) with Nationwide Vision effective March 1, 2007, and provided the examiners with a copy of the Agreement. Article III, section 1 of the Agreement states, in part, that Nationwide shall maintain agreements with the Nationwide Participating Providers. Since GHMSI, through its intermediary Davis Vision, did not provide the examiners with a copy of the contract between Nationwide Vision and JC Penney Optical, the Report appears correct as written.

Section VI. Provider Contracts

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL06D: Upon further consideration, the examiners have removed the violation of § 38.2-3407.15 B 1 of the Code. The examiners acknowledge GHMSI's agreement with the violation of § 38.2-3407.15 B 3 of the Code. The Report has been revised to reflect this change.

CL30D: The violations of §§ 38.2-3407.15 B 6 and 38.2-3407.15 B 7 of the Code have been removed.

EFCL01M: GHMSI provided the examiners with the July 1, 2013, amendment that states the allowable amount payable for CPT 77331 with a modifier of 26 is $49.66 per unit. GHMSI provided copies of screen shots with an allowable amount of $47.18 but did not provide the examiners with documentation that the provider contract fee schedule had been amended after 7/1/13. Therefore, the Report appears correct as written.

Section VIII. Policy and Other Forms

PF04M-GH: The examiners have reviewed the cover letter and the forms filed with SERFF Tracking Number CFBC-130245944 where form VA/CF/LG/INCENT (R. 1/16) was approved to replace form VA/CF/PPO/INCENT (1/15). However, the form used in the EOC was form VA/CF/PPO/INCENT (1/16) and it had not been filed with and approved by the Commission prior to its use. Therefore, the Report appears correct as written.

PF05M-GH through PF10M-GH: The violations of §§ 38.2-316 A and 38.2-316 C of the Code have been removed.

Section XIV. Claim Practices

CL13M: These violations of §§ 38.2-510 A 1 and 38.2-510 A 6 of the Code have been removed.

CL30D: These violations of §§ 38.2-510 A 3, 38.2-510 A 14 and 38.2-3407.4 B of the Code have been removed.

CL04D: The examiners acknowledge GHMSI's agreement that the claim was not affirmed or denied within a reasonable time after proof of loss was received. GHMSI disagrees with the examiners' findings that interest was due to the provider because the provider was an out-of-area provider and that § 38.2-3407.1 F of the Code provides that Virginia interest shall not apply in the event the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. The examiners note that § 38.2-3407.1 F of the Code states, in part, that this section shall not apply to claims proceeds payable to an out-of-state provider of pharmacy services for pharmacy services rendered outside of the Commonwealth. Since these were medical claims rather than pharmacy claims, § 38.2-3407.1 F of the Code would not be applicable. The Report appears correct as written.

CL20D: GHMSI provided the examiners with screen shots showing that on 12/14/2016, Enrollment and Billing processed a request to reinstate the policy without a break in coverage. The claim file indicates that this claim was later adjusted to pay the claim without interest on January 17, 2017, which was more than 15 working days after the date the claim became payable. Therefore, the Report appears correct as written.

CL26D: GHMSI disagrees with the examiners' findings that interest was due to the provider because the provider was an out-of-area provider and that § 38.2-3407.1 F of

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the Code provides that Virginia interest shall not apply in the event the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. The examiners note that § 38.2-3407.1 F of the Code states, in part, that this section shall not apply to claims proceeds payable to an out-of-state provider of pharmacy services for pharmacy services rendered outside of the Commonwealth. Since these were medical claims rather than pharmacy claims, § 38.2-3407.1 F of the Code would not be applicable. The Report appears correct as written.

CL32D: The violations of §§ 38.2-510 A 5 and 38.2-3407.1 B of the Code have been removed.

CL33D: The violation of § 38.2-3407.1 B of the Code was removed in the examiners' response on Review Sheet CL32D which was sent to GHMSI on January 29, 2018. The Report appears correct as written.

CL01D: The violations of §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code have been removed.

CL07D: Upon further consideration, the examiners have removed the violation of § 38.2-3407.4 B of the Code. The examiners acknowledge GHMSI's agreement with the violations of §§ 38.2-510 A 6, 38.2-510 A 14 and 38.2-3418.17 A of the Code. The Report has been revised to reflect this change.

CL08D: Upon further consideration, the examiners have removed the violation of § 38.2-3407.4 B of the Code. The examiners acknowledge GHMSI's agreement with the violations of §§ 38.2-510 A 6, 38.2-510 A 14 and 38.2-3418.17 A of the Code. The Report has been revised to reflect this change.

CL29D: GHMSI stated in their response "The provider billed for both mental health and medical services... When GHMSI is billed for mixed services (medical and mental health), the member has the higher copay responsibility." However, the provider submitting this claim billed GHMSI for three claim lines; 90837 (psychotherapy 60 minutes with patient), 99051 (service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service), and 90785 (interactive complexity). GHMSI assessed a $15 copayment for procedure code 90837 and a $15 copayment for code 99051. These procedure codes were billed for and related to the treatment of adjustment disorder with mixed anxiety and depressed mood. GHMSI has not provided any documentation that would indicate that the provider rendered both mental health and medical treatment to the member separately or that would indicate the services rendered under this claim did not constitute an outpatient non-facility mental health office visit with a participating provider subject to a $15 copayment under the member's Evidence of Coverage for all services rendered. Therefore, the Report appears correct as written.

CL31D: GHMSI disagrees with the examiners' findings that interest was due to the provider because the provider was an out-of-area provider and the state in which the

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provider resides has a timely filing requirement that includes paying interest if the claim is not timely paid. It is the Bureau of Insurance's position that claims paid to the policyholder, insured, claimant or provider, because of an assignment of benefits, should be paid in accordance with the provisions of § 38.2-3407.1 B of the Code, regardless of the state where the provider rendered services. If GHMSI processes a claim under a Virginia issued policy, and the billing provider did not have a contract with GHMSI on the date of service, the claim must be paid in accordance with Virginia's interest statutes. If the provider does have a contract with GHMSI and the contract was executed outside of Virginia, then the interest statute governing that provider's contract may be applied. Since GHMSI has advised the examiners that it does not have a contract with the out-of-state provider, the Report appears correct as written.

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

On the basis of our review of the entire file, it appears that GHMSI violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code, in addition to 14 VAC 5-90-50 A and 14 VAC 5-90-55 A of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that GHMSI violated §§ 38.2-316 A, 38.2-316 C 1, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 2, 38.2-1834 D, 38.2-3407.1 B, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 4, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 11, 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, 38.2-3418.17 A, 38.2-3418.17 D, 38.2-3442 A, 38.2-5804 A, and 38.2-5805 B of the Code, in addition to 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review

Violations of the above sections of the Code can subject GHMSI 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

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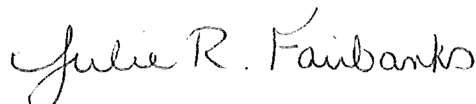
Very truly yours,



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

Jenene L. Williams, Sr. Director, External Audit Coordination
CareFirst BlueCross BlueShield
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January 29, 2020

Ms. Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
1300 E. Main Street
Richmond, Virginia 23219

RE: Market Conduct Examination Report
Response to the Draft Examination Report – Group Hospitalization and Medical Services, Inc.

Dear Ms. Fairbanks:

Thank you for the December 17, 2019 response to the Draft Report dated October 4, 2019 related to the market conduct examination of Group Hospitalization and Medical Services, Inc. ("GHMSI") for the period of July 1, 2016 through December 31, 2016. GHMSI has reviewed the December 17th letter and this letter will serve as its response. GHMSI's responses follow the same order as VBOI's December 17th letter.

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Section II. EXECUTIVE SUMMARY

In the development and implementation of its business policies and day-to-day practices, GHMSI exercises its best intent and good faith efforts to comply with all applicable state and federal law, including Virginia law. GHMSI objects to the assertions that the company knowingly violates Virginia law or engages in general business practices that fail to comply with it.

CareFirst has identified and corrected the errors identified by the VBOI, but disagrees that the frequency of the findings or findings from previous Market Conduct Audits indicate as a matter of practice that CareFirst operates in this manner as a general business practice. CareFirst processes over 100,000 claims on a daily basis, and when viewing the relatively limited errors that the VBOI has identified in comparison to the numerous of claims that are properly adjudicated, such proportion would indicate that CareFirst does not as a business practice operate in the manner proposed by the VBOI.

Section IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

Complaint System

The Plan is committed to maintaining a compliant complaint system where responses are timely and consistent with policies and procedures agreed and approved by the Commission.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

Provider and Intermediary Contracts.
MC01M-GH: With respect to § 38.2-5805 B, GHMSI acknowledges the examiner's finding.

Section VI. PROVIDER CONTRACTS

Ethics and Fairness in Carrier Business Practices – Provider Claims
EFCL01M: Per the attached Amendment to the Participation Agreement effective July 1, 2013, the provider contracting rate for HMO shows the allowable amount of $47.18 per unit for CPT 77331 with modifier 26 (pdf page 7 of 8). GHMSI believes the pricing is correct and respectfully requests that the VBOI review again and reconsider this violation.

Section VIII. POLICY AND OTHER FORMS

PF04M-GH: Regarding violations § 38.2 316 A and § 38.2 316 C, GHMSI acknowledges the examiner's finding.

Section XIV. CLAIM PRACTICES

CL04D: With respect to § 38.2-510 A 5, GHMSI failed to affirm or deny coverage of this claim within a reasonable time after proof of loss statement was completed.

CareFirst respectfully disagrees that it is in violation of Section 38.2-3407.1B. Section 38.2-3407.1 F provides that Virginia interest shall not apply in the event that the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. Because the out-of-area provider was paid by the local plan (Florida Blue), the laws governing the interest paid on claims would fall within that jurisdiction. The provider at issue is not participating with Florida Blue, however, Florida Blue made payment with the provider and would have to comply with any applicable law. Florida has an interest penalty law. Specifically, Sections 641.3155 and 627.613 of the Florida Insurance Code provide for the payment of interest for claims not paid within the timely manner prescribed by the statute.

CL20D: GHMSI disagrees with the findings. The group electronically terminated the policy on 11/16/16 with an 11/05/16 termination date. On 12/14/16, the GHMSI Enrollment and Billing team processed a request to reinstate the policy without a break in coverage. The claim was reprocessed due to a retroactive enrollment change, which is allowed contractually and within the stated guidelines. CareFirst was not a fault for this retroactive adjustment. Additionally, no interest is due on this claim because it is an "out of area" provider paid claim. Section 38.2-3407.1 F provides that Virginia interest shall not apply in the event that the other state in which the out-of-area provider practices provides for the payment of interest for untimely payment of claims. Because the out-of-area provider was paid by the local plan (BlueCross BlueShield of Massachusetts), the laws governing the interest paid on claims would fall within that jurisdiction. Specifically, Chapter 175, Section 108.4(c) of the Massachusetts Insurance Code provides for the payment of interest for claims not paid within the timely manner prescribed the

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law. The provider at issue is a participating provider with the local plan (*i.e.,* there is a contract between the entities). We respectfully request that the VBOI review this violation again.

GHMSI reprocessed the claim due to a retroactive enrollment change. Therefore, no interest is due. GHMSI respectfully requests that the VBOI review this violation again.

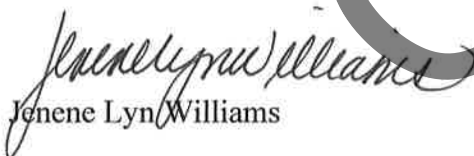
CL26D and CL31D: Representatives of the VBOI and of CareFirst discussed this matter during its conversation on January 21, 2020. GHMSI now confirms that this provider is a participating one.

CL33D: GHMSI respectfully disagrees with the finding. GHMSI received the out-of-network claim on 08/29/16 and fully processed it on 09/22/16. 100% of the allowed amount was applied to the member's out-of-network deductible. There was no payment to which GHMSI could apply interest.

CL29D: GHMSI acknowledges the examiner's finding. The mental health provider billed for both mental health and medical services. GHMSI will adjust the claim to pay at the mental health provider copay of $15 and release $15 back to the member.

Ms. Fairbanks, on behalf of GHMSI I thank you for the opportunity to respond to this market conduct examination draft report.

Sincerely,



Jenene Lyn Williams

Attachment (1)

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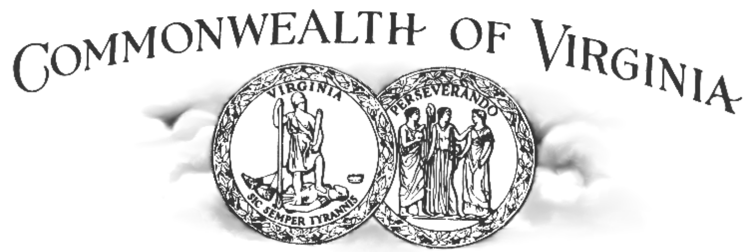
SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE



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March 27, 2020

VIA EMAIL

Jenene Williams
Sr. Director, External Audit Coordination
CareFirst BlueCross BlueShield
1501 South Clinton Street
Room 10147
Baltimore, MD 21224

COPY

RE: Response to the Draft Examination Report
Group Hospitalization and Medical Services, Inc. (GHMSI)

Dear Ms. Williams:

The examiners have received and reviewed GHMSI's additional response to the Draft Report dated January 29, 2020. This letter will address GHMSI's concerns in the same order as presented in your response. Since GHMSI's response will also be attached to the final Report, this response does not address those issues where GHMSI indicated agreement and/or action taken as a result of the Report. GHMSI should note that upon finalization of this exam, GHMSI will be given approximately 90 days to document compliance with all of the corrective actions in the Report.

Section II. Executive Summary

GHMSI's response raised concerns regarding assertions in the Report that GHMSI engages in general business practices that do not comply with Virginia law. The Market Conduct section of the Bureau of Insurance ("Bureau") conducts examinations, to the extent practicable, in accordance with the guidelines and procedures set forth in the Market Regulation Handbook ("Handbook") as set forth in §§ 38.2-1317.1 A and 38.2-1318 B of the Code of Virginia ("the Code"). The Handbook has established a benchmark error rate of 7 percent for auditing claim practices. An error rate exceeding this benchmark indicates a general business practice.

The Group and Individual Mental Health and Substance Use Disorder Denied Claims review revealed 4 out of a sample of 30 that were not processed in accordance with § 38.2-510 A 6 of the Code, resulting in an error rate of 13.3%. The review also revealed 5 out of a sample of 30 that were not processed in accordance with § 38.2-510 A 14 of the Code, resulting in an error rate of 16.7%. Based on the standards set forth in the Market Regulation Handbook, GHMSI's non-compliance with these 2 sections occurred with such frequency as to indicate

a general business practice, placing GHMSI in violation of §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code.

Regarding general business practices, the Report is correct as written.

GHMSI's response also noted objection to assertions that GHMSI knowingly violates Virginia law. GHMSI was cited for violations of §§ 38.2-316 C 1 of the Code in the prior report and should be familiar with the requirements set forth in this section. Under the prior corrective action plan, GHMSI was required to implement processes and procedures to ensure compliance going forward. In that additional violations of this section were found during the current exam, these violations could be construed as knowing.

Please note that upon further review, the examiners have removed the knowing violations of §§ 38.2-510 A 6 and 38.2-3407.1 B of the Code and the Report has been revised to reflect these changes.

In addition, please note that the Executive Summary has been revised to reflect the total number of violations and instances of non-compliance noted in the Report. This correction accurately reflects the findings noted in the Report and the counts in the Area of Violations Summary by Review Sheet section.

Section VI. Provider Contracts

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL01M: Upon further consideration, the examiners have removed the violation of § 38.2-3407.15 B 8 of the Code. The Report has been revised accordingly.

Section XIV. Claim Practices

CL04D: GHMSI disagrees with the examiners' findings that interest was due to the provider because the provider was an out-of-area provider. GHMSI also advised the examiners that the provider was not a participating provider with the Florida Host Blue. It is the Bureau's position that claims paid to a non-participating provider should be paid in accordance with the provisions of § 38.2-3407.1 B of the Code, regardless of the state where the provider rendered services. In other words, if GHMSI processes a claim under a Virginia issued policy, and the billing provider did not have a contract with the Host Blue on the date of service, the claim must be paid in accordance with Virginia's interest statutes. Please note that § 38.2-3407.1 F of the Code applies to claims proceeds payable to out-of-state providers of pharmacy services for pharmacy services rendered outside of the Commonwealth. The Report is correct as written.

CL20D: Upon further consideration, the examiners have removed the violations of §§ 38.2-510 A 5 and 38.2-3407.1 B of the Code. The Report has been revised accordingly.

CL26D: Upon further consideration, the examiners have removed the violations of §§ 38.2-510 A 5 and 38.2-3407.1 B of the Code. The Report has been revised accordingly.

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CL31D: Upon further consideration, the examiners have removed the violation of § 38.2-3407.1 B of the Code. The examiners acknowledge GHMSI's prior agreement with the violation of § 38.2-510 A 14 of the Code. The Report has been revised to reflect the removal of § 38.2-3407.1 B of the Code.

CL33D: The examiners advised GHMSI in the December 17, 2019, response to the Draft Examination Report that the violation of § 38.2-3407.1 B of the Code was removed in the examiners' response on Review Sheet CL33D, which was sent to GHMSI on January 29, 2018. The examiners maintain the cite of non-compliance with § 38.2-510 A 5 of the Code since payment of the claim was not made within 15 working days of receipt of proof of loss. The Report is correct as written.

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

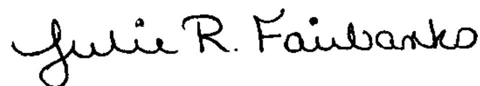
Based on our review of the entire file, it appears that GHMSI violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 6 and 38.2-510 A 14 of the Code, in addition to 14 VAC 5-90-50 A and 14 VAC 5-90-55 A of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that GHMSI violated §§ 38.2-316 A, 38.2-316 C 1, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 2, 38.2-1834 D, 38.2-3407.1 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 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 11, 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, 38.2-3418.17 A, 38.2-3418.17 D, 38.2-3442 A, 38.2-5804 A, and 38.2-5805 B of the Code, in addition to 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review

Violations of the above sections of the Code can subject GHMSI 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.

Considering 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
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COPY

Meryl D. Burgin
Executive Vice President, General Counsel and
Corporate Secretary

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Email: meryl.burgin@carefirst.com
www.carefirst.com

CONFIDENTIAL

July 22, 2010

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

RE: Alleged Violations §§ 38.2-316 A, 38.2-316 C 1, 38.2 510 A 6, 38.2-510 A 14, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 2, 38.2-1834 D, 38.2-3407.1 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 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 11, 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, 38.2-3418.17 A, 38.2-3418.17 D, 38.2-3442 A, 38.2-5804 A, and 38.2-5805 B of the Code, in addition to 14 VAC 5-90-50 A and 14 VAC 5-90-55 A of Rules Governing the Advertisement of Accident and Sickness Insurance and 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review.
Case No. INS-2019-00199

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Dear Ms. Blauvelt:

This will acknowledge receipt of the Bureau of Insurance's letter dated March 30, 2020, concerning the above-referenced matter.

GHMSI 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 $36,250. Payment was received from GHMSI on June 9, 2020.

2. Comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report of GHMSI as of December 31, 2016.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. which are independent licensees of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association.®' Registered trademark of CareFirst of Maryland, Inc.

3. Acknowledge GHMSI'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,

Group Hospitalization and Medical Services, Inc.

____
Meryl D. Burgin
Executive President, General Counsel and Corporate Secretary

July 22, 2020
(Date)

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COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JULY 28, 2020

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COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2019-00199

GROUP HOSPITALIZATION AND
MEDICAL SERVICES, INC.,
Defendant

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SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that Group Hospitalization and Medical Services, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated §§ 38.2-316 A and 38.2-316 C 1 of the Code of Virginia ("Code") by failing to use insurance policies or forms on file and approved by the Commission; § 38.2-510 A 6 of the Code by not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear with such frequency as to indicate a general business practice; § 38.2-510 A 14 of the Code by failing to provide a reasonable explanation of the basis for denial of a claim with such frequency as to indicate a general business practice; § 38.2-610 A 1 of the Code by failing to provide written notice of an adverse underwriting decision; § 38.2-610 A 2 of the Code by failing to provide applicants with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 on an adverse underwriting decision; § 38.2-1833 A 2 of the Code by failing to provide to the licensed agent a verification that the notice of appointment has been filed with the Commission within the 30-day period; § 38.2-1834 D of the Code by

failing to comply with the Commission's notification requirements of the termination of agent appointments; § 38.2-3407.1 B of the Code by failing to pay interest on accident and sickness claim proceeds; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth in the explanation of benefits the benefits payable under the contract; §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, and 38.2-3407.15 B 11 of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in provider contracts; §§ 38.2-3407.15:2 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 demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in carrier contracts; §§ 38.2-3418.17 A and 38.2-3418.17 D of the Code by failing to provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder in accordance with these sections; § 38.2-3442 A of the Code by applying cost sharing requirements to a service that contained a B rating from the U.S. Preventive Services Task Force; § 38.2-5804 A of the Code by failing to maintain its established complaint system approved by the Commission; § 38.2-5805 B of the Code by failing to maintain written copies of provider contracts; as well as 14 VAC 5-90-50 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* ("Rules"), by failing to use the proper format and content in advertisements; 14 VAC 5-90-55 A of the Commission's Rules by failing to include the required disclosure regarding the exclusions and limitations of the policy; and 14 VAC 5-216-40 E 2 of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to notify the insured of the final benefit determination within the required period of time.

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

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting nor denying any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan contained in the target market conduct examination report of Group Hospitalization and Medical Services, Inc. as of December 31, 2016; has tendered to the Treasurer of Virginia the sum of Thirty-six Thousand Two Hundred Fifty Dollars ($36,250); and has waived the right to a hearing.

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

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

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

A COPY of this order shall be sent by the Clerk of the Commission by electronic mail to: Jenene Williams, Senior Director, External Audit Coordination, CareFirst BlueChoice, Inc. at jenene.williams@carefirst.com, 1501 South Clinton Street, Room 10147, Baltimore, Maryland 21224; 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.

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