

REPORT ON
TARGET MARKET CONDUCT EXAMINATION OF
GROUP HOSPITALIZATION AND MEDICAL
SERVICES, INC.

AS OF MARCH 31, 2009

Conducted from August 21, 2009

Through

April 21, 2010

By

Market Conduct Section 1

**Life and Health Market
Regulation Division**

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 53-0078070
NAIC: 53007

COMMONWEALTH OF VIRGINIA

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



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Market Conduct Examination of GHMSI, conducted at its Office in Owings Mill, Maryland, as of March 31, 2009, is a true copy of the original Report on file with this Bureau, and also includes a true copy of the Company's response to the findings set forth therein, the Bureau's review letter, the Company's offer of settlement, and the State Corporation Commission's Settlement Order in Case No. INS-2011-00047.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 2nd day of March, 2012.

A handwritten signature in cursive script that reads "Jacqueline K. Cunningham".

Jacqueline K. Cunningham
Commissioner of Insurance

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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 was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code, including but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1809, 38.2-4234 and 38.2-5808 of the Code of Virginia (hereinafter referred to as “the Code”) and 14 VAC 5-90-170 A.

A previous Target Market Conduct Examination of denied claims covering the period of January 1, 2005, through June 30, 2005 was concluded on October 19, 2006. As a result of that examination, GHMSI made a settlement offer that was accepted by the State Corporation Commission on April 9, 2008, in Case No. INS-2008-00069.

A previous Target Market Conduct Examination covering the period of January 1, 2005, through June 30, 2005 was concluded on October 19, 2006. As a result of that examination, GHMSI made a settlement offer that was accepted by the State Corporation Commission on June 7, 2007, in Case No. INS-2007-00160.

The current examination revealed violations that were also noted in the previous Report. Various sections of this Report will refer to recommendations previously made. GHMSI had agreed to change its practices in these instances to comply with the Code and regulations; however, GHMSI has not done so. In the examiners’ opinion; therefore, GHMSI has knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2009 through March 31, 2009. The on-site examination was conducted from October 7, 2009 through November 12, 2009 at GHMSI's office in Owings Mills, Maryland and was completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on April 21, 2010. The violations cited and the comments included in this Report are the opinions of the examiners.

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. Compliance with the following regulations was considered in this examination process:

- 14 VAC 5-90-10 et seq. Rules Governing Advertisement of Accident and Sickness Insurance;
- 14 VAC 5-110-10 et seq. Rules and Regulations for Simplified and Readable Accident and Sickness Insurance Policies;
- 14 VAC 5-130-10 et seq. Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms;
- 14 VAC 5-140-10 et seq. Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act;
- 14 VAC 5-180-10 et seq. Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS); and
- 14 VAC 5-215-10 et seq. Rules Governing Independent External Review of Final Adverse Utilization Review Decisions.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIP)
- Ethics and Fairness in Carrier Business Practices
- Advertising/Marketing Communications
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices
- Cancellations/Nonrenewals
- Complaints
- Claim Practices
- External Review of Final Adverse Utilization Review Decisions

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.

II. 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, DC, 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.

As of March 31, 2009, enrollment in Virginia totaled 138,655 members.

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III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIP)

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

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. A sample of 27 out of a total population of 41 complaints/appeals received during the examination time frame was reviewed.

The review revealed 5 instances where GHMSI failed to maintain its established complaint system, in violation of § 38.2-5804 A of the Code. Examples are discussed in the following paragraphs.

TIMELINESS

Section C.7. of GHMSI's complaint procedures titled Timing of Plan Responses states that "CareFirst will make an appeal decision and written notification will be sent...within 60 days after receipt of the appeal for a case involving a Post-Service Claim." Additionally, GHMSI's Internal Grievance and Appeal procedures state that "the service area will prepare the appeal/grievance packet for the Central Appeals Unit and will forward the packet to the Central Appeals Unit within 3 working days of the receipt of the appeal/grievance." The procedures further state that "an appeal/grievance decision will be rendered, and sent in writing within the following timeframes unless it is an emergency case...within 60 days for a case involving a Post-Service Claim." As

discussed in Review Sheet MC11, GHMSI failed to respond to a subscriber's appeal/grievance letter until 90 days after receipt, and the response was not issued until the member sent a second appeal/grievance letter 50 days after the initial letter was sent. GHMSI agreed with the examiners' observations.

HANDLING

Sections D.2. and D.3 of GHMSI's complaint procedures titled Fair and Full

Review state that:

CareFirst will provide a review that...does not afford deference to the initial Adverse Benefit Determination and is conducted by an appropriate named fiduciary of CareFirst who is neither the individual who made the Adverse Benefit Determination that is subject to the appeal, nor the subordinate of such individual...in deciding an appeal an Adverse Benefit Determination that is based in whole or in part on a judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment.

As discussed in Review Sheet MC04, the review revealed that the appeal involved a denied claim for a 63 year old patient for the treatment of sleep apnea; however, the documentation in the file indicated that the field of medicine of the Medical Director who reviewed the case was Pediatrics. GHMSI disagreed with the examiners' observations and stated, in part,

In this case, the nurse reviewer was able to determine following review of the contract and the clinical documentation submitted with the appeal that the adverse decision could be overturned and approved. If the CareFirst Medical Director could not make a determination to overturn this post claim denial following review of the medical records submitted on appeal and review of the health benefit contract, then the clinical documentation and the applicable portions of the contract would have been forwarded and reviewed by a physician board certified in the same specialty as the treatment under review who was not involved in the adverse decision.

The examiners responded that GHMSI failed to maintain the procedures of its established complaint system approved by the Commission in this instance. The approved procedures do not state that a health care professional with appropriate training and experience in the field of medicine involved in the judgment will only be consulted if the Medical Director is unable to make a determination regarding a post-claim appeal.

Due to the fact that violations of § 38.2-5804 A of the Code were discussed in a prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

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IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

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

PROVIDER CONTRACTS

The examiners reviewed a sample of 17 provider contracts from a total population of 14,976 in force during the examination time frame. The examiners also reviewed GHMSI's 6 contracts with intermediary organizations for the purpose of providing health care services pursuant to an MCHIP. 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 20 instances where GHMSI's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	2	EF02
§ 38.2-3407.15 B 2	2	EF02
§ 38.2-3407.15 B 3	2	EF02
§ 38.2-3407.15 B 4	2	EF02
§ 38.2-3407.15 B 5	2	EF02
§ 38.2-3407.15 B 6	2	EF02
§ 38.2-3407.15 B 7	2	EF02
§ 38.2-3407.15 B 8	1	EF01
§ 38.2-3407.15 B 9	2	EF02
§ 38.2-3407.15 B 10	2	EF02
§ 38.2-3407.15 B 11	1	EF01

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 occurred with such frequency as to indicate a general business practice, placing GHMSI in violation of § 38.2-510 A 15 of the Code in 20 instances. All of the violations involved GHMSI's contract with a pharmacy intermediary organization and that intermediary organization's contract with a participating pharmacy.

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 150 out of a total population of 5,766 claims processed under the 17 provider contracts selected for review. The review revealed that GHMSI was in substantial compliance.

V. ADVERTISING/MARKETING COMMUNICATIONS

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)

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 with this section.

14 VAC 5-90-170 B requires each insurer to file with its Annual Statement a Certificate of Compliance executed by an authorized officer of the insurer. A copy of the required Certificate of Compliance was furnished to the examiners and was in substantial compliance. However, the examination revealed that GHMSI's advertisements were not in compliance with the Code and regulations in all instances.

A sample of 25 advertisements was selected from a population of 198 disseminated during the examination time frame. The review revealed that 7 of the advertisements were not in compliance with one or more sections of 14 VAC 5-90-10 et seq. In the aggregate, there were 25 violations.

14 VAC5-90-30 states that an "invitation to inquire" means an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable and does not contain an application for coverage.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [write] your insurance agent or the company [whichever is applicable]." As discussed in Review Sheets AD01A, AD26A, AD27A, AD29A, AD30A and AD31A, the review revealed 6 violations of this section. In each instance, GHMSI failed to include the required disclosure language in the invitation to inquire. An example is discussed in Review Sheet AD27A, where GHMSI stated in response to the examiners' observations that it "...concedes that it did not include the disclosure under 14 VAC 5-90-55 A."

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

an application for coverage; and (iv) benefit exclusions and limitations may apply. Any rate information mentioned in any advertisement disseminated pursuant to this section shall indicate the age, gender, and geographic location on which that rate is based. As discussed in Review Sheets AD30A and AD31A, the review revealed 2 violations of this section. In each instance, the advertisement included rate information and failed to provide the required disclosures. An example is discussed in Review Sheet AD31A, where GHMSI stated in response to the examiners' observations that it "...acknowledges the absence of certain disclosures referenced in 14 VAC 5-90-55 B."

14 VAC 5-90-60 A 1 states that an advertisement shall not use words or phrases if the use of the words or phrases has the capacity, tendency or effect of misleading prospective purchasers as to the nature or extent of any premium payable. As discussed in Review Sheets AD01A and AD27A, the review revealed 2 violations of this section. An example is discussed in Review Sheet AD01A, where the advertisement used words and phrases such as "lower" "more affordable" and "lower cost" that had the tendency to mislead prospective purchasers as to the amount of premium payable. GHMSI agreed with the examiners' observations.

14 VAC 5-90-60 A 2 states that an advertisement shall not contain or use words or phrases such as "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," or similar words and phrases in a manner that exaggerates a benefit beyond the terms of the policy, but may be used only in such manner as to fairly describe the benefit. As discussed in Review Sheets AD01A and AD27A, the review revealed 2 violations of this section. An example is discussed in Review Sheet AD01A, where the advertisement made reference to "...plans that give you 'first dollar'

coverage, with benefits available as soon as medical expenses are incurred.” This statement has a tendency to exaggerate the benefits available. GHMSI agreed with the examiners’ observations.

14 VAC 5-90-60 B 3 states that when an advertisement refers to the cost of the policy, a specific policy benefit, or the loss for which a benefit is payable, it shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead. As discussed in Review Sheets AD01A, AD26A, AD27A and AD29A, the review revealed 4 violations of this section. An example is discussed in Review Sheet AD29A, where the advertisement used words such as “economical” and “more economical” to describe the cost of the policy and failed to disclose the exceptions, reductions, and limitations affecting the basic provisions of the policy.

14 VAC 5-90-60 B 4 states that when a policy contains a waiting period between the effective date of the policy and the effective date of coverage under the policy or at a time period between the date a loss occurs and the date benefits begin to accrue for the loss, an advertisement shall disclose the existence of these periods. As discussed in Review Sheets AD01A, AD26A, AD27A and AD29A, the review revealed 4 violations of this section. In each instance, the advertisement made reference to the cost of the policy or a specific policy benefit, without disclosing the existence of a waiting period for preexisting conditions.

14 VAC 5-90-80 A states that testimonials and endorsements used in advertisements shall be genuine. The review revealed 1 violation of this section.

As discussed in Review Sheet AD27B, the testimonials used in the advertisement were not genuine.

14 VAC 5-90-100 A states that when a choice of the amount of benefits is referred to, an advertisement shall disclose that the amount of benefits provided depends upon the plan selected and that the premium will vary with the amount of the benefits selected. As discussed in Review Sheets AD01A and AD26A, the review revealed 2 violations of this section. An example is discussed in Review Sheet AD26A, where the advertisement makes reference to “Flexible, customized coverage with 6 benefit levels to choose from” and failed to disclose that the premium will vary with the amount of the benefits selected.

14 VAC 5-90-100 B states that when an advertisement refers to various benefits that may be contained in two or more policies, other than group master policies, the advertisement shall disclose that such benefits are provided only through a combination of policies. The review revealed 1 violation of this section. As discussed in Review Sheet AD01A, the advertisement failed to disclose that the “opt-out” product’s policy benefits are only provided through a combination of 2 policies offered by both GHMSI and an affiliate company.

14 VAC 5-90-110 states that an advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits and shall not disparage competitors or their policies. The review revealed 1 violation of this section. As discussed in Review Sheet AD27A, the advertisement states that “Unlike other plans, our preventative care is included with no deductible and just a small copayment.”

However, several of GHMSI's competitors offer HSA qualified plans with similar preventative care benefits.

SUMMARY

GHMSI violated 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-80 A, 14 VAC 5-90-100 A, 14 VAC 5-90-100 B and 14 VAC 5-90-110. These violations place GHMSI in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code.

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VI. 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.

Section 38.2-316 of the Code sets forth the filing and approval requirements for forms and rates that are to be issued or issued for delivery in Virginia.

A sample of 53 individual new business files from a total population of 748 issued during the examination time frame was selected for review. Additionally, the application/enrollment forms associated with the issuance of 2 group contracts were also reviewed.

The review revealed that an amendment to the Individual Enrollment Agreement, Hair Prosthesis Amendment, VA/CF/WIG/DB 10/00, was issued in 5 instances prior to the form being filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. An example is discussed in Review Sheet PF55. GHMSI agreed with the examiners' observations.

RATE FILING

Section 38.2-316 A of the Code sets forth requirements for the filing of rates and rate changes. The review revealed that GHMSI was in substantial compliance with this section.

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application forms prior to use. As discussed in Review Sheet PF54, the review revealed that 1 application form, BluePreferred Conversion Application 1F1-06061 (4/05), was used to enroll an individual under a conversion

contract prior to the form being filed with and approved by the Commission. Additionally, as discussed in Review Sheet PF50, an enrollment form created by an insurance agency, titled EMPLOYEE ELECTION FORM, was used by GHMSI in 81 instances to enroll individuals under a group contract prior to the form being filed with and approved by the Commission. In the aggregate, there were 82 violations of §§ 38.2-316 B and 38.2-316 C 1 of the Code associated with the use of non-approved application/enrollment forms.

EXPLANATIONS 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.

VII. 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. The agencies and writing agents associated with the sample of 53 individual new business files were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A and 38.2-4224 of the Code requires that a person be licensed prior to soliciting subscription contracts. The review revealed that GHMSI was in substantial compliance.

APPOINTED AGENT REVIEW

Sections 38.2-1833 A 1 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, either reject such application or appoint the agent.

The review revealed 4 violations of this section. An example is discussed in Review Sheet AG54, where GHMSI accepted an application for an individual service agreement and failed to appoint the writing agent within 30 days of the execution of the application. GHMSI agreed with the examiners observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the direct or indirect payment of commissions or other valuable consideration to an agent or agency that is not appointed and that was not licensed at the time of the transaction.

The review revealed 4 violations of this section. An example is discussed in Review Sheet AG51, where GHMSI paid commission to an agent that was not appointed. GHMSI agreed with the examiners' observations.

VIII. 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; the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620; 14 VAC 5-140-10 et seq., Rules Governing the Implementation of Individual Accident and Sickness Insurance Minimum Standards Act and 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 made to determine whether GHMSI's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with GHMSI's guidelines and whether correct premiums were being charged.

UNDERWRITING REVIEW

A sample of 53 from a population of 745 individual subscription contracts underwritten and issued during the examination time frame was selected for review. In addition, a sample of 30 from a total population of 259 declined files was reviewed. The review revealed 6 instances where applications for coverage were not handled in accordance with GHMSI's guidelines. However, the examiners found no evidence of unfair discrimination.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS. GHMSI was in substantial compliance with this section.

MECHANICAL RATING REVIEW

The review revealed that GHMSI had calculated its premiums in accordance with its filed rates.

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INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires a company to establish standards for collection, use, and disclosure of personal/privileged information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES (NIP)

Section 38.2-604 of the Code sets forth the requirements for a NIP, either full or abbreviated, to be provided to all individual applicants and to applicants for group insurance that are individually underwritten.

Section 38.2-604 C 3 of the Code states that instead of the notice prescribed in subsection B of this section, the insurance institution or agent may provide an abbreviated notice in writing or, if the applicant or policyholder agrees, in electronic format, informing the applicant or policyholder that a right of access and correction exists with respect to all personal information collected.

As discussed in Review Sheet UN99, the abbreviated NIP form provided to applicants by GHMSI stated that “medical information will be disclosed only to your attending physician”. The examiners observed that § 38.2-604 C 3 of the Code would require that the applicant have access to medical record information, not just the applicant’s attending physician. GHMSI disagreed with the examiners’ observations, stating that:

CareFirst intended to advise the applicant that Medical record information collected in the application process would only be disclosed by CareFirst to a third-party if that third party is a provider who attended the applicant, but that would not preclude disclosure of Medical record information to the individual applicant.

CareFirst observes that the Virginia Code Section cited (38.2-604 C.3) only requires access to Personal information. A distinction is made between Personal information and Medical record information where the former is information about the personal characteristics of an individual and the latter is information relating to the physical or mental condition of an individual obtained from confidential sources.

The letter does state that if after reviewing the information in your file, you believe it is inaccurate, you should notify us, indicating what you believe is inaccurate and why. We will tell you at that time how to correct or amend your file. CareFirst Privacy Office does get requests from applicants to review information in their files and Central Medical Review will release the entire file for review.

The examiners responded that “medical-record information” is included in the definition of “personal information” stated in § 38.2-602 of the Code. Therefore, there is no distinction made between Personal Information and Medical record information.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of the disclosure authorization forms to be used when collecting personal or privileged information about individuals. The examiners reviewed the disclosure authorization forms used during the underwriting process and found them to be in compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 A 2 of the Code states that in the event of an adverse underwriting decision, the insurance institution 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 6 violations of this section. An example is discussed in Review Sheet UN08 where, although there were procedures in place to send a written AUD notice in a form approved by the Commission, the review revealed that GHMSI failed to send the appropriate notice. GHMSI agreed with the examiners' observations, stating that, "The wrong template was selected for the applicant" and "...a non-Virginia letter was used."

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IX. PREMIUM NOTICES

GHMSI's practices for notifying contract holders of the intent to increase premiums by more than 35% were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

Section 38.2-3407.14 A of the Code requires a corporation providing individual or group accident and sickness subscription contracts to provide notice of intent to increase premiums by more than 35%. Section 38.2-3407.14 B of the Code states that the notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under any such contract to the contract holder or subscriber, or to the designated consultant or other agent of the group contract holder or subscriber, if requested in writing by the group contract holder or subscriber.

Group

The examiners reviewed the total population of 9 group contracts for which GHMSI intended to increase the premium by more than 35% at renewal during the examination time frame.

The review revealed 3 violations of §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code. An example is discussed in Review Sheet PB08. GHMSI disagreed with the examiners' observations, stating that the "...CareFirst Account Representative, e-mailed the renewal to...the broker...on 11/4/2008 at 1:37 PM. Attached is a copy of the e-mail..." The examiners responded that notice to the broker would not constitute the notice required by § 38.2-3407.15 B of the Code unless GHMSI could produce documentation that the group contract holder had designated in writing that the agent

was permitted to receive premium notices on the group's behalf. As of the writing of the Report, GHMSI has failed to provide the examiners with such documentation.

Individual

The examiners reviewed the total population of 6 individual contracts for which GHMSI intended to increase the premium by more than 35% at renewal during the examination time frame.

The review revealed 6 violations §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code. An example is discussed in Review Sheet PB01. GHMSI agreed with the examiners' observations in all 6 instances.

SUMMARY

In 2003, a complaint investigation by the Consumer Services Section of the Life and Health Market Regulation Division of the Bureau of Insurance revealed that GHMSI was in violation of § 38.2-3407.14 of the Code. As a result of the complaint investigation, GHMSI made a settlement offer that was accepted by the State Corporation Commission on August 8, 2003, in Case No. INS-2003-00125. During the course of settlement, GHMSI agreed to revise its procedures to ensure compliance with the 60-day notification requirement and to include in each notice the actual amount of the premium increase. During the course of the prior examination, GHMSI informed the examiners that:

GHMSI has changed its rate notification process to include in the rate notification letters the old monthly rates and the new monthly rate. The rate notification letters are mailed 60 days in advance of the effective date of increase...This letter will comply with 38.2-3407.14.

The current review revealed that GHMSI had failed to implement the notification process described above. In response to the findings of the current examination,

GHMSI informed the examiners in a November 24, 2009 Memo that it had implemented an alternative process to address its failure to comply with § 38.2-3407.14, which was described as follows:

CareFirst is providing the following in response to your memo of November 13, 2009, concerning Premium Increase Procedures and Cancellations.

Rate notifications for all three jurisdictions are sent out every month in accordance with CareFirst's established Standard Operating Procedure (SOP) that is attached for your reference. To ensure that CareFirst BCBS is in compliance with all three jurisdictions, the request to run the rate notification job is done at least 60 days prior to the member's renewal date.

In the event that CareFirst is out of compliance with the VBOI or any other jurisdiction regarding Rate Notification, CareFirst BCBS will give the member a credit or refund based upon the situation. A credit or refund is determined by taking the member's new rate as of their renewal and subtracting the old rate that the member has been paying over the past year. The difference between those two amounts would be considered a "credit". All identified credits are then forwarded to the Collections Department and applied to the accounts of all the affected members where it was determined that CareFirst BCBS was out of compliance. Although CareFirst BCBS typically processes credits for the members, there are some situations where CareFirst will issue refund checks that would equal the amount of the credit as well. With any credit or refund check, the affected members also receive an appropriate apology letter that would advise why they are receiving a credit or refund check and typically language is included within that letter to advise the member when the proper rate would go into effect.

The examiners would comment that, although GHMSI has implemented an alternative notification process in conjunction with an internal process of remediation, the company has continued to violate § 38.2-3407.14 of the Code. The examiners would also note that the Memo fails to make any mention of when the remediation process described above was implemented.

Due to the fact that violations of § 38.2-3407.14 of the Code were discussed during the Consumer Services complaint investigation and in the prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations. GHMSI would also be considered to be in violation of the Commission's Order to cease and desist issued on August 8, 2003, in Case No. INS-2003-00125. Section 12.1-33 of the Code sets forth the penalties for such violations.

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X. CANCELLATIONS/NON-RENEWALS

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.

Group Cancellations

A sample of 15 from a total population of 154 groups terminated during the examination time frame was selected for review.

Section 38.2-3542 C of the Code requires a Health Service Plan to provide an employer, whose coverage is terminating due to nonpayment of premiums, with a written notice of termination 15 days before the date coverage will terminate, and that coverage shall not be permitted to terminate for at least 15 days after such notice has been mailed. Review Sheet CN03 discusses the 1 violation of this section, where GHMSI delegated the premium billing and collection function to an insurance agency and the notice required by § 38.2-3542 C of the Code was not provided.

Individual Rescissions

The total population of 3 individual policies rescinded during the examination time frame was reviewed. The review revealed substantial compliance with GHMSI's established procedures.

XI. COMPLAINTS

GHMSI's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 27 from a total population of 41 written complaints received during the examination time frame was reviewed. The review revealed that GHMSI was in substantial compliance with this section.

XII. 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 closed claims. The examiners were furnished with written and online claim processing procedures during the review. All claims were processed internally by GHMSI, with the exception of claims for pharmacy health care services.

PAID CLAIM REVIEW

Medical

A sample of 165 was selected from a total population of 166,484 individual and group claims paid during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies and failing to implement reasonable standards for the prompt investigation of claims. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 3 instances of noncompliance with these sections. An example is discussed in Review Sheet CL05, where GHMSI had obtained all of the documentation necessary to determine whether the diagnosis submitted was for a preexisting condition on September 2, 2008 but did

not pay the claim until February 9, 2009. GHMSI agreed with the examiners' observations.

Mental Health and Substance Abuse

A sample of 88 was selected from a total population of 8,641 individual and group claims paid during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies and failing to implement reasonable standards for the prompt investigation of claims. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 4 instances of noncompliance with these sections. An example is discussed in Review Sheet CL08, where GHMSI took 176 working days from receipt of complete proof of loss to pay a claim. GHMSI agreed with the examiners' observations.

Dental

A sample of 55 was selected from a total population of 7,193 individual and group claims. The review revealed that the claims were processed in accordance with the subscriber agreement.

Pharmacy

A sample of 50 was selected from a total population of 249,476 individual and group claims. The review revealed that the claims were processed in accordance with the subscriber agreement.

Interest

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of 15 working days from the insurer's receipt of proof of loss to the date of claim payment.

Of the 358 paid claims reviewed by the examiners, there were 45 claims where statutory interest was required to have been paid. In 27 instances, GHMSI paid the required amount of interest. In 6 instances, GHMSI underpaid the amount of interest due. In 12 instances, GHMSI failed to pay interest. In the aggregate, there were 18 violations of § 38.2-3407.1 B of the Code.

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

DENIED CLAIM REVIEW

Medical

A sample of 110 was selected from a total population of 36,847 individual and group claims denied during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies and failing to implement reasonable standards for the prompt investigation of claims. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 25 instances of

noncompliance with these sections. An example is discussed in Review Sheet CL31, where a review of the claim record indicated that on May 18, 2009, Medical Review made the determination that the diagnosis of pulmonary fibrosis was not preexisting for this subscriber. However, GHMSI made no attempt to pay this previously denied claim for health care services related to pulmonary fibrosis. GHMSI agreed with the examiners' observations.

Section 38.2-510 A 4 of the Code prohibits, as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 2 instances of noncompliance with this section. An example is discussed in Review Sheet CL25, where the claim record indicated that GHMSI received the proof of prior coverage for this subscriber on May 14, 2009, and made no attempt to pay a claim that had been previously denied as preexisting. GHMSI agreed with the examiners' observations.

Mental Health and Substance Abuse

A sample of 60 was selected from a total population of 2,083 individual and group claims denied during the examination time frame.

Sections 38.2-510 A 2 and 38.2-510 A 3 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies and failing to implement reasonable standards for the prompt investigation of claims. The review revealed 15 instances of noncompliance with these sections. An example is discussed in Review Sheet CL54 where GHMSI took 27 working days from receipt to deny the claim and request more complete medical records. GHMSI agreed with the examiners' observations.

Section 38.2-510 A 4 of the Code prohibits, as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed 4 instances of noncompliance with this section. An example is discussed in Review Sheet CL55, where GHMSI denied the claim stating that the subscriber's coverage was no longer in effect when in fact coverage was in effect. GHMSI agreed to pay the claim with interest in response to the examiners' comments.

Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed 16 instances of noncompliance with this section. An example is discussed in Review Sheet CL45, where GHMSI denied a claim as preexisting and failed to adjust the claim to pay once the subscriber provided a certificate of creditable coverage from the prior carrier. GHMSI agreed to pay the claim with interest in response to the examiners' comments.

BlueCard – Inter-Plan Teleprocessing (ITS) Claims

Sections 38.2-510 A 4 and 38.2-510 A 6 of the Code prohibit, as a general business practice, refusing arbitrarily and unreasonably to pay claims and not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. 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 denial of a claim.

Upon reviewing 2 denied "out-of-area" claims in the medical and mental health claim samples that were handled by GHMSI in conjunction with other BlueCross

BlueShield plans through the “BlueCard Program,” the review revealed 2 instances of non compliance with these sections.

As discussed in Review Sheet CL61, GHMSI received a claim for outpatient psychotherapy services from a nonparticipating provider in the town of Vienna, Virginia and denied the claim with remark code PR02, which states:

This claim was submitted to CareFirst BlueCross BlueShield. Since these services were rendered out-of-area, the provider should have submitted to the local BlueCross BlueShield plan for processing. As a courtesy, we will forward this claim to the provider’s local BlueCross BlueShield plan. There is no need for you to resubmit this claim.

The EOB for this denied claim indicated that the subscriber was responsible for the entire billed charges. GHMSI responded that, “The claim was processed correctly based upon the edit resolution in place at the time the claim was paid. Please see the documentation for E1438.” The procedures for resolving edit code E1438 direct the claims processor to view a grid listing certain addresses and Zip Codes in Vienna, Virginia, to determine if the provider’s location is in the CareFirst service area; otherwise, the claim is forwarded to the local plan, with the exception of 1 particular provider that was completely exempt from the forwarding procedures. In this instance, based on the provider’s address and Zip Code, the processor was given directions to “Do NOT Forward” and “Process as Normal”. GHMSI, as the underwriting insurer, is ultimately responsible for indemnifying the covered subscriber in accordance with the provisions of the subscription contract for the loss that occurred. Since the provider did not have a contract with either plan, there was no basis to deny the claim and send it to the local plan for pricing and processing.

As discussed in Review Sheet CL63, a claim was received on January 2, 2009, and was denied on January 14, 2009 with Remark Code PR02. The EOB indicated that the subscriber was responsible for the entire billed charges. The examiners requested an explanation as to why the local BlueCross BlueShield Plan has not processed the claim. The examiners also requested "...a detailed explanation of the claim's current status." GHMSI's response stated that, "The claim was manually mailed to the Michigan plan per the BlueCross BlueShield Association Guidelines in place at that time. The claim has not been processed by Michigan and returned to CareFirst to date." The examiners have not been provided with any documentation that the claim has ever been paid.

Dental

A sample of 27 was selected from a total population of 2,234 individual and group claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the subscriber agreement.

SUMMARY

The review of paid and denied claims revealed that GHMSI's failure to comply with §§ 38.2-510 A 2, 38.2-510 A 3 and 38.510 A 6 of the Code occurred with such frequency as to indicate a general business practice and placed GHMSI in violation of these sections.

Due to the fact that violations of § 38.2-510 A 6 of the Code were discussed in a prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

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 358 sample paid claims and 197 sample denied claims reviewed, GHMSI failed to affirm or deny coverage within a reasonable time in 56 instances, in noncompliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL10, where GHMSI took 110 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 occurred with such frequency as to indicate a general business practice and placed GHMSI in violation of this section.

Due to the fact that violations of § 38.2-510 A 5 of the Code were discussed in a prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

THREATENED LITIGATION

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

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XIII. EXTERNAL REVIEW OF FINAL ADVERSE UTILIZATION REVIEW DECISIONS

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a utilization review entity. 14 VAC 5-215-10 et seq. provides a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions and procedures for expedited consideration of appeals in cases of emergency health care.

The examiners reviewed a sample of 27 from a total population of 49 appeal and complaint files and the total population of 2 final adverse decisions that were appealed to the Bureau of Insurance during the examination time frame.

FINAL ADVERSE DECISIONS

14 VAC 5-215-20 B states that in the event of a final adverse decision, a utilization review entity shall provide to the covered person or treating health care provider requesting the decision a clear and understandable written notification of (i) the right to appeal final adverse decisions to the Bureau of Insurance in accordance with the provisions of Chapter 59 (§ 38.2-5900 et seq.) of Title 38.2 of the Code of Virginia; (ii) the procedures for making such an appeal; and (iii) the binding nature and effect of such an appeal.

The review revealed that the 2 final adverse decisions which were appealed to the Bureau of Insurance were handled by GHMSI in compliance with the requirements of Chapter 59 of Title 38.2 of the Code; however, the review also revealed that the claim related correspondence between GHMSI and the subscriber that preceded the

final adverse decision and external appeal were not handled in compliance with the Unfair Claim Settlement Practices Act, (Section 38.2-510 of the Code).

Section 510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Review Sheet CP03 discusses the 1 instance of non-compliance of this section, when GHMSI initially denied the claims; it mistakenly sent 2 Notice of Adverse Decision letters advising the subscriber to contact the Health Advocacy Unit of Maryland's Consumer Protection Division and/or the Maryland Insurance Administration to dispute the Plan's decision. However, when the final adverse decision was made, GHMSI correctly referred the insured to the Bureau of Insurance and furnished the information and forms required by Virginia statute.

Sections 38.2-510 A 2 and 38.2-510 A 5 of the Code prohibit, as a general business practice, failing to acknowledge and act reasonably promptly upon communications with respect to claims and failing to deny coverage of claims within a reasonable time. Review Sheet CP03 discusses the 1 violation of each section, where GHMSI failed to acknowledge the claim and took 27 working days to deny the claim after it was received.

EXPEDITED APPEALS

14 VAC 5-215-50 I states that if an appeal that is reviewed as an expedited appeal results in a final adverse decision, the utilization review entity shall notify the person who requested the expedited review of the final adverse decision and notify the appellant, by telephone, telefacsimile, or electronic mail, that the appellant is eligible for an expedited appeal to the Bureau of Insurance. The notification shall be followed

within 24 hours by written notice to the appellant and the treating health care provider, if not the appellant, clearly informing them of the right to appeal this decision to the Bureau of Insurance and providing the appropriate forms by which such appeal may be filed.

The review revealed that GHMSI had procedures in place to provide the notification required by this section.

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XIV. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, GHMSI will be required to implement the following corrective actions, GHMSI shall:

1. As recommended in the prior Report, establish and maintain its complaint system as approved by the Commission, as required by § 38.2-5804 A of the Code;
2. Establish and maintain procedures to ensure that its provider contracts with pharmacy intermediary organizations and the intermediary organization's provider contracts with participating pharmacies contain the 11 provisions required by § 38.2-3407.15 B of the Code;
3. As recommended in the prior Report, review its advertisements to ensure compliance with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502, and § 38.2-503 of the Code;
4. Strengthen its procedures for the filing of amendments, applications, and enrollment forms used or issued for delivery in connection with group and individual subscription contracts, to ensure that these policy forms are approved by the Commission, as required by §§ 38.2-316 B and 38.2-316 C 1 of the Code;
5. Strengthen its procedures for compliance with §§ 38.2-1812 A, 38.2-1833 A 1 and 38.2-4224 of the Code concerning the payment of commissions and appointment of agents and agencies;
6. Strengthen its established underwriting procedures to ensure that AUD notices approved by the Commission are sent to applicants for coverage under Virginia issued policies, as required by § 38.2-610 A 2 of the Code;

7. As recommended in the prior Report, establish and maintain procedures for compliance with § 38.2-3407.14 of the Code and include the actual amount of the premium increase within its written notices of intent to increase premiums by more than 35%;
8. Review all renewals of group and individual subscription contracts issued in Virginia for the years 2005, 2006, 2007, 2008, 2009 and the current year that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which contract holders were not notified in writing 60-days prior to such increase as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the individual and group contract holder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refund along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that GHMSI had failed to provide 60 days written notice to the contract holder of intent to increase premiums by more than 35%. Please accept the enclosed check for the refund amount";
9. Review all groups whose premium billing was handled by third parties and that were cancelled for non-payment of premium during the years 2005, 2006, 2007, 2008, 2009 and the current year to determine compliance with § 38.2-3542 C of the Code. For all instances of noncompliance, provide coverage until 15 days after a final termination notice was sent, as required by this section. Send a

letter to the group contract holder stating that “as a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that GHMSI had failed to comply with § 38.2-3542 C of the Code of Virginia, which requires a 15-day notice prior to the termination of coverage”;

10. As recommended in the prior Report, establish and maintain procedures for the payment of interest due on claims, as required by § 38.2-3407.1 B of the Code;
11. As recommended in the prior Report, establish and maintain procedures for compliance with the Unfair Trade Practices Act (§ 38.2-500 et seq. of the Code), specifically §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code;
12. Strengthen its established procedures to review its claims payment system to identify claims relevant to a pre-existing decision and notify the claims department to reprocess impacted claims;
13. From October 1, 2007, through December 31, 2010, review all claims adjusted upon receipt of documentation that resulted in a determination that a condition was not pre-existing or that credible coverage existed and the waiting period should have been waived. Review all relevant claims for the members and re-open and pay with interest those that were not adjusted based on the aforementioned determinations. Send reimbursement checks along with letters of explanation to the member and provider stating specifically that, “As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that GHMSI should have

paid this claim based on a subsequent decision that the condition was not pre-existing. This check represents the additional payment due.”;

14. Enhance and monitor its coordination efforts with local Blue Cross Blue Shield Plans to ensure that claims processed under the BlueCard program are handled in accordance with the Unfair Claims Settlement Practices Act (§ 38.2-510 of the Code); and
15. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

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XV. ACKNOWLEDGMENT

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

Greg Lee, FLMI, CIE, Laura Wilson, Daedre Holland and Brant Lyons of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Carly B. Daniel AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance

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XVI. REVIEW SHEET SUMMARY BY AREA

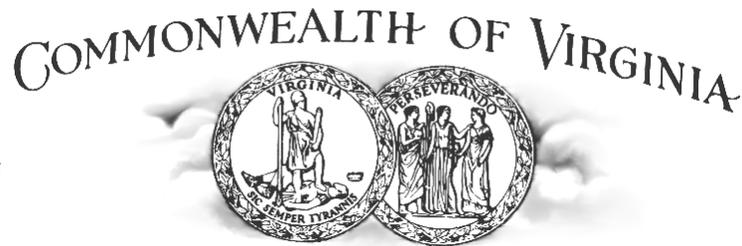
MCHIPS
§ 38.2-5804 A, 5 violations, MC04, MC05, MC06, MC07, MC11
ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES
<i>Provider Contracts</i>
§ 38.2-3407.15 B 1, 2 violations, EF01, EF02
§ 38.2-3407.15 B 2, 2 violations, EF01, EF02
§ 38.2-3407.15 B 3, 2 violations, EF01, EF02
§ 38.2-3407.15 B 4, 2 violations, EF01, EF02
§ 38.2-3407.15 B 5, 2 violations, EF01, EF02
§ 38.2-3407.15 B 6, 2 violations, EF01, EF02
§ 38.2-3407.15 B 7, 2 violations, EF01, EF02
§ 38.2-3407.15 B 8, 1 violation, EF01,
§ 38.2-3407.15 B 9, 2 violations, EF01, EF02
§ 38.2-3407.15 B 10, 2 violations, EF01, EF02
§ 38.2-3407.15 B 11, 1 violation, EF01
POLICY AND OTHER FORMS
§§ 38.2-316 B and 38.2-316 C 1, 87 violations, PF50 (81), PF54, PF55, PF57, PF62, PF63, PF64
AGENTS
§§ 38.2-1812 A and 38.2-1833 A 1, 4 violations, AG50, AG51, AG53, AG54
UNDERWRITING/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-610 A 2, 6 violations, UN02, UN03, UN04, UN05, UN06, UN08
PREMIUM NOTICES
§§ 38.2-3407.14 A and 38.2-3407.14 B, 9 violations, PB01, PB02, PB03, PB04, PB05, PB06, PB07, PB08, PB09

CANCELLATIONS/NON-RENEWALS
§ 38.2-3542 C, 1 violation, CN03
CLAIMS PRACTICES
§ 38.2-510 A 2, 47 violations, CL03, CL04, CL05, CL06, CL07, CL08, CL10, CL11, CL12, CL13, CL14, CL15, CL16, CL17, CL18, CL19, CL22, CL24, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL32, CL33, CL35, CL36, CL37, CL38, CL40, CL41, CL42, CL43, CL44, CL45, CL46, CL48, CL49, CL50, CL51, CL54, CL56, CL58, CL59, CL60
§ 38.2-510 A 3, 47 violations, CL03, CL04, CL05, CL06, CL07, CL08, CL10, CL11, CL12, CL13, CL14, CL15, CL16, CL17, CL18, CL19, CL22, CL24, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL32, CL33, CL35, CL36, CL37, CL38, CL40, CL41, CL42, CL43, CL44, CL45, CL46, CL48, CL49, CL50, CL51, CL54, CL56, CL58, CL59, CL60
§ 38.2-510 A 4, 7 instances of non-compliance, CL25, CL31, CL45, CL46, CL55, CL61, CL63
§ 38.2-510 A 5, 56 violations, CL03, CL04, CL05, CL06, CL07, CL08, CL10, CL11, CL12, CL13, CL14, CL15, CL16, CL17, CL18, CL19, CL20, CL21, CL22, CL23, CL24, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL32, CL33, CL34, CL35, CL36, CL37, CL38, CL39, CL40, CL41, CL42, CL43, CL44, CL45, CL46, CL47, CL48, CL49, CL50, CL51, CL52, CL54, CL56, CL58, CL59, CL60, CL62, CL79
§ 38.2-510 A 6, 50 violations, CL03, CL04, CL05, CL06, CL07, CL08, CL10, CL11, CL12, CL13, CL14, CL15, CL16, CL17, CL18, CL19, CL22, CL24, CL25, CL26, CL27, CL28, CL29, CL30, CL31, CL32, CL33, CL35, CL36, CL37, CL38, CL40, CL41, CL42, CL43, CL44, CL45, CL46, CL48, CL49, CL50, CL51, CL54, CL55, CL56, CL58, CL59, CL60, CL61, CL63
§ 38.2-3407.1, 18 violations, CL04, CL08, CL12, CL14, CL17, CL19, CL21, CL22, CL28, CL30, CL40, CL41, CL43, CL45, CL46, CL51, CL56, CL79

EXTERNAL REVIEW OF FINAL ADVERSE UTILIZATION REVIEW DECISIONS
§ 38.2-510 A 2, 1 violation, CP03
§ 38.2-510 A 5, 1 violation, CP03

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



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

September 15, 2010

CERTIFIED MAIL 7005 1820 0007 5460 5145
RETURN RECEIPT REQUESTED

Mr. Emory Hill
Manager, External Audit Coordination
Group Hospitalization and Medical Services, Inc.
10455 Mill Run Circle
Owings Mill, MD 21117

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Hill:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Group Hospitalization and Medical Services, Inc. (GHMSI) for the period of January 1, 2009 through March 31, 2009. 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,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance
Telephone No. (804) 371-9492

CBD:mhh
Enclosure
cc: Jacqueline Cunningham

Virginia Bureau of Insurance
Market Conduct Examination Report
Exposure Draft

GHMSI
Required Corrective Action Plan Responses

GHMSI – Corrective Action Plan

1. As recommended in the prior Report, establish and maintain its complaint system as approved by the Commission, as required by § 38.2-5804 A of the Code.

GHMSI Response:

Timeliness – Samples MC06 and MC07

The Company disagrees with the Examiners observations that it failed to comply with the requirement of §38.2-5804 A of the Virginia Insurance Code, to establish and maintain a complaint system, for complaint files MC06 and MC07.

The Company's internal procedure for handling appeals outlines the timeframe for routing appeal correspondence to the Central Appeals and Analysis Unit (CAU). The internal procedure was put in place to ensure that the timeliness requirement as written in §38.2-5804 A of the Virginia Insurance Code for completion of the appeal review and notification of the decision was met.

In each instance the appeal was completed, including written notification of the decision, within the required 60 Calendar Days timeframe in accordance with §38.2-5804 A of the Virginia Insurance Code. The written notification was communicated for MC06 within 49 Calendar Days and the written notification for MC07 was communicated within 47 Calendar Days.

Therefore, the delay in transferring the appeal correspondence from the Service area to the CAU had no negative impact on the completion of the appeal including notification of the appeal determination within the required compliance timeframe. The Company is in compliance with §38.2-5804 A of the Virginia Insurance Code.

Handling – Sample MC04

The Company disagrees with the Examiners observation that it failed to comply with the requirement of §38.2-5804 A of the Virginia Insurance Code, to establish and maintain a complaint system, for complaint file MC04.

Section D. Full and Fair Review has in fact five (5) total elements to consider as a part of the full and fair review process. The Company has followed this process, in order, as appropriate. Please see comments related to each of these elements.

1. *The Company will provide a review that takes into account all comments, documents, records and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.*

The appeal was received with additional information and medical records which were submitted by the provider with the appeal request. It was obvious to the Appeals Nurse Analyst that the additional information, including comments, documents and records provided on appeal, (in consideration of the member's contract and the initial benefit denial) would allow for approval of the claim and subsequent claim payment. The initial benefit determination was a claim denial for coverage. DENIAL REASON: "Under this member's coverage, benefits are not available for these services except when provided in direct relation to an accidental, bodily injury. Since it appears that these services were not related to an accidental injury, we are unable to provide benefits". This denial reason is automatically generated by the claims system.

2. *Does not afford deference to the initial Adverse Benefit Determination and is conducted by an appropriate named fiduciary of CareFirst who is neither the individual who made the Adverse Benefit Determination that is subject to the appeal, nor the subordinate of such individual;*

The initial Adverse Benefit Determination was not reviewed initially by a Medical Director. The initial adverse benefit determination which was in fact a coverage decision was denied by the Company's claims system based on the initial submission of the claim.

3. *In deciding an appeal an Adverse Benefit Determination that is based in whole or in part on a judgment, including determinations with regard to where a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the appropriate named fiduciary shall consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the judgment;*

The original adverse benefit determination (denial) was not based wholly or in part on medical necessity or experimental/Investigational. DENIAL REASON: "Under this member's coverage, benefits are not available for these services except when provided in direct relation to an accidental, bodily injury. Since it appears that these services were not related to an accidental injury, we are unable to provide benefits".

4. *Upon request, provides for the identification of medical or vocational experts whose advice was obtained on behalf of CareFirst in connection with a Member's Adverse Benefit Determination, without regard to where the advice was relied upon in making the Adverse Benefit Determination; and,*

This step is not applicable.

5. *The health care professional engaged for purposes of a consultation is an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination, nor the subordinate of any such individual.*

This step is not applicable as this appeal was related to a claims system generated coverage decision, and as the appeal of the coverage decision was approved.

The new information submitted for review on appeal was taken into account, and the denied claim was subsequently overturned and approved for payment based upon the review findings that the billed service was coverable, and in fact could be paid under the medical benefit. The Company is in compliance with §38.2-5804 A of the Virginia Insurance Code.

2. Establish and maintain procedures to ensure that its provider contracts with pharmacy intermediary organizations and the intermediary organization's provider contracts with participating pharmacies contain the 11 provisions required by § 38.2-3407.15 B of the Code.

GHMSI Response:

The Company has procedures in place to assure compliance with Virginia laws and regulations. The Company respectfully disagrees that its contract does not include the language required by Section 38.2-3407 15 B. While the VBOI has listed all of 38.2-3407 15 B, only certain subsections of that provision require specific contract language. This will be addressed in order:

Section 38-2-3407.15B4 requires, "If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclosed that practice in each provider contract." As the Company does not routinely or as a matter of policy, bundle or downcode pharmacy claims, this language is not required in the contract.

Section 38.2-3407. 15B4 requires that fee schedules and reimbursement rates be attached to the contract. This section has been inserted into the applicable contracts.

3. Maintain procedures to ensure that claims are paid in accordance with the provider fee schedule as required by §§ 38.2-3407.15 B 4 a ii c, 38.2-3407.15 B 4 a ii d, 38.2-3407.15 B 8 and 38.2-3407.15 B 9 of the Code.

GHMSI Response:

The Company disagreed with these 5 violations: EFCL03, EFCL06, EFCL07, EFCL13, and EFCL14. The examiners identified an issue with anesthesia pricing that had been identified and remediated by the Company prior to the beginning of the audit. However, since the Company's actions took place outside the examination period, the examiners did not accept the Company's disagreement on the violations.

The Company does have procedures in place to ensure claims are paid in accordance with provider fee schedules as required by Virginia regulations.

4. As recommended in the prior Report, review its advertisements to ensure compliance with 14 VAC 5-90-10 et seq., as well as subsection 1 of § 38.2-502, and § 38.2-503 of the Code.

GHMSI Response:

The Company will review its advertising with the Legal Staff to ensure that its advertising is in compliance with 14 VAC 5-90-10, et seq., as well as subsection 1 of § 38.2-502, §§ 38.2-503 and 38.2-4312 of the Code. In addition, many of the pieces of advertising reviewed by the examiners are no longer in use.

5. Strengthen its procedures for the filing of amendments, applications, and enrollment forms used or issued for delivery in connection with group and individual subscription contracts, to ensure that these policy forms are approved by the Commission, as required by §§ 38.2-316 Band 38.2-316 C 1 of the Code.

GHMSI Response:

The Company's Contracting and Compliance Department has procedures in place to ensure all policy and enrollment applications are filed with and approved by The Bureau prior to issuance. These procedures will be reinforced within the Department. The Department will conduct periodic audits of existing forms that are in production, when new forms are placed into production, to ensure all forms are in compliance.

6. Strengthen its procedures for compliance with §§ 38.2-1812 A, 38.2-1833 A 1 and 38.2-4224 of the Code concerning the payment of commissions and appointment of agents and agencies.

GHMSI Response:

Policies and Procedures have been put in place to ensure that all Broker of Record Associates are following the same guidelines.

7. Revise its abbreviated Notice of Insurance Information Practices (NIP) Form to comply with § 38.2-604 C 3 of the Code.

GHMSI Response:

The Company observes that the Virginia Code Section cited (38.2-604 C.3) only requires access to Personal information. A distinction is made between Personal information and Medical record information in 38.2-602, Definitions of the Code. Personal information is about the personal characteristics of an individual and the latter is information relating to the physical or mental condition of an individual obtained from confidential sources as defined by the Code.

The Health Insurance Portability and Accountability Act [45 CFR §164.524(a)(3)(i)] prevents The Company from just carte blanche releasing medical record information to an applicant. The Company is obligated to review the medical documentation to ensure that what has been obtained from outside sources other than the applicant would not be considered harmful to the applicant or dependent of an applicant prior to the release of such information. As quoted from the Health Insurance Portability and Accountability Act: *A covered entity may deny access to information if a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person [45 CFR §164.524(a)(3)(i)].*

If a request is received to arrange disclosure of the information used to make any medical underwriting decisions, all documentation is presented to the Privacy Office from the Medical Underwriting Unit. At that time, a review is performed to determine if there is any medical record information which could potentially be harmful to the applicant if released. For example, an applicant that had a prior history of suicidal ideation and in treatment for depression, should not always see the narrative summarization or medical information presented by the attending provider. The Company would consult with the attending provider first before releasing such information. Further, a spouse currently being treated for a sexually transmitted disease should not have the Company be the vehicle to disclose this information. The Company has made an update to the Notice of Information Practices form which includes a reference to The Health Insurance Portability and Accountability Act [45 CFR §164.524(a)(3)(i)]. See Attachment A

8. Strengthen its established underwriting procedures to ensure that AUD notices approved by the Commission are sent to applicants for coverage under Virginia issued policies, as required by § 38.2-610 A 2 of the Code.

GHMSI Response:

This has been completed. In May of 2009, during a quality review of applications for Virginia residents who had an adverse underwriting decision, it was found that an incorrect template was used. Once discovered, an update was performed on the letter generation system and warning messages were added to the software system in Medical Underwriting. This warning asks associates if this applicant is a Virginia resident. This forces associates to review an applicant's address and select the appropriate template to ensure that the correct rights be given to all medically underwritten applicants with an adverse decision. See Attachment B

9. As recommended in the prior Report, establish and maintain procedures for compliance with § 38.2-3407.14 of the Code and include the actual amount of the premium increase within its written notices of intent to increase premiums by more than 35%.

GHMSI Response:

The Company will continue to provide at least 90 days notice on all 51+ renewals. For groups which receive a 35% or greater increase, the broker of record will receive the renewal via e-mail from the assigned Company's sales representative. The Company's sales representative will then obtain verification from the broker that a representative from the group policyholder received the renewal within the 60 day requirement. It is the position of The Company that a signed broker of record letter from the group policyholder constitutes the group policyholder authorizing the broker of record to receive renewals on group policyholder's behalf. Even with that authorization, the Company will verify that the group policyholder also receives the renewal with the appropriate 60 day notice.

The Company has also strengthened its policies and procedures to ensure the timely notification of members concerning premium increases of 35% or more. In addition, new procedures have been implemented to trigger apology letters and defer premium increases, whenever a member has not received sufficient notice. This internal change has allowed the Company to maintain compliance with § 38.2-3407.14 .

10. Review all renewals of group and individual subscription contracts issued in Virginia for the years 2005, 2006, 2007, 2008, 2009 and the current year that resulted in a more than 35% increase in the annual premium charged for the coverage there under; determine which contract holders were not notified in writing 60-days prior to such increase as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the individual and group contract holder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refund along with letters of explanation stating

specifically that, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that GHMSI had failed to provide 60 days written notice to the contract holder of intent to increase premiums by more than 35%. Please accept the enclosed check for the refund amount."

GHMSI Response:

From 2005 through 2009, a total of 51 group renewals were released with increases of at least 35%. All of the renewals were released to the broker and group policyholder with at least 60 days notice.

The Company previously identified individual members from last year, who failed to receive a 60 day notification from the time period of 2007 through May of 2009. Refund checks were sent to approximately 126 VA members, amounting to a one month credit along with an apology letter. The Company is actively working with IT developers to produce reports to capture 2005, 2006 and June of 2009 to present. Once received, the Company will work diligently to identify any members who did not receive the appropriate notice. All eligible members will receive a one month credit of the difference in the old and new premium amount.

11. Review all groups whose premium billing was handled by third parties and that were cancelled for non-payment of premium during the years 2005, 2006, 2007, 2008, 2009 and the current year to determine compliance with § 38.2-3542 C of the Code. For all instances of non-compliance, provide coverage until 15 days after a final termination notice was sent, as required by this section. Send a letter to the group contract holder stating that "as a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that GHMSI had failed to comply with § 38.2-3542 C of the Code of Virginia, which requires a 15-day notice prior to the termination of coverage."

GHMSI Response:

Although the examiners only found one instance of non-compliance in a sample of fifteen, the Company will review all groups whose premium billing was handled by third parties and were cancelled for non-payment of premiums during the years 2005 to the current year to determine compliance with the Virginia code. If any instances of non-compliance are found, a letter will be sent to the group contract holder stating that "as a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, It was revealed that GHMSI had failed to comply with 38.2-3542 C of the Code of Virginia, which requires a 15-day notice prior to termination of coverage." This action will be completed within 120 days of receiving the final report from the VBOI.

12. As recommended in the prior Report, establish and maintain procedures for the payment of interest due on claims, as required by § 38.2-3407.1 B of the Code.

GHMSI Response:

The Company has procedures and processes in place to comply with § 38.2-3407.1 B of the Code. The violations that the Company agreed to were human processor errors and not systemic problems. To the extent a process or procedure needs to be strengthened, the Company will do so.

13. Review and re-open all claims where interest is due for 2008, 2009, and the current year, and make interest payments where necessary as required by § 38. 2-3407.1 B of the Code. Send a letter stating specifically that, "as a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that interest on claim proceeds had not been paid as required by Virginia statute."

GHMSI Response:

The Company will comply with this request to reopen claims and pay interest, if interest is required. The Company is also requesting that only those claims where interest owed will be five dollars or greater be included in this action plan. This will prevent numerous irate telephone calls from providers who in the past have received checks for several cents.

14. As recommended in the prior Report, establish and maintain procedures for compliance with the Unfair Trade Practices Act (§ 38.2-500 et seq. of the Code), specifically §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code.

GHMSI Response:

The Company has procedures and processes in place to comply with the Unfair Trade Practices Act (§ 38.2-500 et seq. of the Code), specifically §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code. The violations that the Company agreed to were human processor errors and not systemic problems. To the extent a process or procedure needs to be strengthened, the Company will do so.

15. For the years, 2005, 2006, 2007, 2008, 2009 and the current year, review all claims denied as preexisting or claims that were denied for medical records to determine whether the health care services provided were for a preexisting condition. Re-open all claims for covered services denied as preexisting or claims that were denied for

medical records to determine whether the services provided were for a preexisting condition and pay those claims where subsequent documentation received by GHMSI indicated that the diagnosis associated with the covered health care services was not preexisting.

GHMSI Response:

The Company recently completed a major project on denied claims for Maryland and Virginia subscribers (initiated by the MIA) which included claims denied for pre-existing conditions. GHMSI subscriber denied claims were included in the project, which covered the time period of 2004 – 9/30/07. See my letter to Ms. Jacqueline Cunningham, dated December 29, 2008, and the attached completed action plan, Attachment C, which includes the results of the 2004 – 9/30/07 project.

To reopen and review denied claims for pre-existing conditions is a very labor intensive effort. The Company is therefore, requesting that the time frame for reopening claims begin where the prior project ended, September 30, 2007 and run through current 2010.

The Company also disagrees that it is in violation of not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. As a further example, the details around CL31, which was cited for violation, are summarized for review: This member had group coverage beginning June 1, 2008. The member's waiting period began May 21, 2008, her date of hire. There is a note on the Inquiry Analysis and Claims system, one of the Company's' call and correspondence tracking systems, dated 8/21/08 from the member asking why her claims were not paid. She was advised that she had a waiting period and the member stated she did not have prior coverage. The claim in question, xxxxxxx900 was received on January 26, 2009. This claim was from Dr. N. Central Medical Review (CMR) received the claim with a primary diagnosis of 516.9 (Unspecified alveolar and parietoalveolar pneumonopathy) and secondary diagnosis of respiratory distress on February 4, 2009 with an edit of a potential pre-existing condition. CMR returned the claim to the Claim Processing area on February 6, 2009 and advised to reject the claim as pre-existing. The claim was processed on February 11, 2009 and an Explanation of Benefits was sent on February 18, 2009 stating that the services were related to a pre-existing condition. This information was provided during the audit review.

On April 1, 2009, Central Appeals Unit received an appeal from Dr. M. Dr. M. was appealing the pre-existing denial decision for the ICD 9 code 515. The case was reviewed by two Medical Directors within the Company and a decision was made to overturn the denial of pre-existing for the pulmonary fibrosis (515) for the dates of service 6/25/08, 7/2/08, 7/8/08, 7/28/08, 9/15/08 and 9/29/08. Notification was sent to Dr. M. and the member. See Attachment D. The appeal decision was for the diagnosis of pulmonary fibrosis solely. The member also had a diagnosis of Chronic

Obstructive Pulmonary Disease (COPD) which was felt to be pre-existing by the Medical Directors. Only the diagnosis code of pulmonary fibrosis (515) was being overturned.

In reviewing the clinical facts for CL31, the diagnosis for the case identified was not the same as the diagnosis as the appeal. The Company did not violate any mandate by not adjusting the doctor's claim as it was not the same diagnosis as that of the other physician.

16. For the years, 2005, 2006, 2007, 2008, 2009 and the current year, review all claims denied as preexisting or claims that were denied for medical records to determine whether the health care services provided were for a preexisting condition. Re-open and pay all claims for covered services where documentation of creditable coverage was received by GHMSI indicating that the preexisting waiting period should have been waived.

GHMSI Response:

To reopen denied claims for preexisting conditions to search for Certificates of Coverage (COC) that may have been received after the claim was denied, for the period 2005 forward, is a huge manual effort. The Company has a process in place, that upon late arrival of COCs, a review takes place to determine if adjustments are required for previously denied claims. Additionally, members have appeal rights, and if a member knows a COC is required upon receiving an EOB denying a claim, that member will be actively engaged to get that claim reviewed and paid

The examiners only found 2 instances where a claim was denied for preexisting conditions that would not have been denied if the COC was present at the time of processing. Therefore, the Company is respectfully requesting the VBOI remove this required action.

The details around CL25, which was cited for violation, are summarized for review: This member had group coverage beginning July 1, 2008. Medical records were requested and per the records, member stated he had a long standing (five year history) of low back pain for which he had received treatment. Therefore, based upon medical review of medical documentation, claims were denied as pre-existing and an Explanation of Benefits was sent on January 4, 2009. On May 14, 2009, a request was received in the Broker Service area to update the eligibility files with information from the certificate of creditable coverage from the member's prior carrier. The Broker stated that the member did not realize that he needed to submit his prior carrier's information. Ten claims were identified for adjustment, including one BlueCard claim. However, one claim was inadvertently missed, 8218109946 and not adjusted to allow benefits. This was a manual error.

The initial claim rejected correctly based upon information on the member file and medical records submitted. To further evaluate claims from 2005 through 2009 in situations where the member did not realize the importance of presenting a Certificate of Creditable coverage at the time of enrollment because of one manual error would be a labor intensive process. All claims that denied as pre-existing would have to be identified and then all related Service cases and Enrollment files pulled and evaluated.

There is no listing of a violation of Section 38.2-510 A 4 in the VBOI Market Conduct Report under Section XVI, Area Violations Summary By Review Sheet. To require the Company to reopen claims for the prior five years for only two violations seems unwarranted. The Company respectfully requests the VBOI to delete Corrective Action Plan Item 16. In absence of a full deletion, the period for reopening denied claims should only go back to September 30, 2007, the date covered under Settlement Order INS-2008-00079, which covered claims inappropriately denied for the period 2004 through September 30, 2007 for GHMSI, BlueChoice and CapitalCare See Attachment E.

17. Enhance and monitor its coordination efforts with local Blue Cross Blue Shield Plans to ensure that claims processed under the BlueCard program are handled in accordance with the Unfair Claims Settlement Practices Act (§ 38.2-510 of the Code.

GHMSI Response:

The BlueCard Program has significant policies in place to insure the timeliness of claims processing. Daily reports are generated to track inventory, and financial penalties are imposed when policies are not met. A Hosting Plan must transmit a claim to a Home Plan within 5 days of receipt from the provider. The Home Plan must transmit disposition of the claims within 10 days of receipt of the Hosting Plans transmission. The Host plan must then finalize and process payment according to the Plans next predetermined payment schedule with the provider.

18. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

GHMSI Response:

It is the intent of the Company to comply with this requirement. In the event, one or more of the actions needs additional time, for example, opening claims, the Company will notify the VBOI at the point it is determined the 120 days will not be sufficient, and will request an extension of time.

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117



December 3, 2010

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Virginia Bureau of Insurance
Market Conduct Section 1
Life and Health Market Regulation Division
Tyler Building
1300 East Main Street
Richmond, VA 23219

RE: **Market Conduct Examination Reports – GHMSI, BlueChoice, and CapitalCare – Supplemental Response to Action Plans** (CORRECTED)

Dear Ms. Daniel:

Thank you for the opportunity to re-visit our October 21, 2010 response to the Draft Market Conduct Examinations of CapitalCare, BlueChoice, and GHMSI, as regarding the action plans requiring the re-opening of claims for possible additional interest due, before you send the final reports.

We have had an opportunity to analyze the claim interest violations pertaining to those VBOI action plans requiring the re-opening of claims for CapitalCare (2005-2010 YTD), BlueChoice (2008-2010 YTD), and GHMSI (2008-2010 YTD) and then pay any interest that may be due. The specific interest violations noted in the examinations were all manual processor errors, not system errors. CareFirst is dedicated to the consistent quality administrative results whether manual or systemic and through quality performance monitoring and ongoing re-training of staff. However, manual errors will unfortunately occur. CareFirst has continued to enhance the desktop tools that support manual Standard Operating Procedures both real time and through retrospect quality review and training.

The following represents the findings based on a claims sample of 815 claims for the three companies. Based on there being no systemic findings in the interest violations identified the recommended Plan of Action to search for manual human errors does not seem appropriate or in line with the findings identified in the audit.

For CapitalCare there were 6 processor interest violations, of which we agreed to 3 violations and disagreed with 3 violations. For BlueChoice there were 8 interest processor violations, of which we agreed to 2 interest violations and disagreed with 6 violations. For GHMSI there were 18 processor interest violations, of which we agreed to 9 violations and disagreed with 9 violations.

In attempting to understand the magnitude of the effort required to comply with these action plans, we completed a compilation of the claims paid for the time periods stated in the action plans. CareFirst processed approximately 4.8 million claims during this time period requested for Action Plan review. Adjustment activity trended experience estimates 4% to 5% volume of the claims processed result in adjustment. Approximately 240,000 adjustments could require manual review to identify why the claim was adjusted and assess if interest was applicable and manually determine if applied correctly. The review cannot be done in a way that will produce automated or systemic output accurately due to the multiple variables which contribute to adjustment reasons. (i.e., late charges billing, corrected claims, appeals, additional information etc.). This would require an individual claim/adjustment level review process and there is no way this can be accomplished. It would be like finding a needle in a haystack. Therefore, the companies are respectfully requesting the VBOI remove these required actions prior to sending the final reports.

Subject: Carly Daniel re: VBOI Market Conduct Examination Reports GHMSI, BlueChoice, and CapitalCare –
Supplemental Response to Action Plans

December 2, 2010

Page 2 of 2

To additionally support our request to remove these action plans for original claims processing of which the majority of 8 violations cited primarily were related to the following. Please understand that In the past, interest has been calculated on CareFirst claims to two days *after* CareFirst's system reflects payment of the claim. The additional two days was added to the calculation several years ago, at a time when CareFirst's systems required two days to print and mail claim checks for both Maryland and Virginia subscribers. In 2006, however, CareFirst changed its processes and has obtained and maintained excellent results in processing and mailing claim checks on the same day. In 2006, the MIA allowed CareFirst to remove the two days from its interest calculation for Maryland claims. CareFirst now requests that VBOI also not include this additional two-day period.

It is no longer appropriate to add two days of interest beyond the process date, because CareFirst now sends substantially all of its checks on the same day that the claim is adjudicated. In 2008, CareFirst sent 89.3% of checks on the day of adjudication, and 98.6% within one day. For 2009, 95.6% of checks were mailed on the same day that the claim was adjudicated, and 97.7% were sent within one day. From January 1, 2010 to November 24, 2010, 95.9% of CareFirst's checks were mailed on the date of adjudication, and 99.1% were mailed within one day. There is no basis, therefore, upon which it could be assumed that it takes two days for a check to be issued, and no basis for the assessment of interest for any day beyond the date of claim adjudication.

In essence, CareFirst has been overpaying two days of interest on Virginia claims since improving its mailing processes. CareFirst, respectfully asks that the VBOI take this overpayment of interest into consideration in addressing CareFirst's request to remove the action plans that require reopening of claims to look for processor errors when calculating interest on claims that required processor intervention. It should be noted that the VBOI allowed such a request in the 2005 examination when the VBOI found that CareFirst had been paying 8% interest for a number of years when the rate had been reduced to 6% several years earlier.

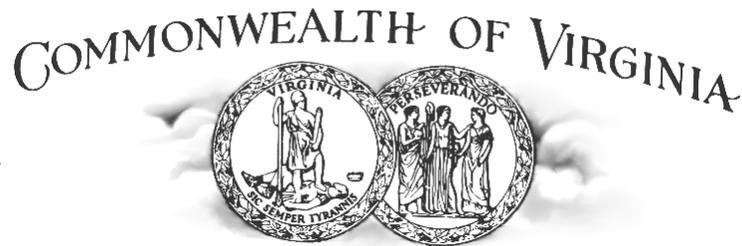
Please note, that CareFirst is also requesting approval of the VBOI to remove these two days from its interest calculations going forward. Please contact me should you have any questions concerning this supplemental response.

Sincerely,

Jimmy W. Riggs
Assistant General Auditor

JWR/dkg

cc: Jacqueline Cunningham
Emery Hill



March 1, 2011

**CERTIFIED MAIL 7005 1820 0007 5460 5282
RETURN RECEIPT REQUESTED**

Jimmy W. Riggs
Assistant General Auditor
Group Hospitalization and Medical Services, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

**RE: Response to Group Hospitalization and Medical Services, Inc. for the
Target Market Conduct Examination Exposure Draft**

Dear Mr. Riggs:

The examiners have received and reviewed Group Hospitalization and Medical Services, Inc.'s (GHMSI) response to the Draft Report dated October 21, 2010. This response will only address those areas of the response where GHMSI disagreed with the findings and corrective actions of the Report or where upon further review, the examiners decided to modify our findings.

GHMSI – Corrective Action Plan

- 1. As recommended in the prior Report, establish and maintain its complaint system as approved by the Commission, as required by § 38.2-5804 A of the Code;**

Timeliness – Review Sheets MC06 and MC07

The examiners concede that the appeals referred to in the Review Sheets were completed within the 60 Calendar Day timeframe specified in the procedures of GHMSI's filed complaint system. However, the requirement that the GHMSI's service areas prepare and forward the appeal to the Central Appeals Unit within 3 working days is also an established procedure of GHMSI's filed complaint system that GHMSI failed to perform in the 2 instances cited in Review Sheets MC06 and MC07. The Report appears correct as written.

Handling – Review Sheet MC04

The examiners would comment that Section D.2 of GHMSI's Appeal procedures, which states that "CareFirst will provide a review that does not afford deference to initial Adverse Benefit Determination...", would preclude the efficacy of GHMSI's disagreement due to the fact that the Nurse Analyst took the initial benefit denial into consideration.

In addition, GHMSI's appeal procedures state the following:

In deciding an appeal an Adverse Benefit Determination that is based in whole or in part on a judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment.
[Emphasis Added]

The examiners can find no provision of GHMSI's approved complaint system procedures where it states that the "judgment" referred to above cannot be performed by the claims system. The claims system is not an autonomous actor. Claim system edits and denial codes are conceived and implemented by health insurers in consultation with doctors and nurses employed by the company in light of the propriety of specific procedure, supply, and diagnosis code combinations. If the original benefit determination (denial) was not based wholly or in part on medical necessity, then there would have been no basis for GHMSI to consider and approve the appeal.

GHMSI's interpretation that a physician board certified in the same specialty is only consulted if the Medical Director cannot make a determination does not support compliance with § 32.1-137.15 B of the Code or follow its approved complaint system and internal procedures. The Report appears correct as written.

2. Establish and maintain procedures to ensure that its provider contracts with pharmacy intermediary organizations and the intermediary organization's provider contracts with participating pharmacies contain the 11 provisions required by § 38.2-3407.15 B of the Code;

There is no provision of § 38.2-3407.15 B of the Code that would permit a carrier to exclude any part of the 11 specific provisions required because it believes the provision is not applicable to the health care service provided. The Report appears correct as written.

3. Maintain procedures to ensure that claims are paid in accordance with the provider fee schedule as required by §§ 38.2-3407.15 B 4 a ii c, 38.2-3407.15 B 4 a ii d, 38.2-3407.15 B 8 and 38.2-3407.15 B 9 of the Code;

Subsequent to its written response, GHMSI indicated that it performs monthly self audits to ensure the accuracy of pricing and also performs reviews initiated by provider inquiries. Due to the fact that the remediation implemented by GHMSI subsequent to the examination time frame resulted from a provider inquiry, the violations will be removed.

7. Revise its abbreviated Notice of Insurance Information Practices (NIP) Form to comply with § 38.2-604 C 3 of the Code;

The examiners have reviewed GHMSI's response and have removed the statement that "...the abbreviated NIP form used by GHMSI failed to comply with § 38.2-604 C 3 of the Code." The examiners have reviewed the revised abbreviated NIP form presented by GHMSI in Attachment A, and have no further comment at this time.

9. As recommended in the prior Report, establish and maintain procedures for compliance with § 38.2-3407.14 of the Code and include the actual amount of the premium increase within its written notices of intent to increase premiums by more than 35%;

The requirements of § 38.2-3407.14 of the Code apply to all group renewals, not just groups with 51 or more subscribers. The examiners acknowledge that, in addition to the communication between the broker and group policyholder, the company will also verify that the group policyholder receives the required written notice at least 60 days prior to renewal.

10. Review all renewals of group and individual subscription contracts issued in Virginia for the years 2005, 2006, 2007, 2008, 2009 and the current year that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which contract holders were not notified in writing 60-days prior to such increase as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the individual and group contract holder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refund along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that GHMSI had failed to provide 60 days written notice to the contract holder of intent to increase premiums by more than 35%. Please accept the enclosed check for the refund amount";

The examiners found at least 3 instances where GHMSI violated § 38.2-3407.14 of the Code during the examination time frame in relation to a group contract. GHMSI's response provided no documentation to support its assertion that "All of the renewals were released to the ... group policyholder with at least 60 days notice" for the 51 group policyholders referenced. The examiners will require more substantial documentation in order to document compliance with the Corrective Action. Subsequent to its October 21, 2010, response, the company informed the examiners that, of the total 51

group renewals with a premium increase greater than 35%, 3 were BlueChoice, 11 were GHMSI and 37 were both BlueChoice and GHMSI.

In regards to individual subscribers who did not receive the notice required by § 38.2-3407.14 of the Code, a blanket “one-month” credit of the difference between the old and new premium would not comply with the requirements of the Corrective Action. The Corrective Action states that the refund must be for the entire contract period for which notice was not provided. This period could be greater than or less than one month, depending on the documentation in the premium billing file for the particular individual whose coverage was renewed. GHMSI’s proposal for compliance with this Corrective Action is not sufficient and a more in-depth review of the yet to be determined number of individual policy renewals should be performed by the company in order for GHMSI to comply with the Corrective Action.

13. Review and re-open all claims where interest is due for 2008, 2009, and the current year, and make interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send a letter stating specifically that, “as a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that interest on claim proceeds had not been paid as required by Virginia statute”;

The examiners are willing to consider a minimum threshold amount, with smaller amounts remitted to the Commonwealth’s Department of the Treasury, Unclaimed Property Division, upon GHMSI’s submission of a spreadsheet showing summary detail for all years in question. Please note that the amounts due to an individual provider or insured will need to be combined prior to determining if the threshold has been met.

The examiners have reviewed the supplemental documentation provided on December 3, 2010, and December 9, 2010. The Contractor Agreement states the following in regard to Checks: “CareFirst shall provide Contractor files for all Documents within a Mail Set by 8:00 a.m. ET (“Data Receipt Day”). Contractor shall Process Mail Sets and submit them to USPS by close of business.....within (1) Business Day.” The Agreement states that, “When a Mail Day falls on a USPS Holiday, the next day that is not a USPS Holiday will be used” and that “When a Process day falls on a Contractor Holiday, the next day that is not a Contractor Holiday will be used.” The Agreement also states that Checks with a Data Receipt Day of Saturday will not be mailed until Monday. Therefore, weekends, holidays and changes to the Agreement may affect the number of days it takes GHMSI to place claim checks in the mail. Consequently, it does not appear that it is appropriate to remove the additional days from the interest calculation.

In regards to interest miscalculations in the last exam, only interest overpayments and underpayments to one particular insured or provider was taken into consideration. Offsetting one insured or provider’s overpayment with another insured or provider’s underpayment was not permitted, as it did not appear to comply with GHMSI’s participating provider contracts or § 38.2-3407.1 of the Code.

14. As recommended in the prior Report, establish and maintain procedures for compliance with the Unfair Trade Practices Act (§ 38.2-500 et seq. of the Code), specifically §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code;

The number of violations of §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code occurred with such frequency as to indicate a general business practice and cannot be solely accounted for by human error. Claims remained denied after proof of loss had been received that indicated the health care services were covered under the terms of the policy. The violations appear to be correctly stated in the Report.

15. For the years, 2005, 2006, 2007, 2008, 2009 and the current year, review all claims denied as preexisting or claims that were denied for medical records to determine whether the health care services provided were for a preexisting condition. Re-open all claims for covered services denied as preexisting or claims that were denied for medical records to determine whether the services provided were for a preexisting condition and pay those claims where subsequent documentation received by GHMSI indicated that the diagnosis associated with the covered health care services was not preexisting;

The examiners are aware of the recently completed claims project concerning denied claims initiated by the Maryland Insurance Administration for Maryland and Virginia subscribers. The current examination revealed that GHMSI has failed to fully implement the Action Plan referred to in Attachment C.

The examiners have revised the time frame of review required by the Corrective Action to start on September 30, 2007, and run through 2010.

In regards to Review Sheet CL31, the examiners would note that during the course of the examination, GHMSI agreed with the examiners' observations and paid the claim with interest in response to our findings. The Medical Director determined that COPD was a co-existing disease and the treatment received for pulmonary fibrosis was not pre-existing. Although the ICD9 presented in the claim and appeal differ, the Medical Director only determined that COPD was pre-existing. Therefore, the violations discussed in Review Sheet CL31 will remain in the Report. The examiners are willing to review any additional documentation GHMSI may have to support its contention that the diagnosis present on this claim was preexisting.

16. For the years, 2005, 2006, 2007, 2008, 2009 and the current year, review all claims denied as preexisting or claims that were denied for medical records to determine whether the health care services provided were for a preexisting condition. Re-open and pay all claims for covered services where documentation of creditable coverage was received by GHMSI indicating that the preexisting waiting period should have been waived;

The examiners have revised the time frame of review required by the Corrective Action to start on September 30, 2007, and run through 2010.

Under a contract of adhesion, the responsibility for administering benefits in accordance with provisions of the contract rests primarily with the insurer, not the group or individual contract holder. Once a Certificate of Creditable Coverage is received and accepted by GHMSI, the waiting period is waived and the subscriber should not be required to actively engage in an appeal process in order to receive coverage for benefits that are clearly provided for under the terms of the health service plan contract.

The Area Violation Summary by Review Sheet section of the Report has been revised to reflect each section of the Unfair Claim Settlement Practices Act (§ 38.2-510) where instances of non-compliance were found.

The failure to timely pay and adjust to pay claims previously denied as possibly preexisting upon receipt of a Certificate of Creditable Coverage was documented in 12 instances (Review Sheets CL17, CL19, CL21, CL22, CL25, CL30, CL32, CL44, CL45, CL46, CL49 and CL50). The examiners would assert that the failure to perform the required action in 12 instances cannot be attributed solely to manual errors. When claims remain unpaid for covered services, subscribers are often balanced billed for the retail cost of the health care services provided. Therefore, the Report appears correct as written.

17. Enhance and monitor its coordination efforts with local Blue Cross Blue Shield Plans to ensure that claims processed under the BlueCard program are handled in accordance with the Unfair Claims Settlement Practices Act (§ 38.2-510 of the Code); and

The examiners are aware that the BlueCard Program has policies in place in regards to timeliness. However, it appears that these guidelines are not being followed by either the home or host plans. To date, GHMSI has not provided the examiners with documentation that the 2 claims discussed in Review Sheets CL61 and CL63 have been properly adjudicated, as requested repeatedly by the examiners.

18. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

The examiners acknowledge that in the event one of the corrective actions takes longer than 120 days to perform, that GHMSI will notify the examiners of the additional time needed.

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

On the basis of our review of the entire file, it appears that GHMSI violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-503 and § 38.2-503 of the

Code, and §§ 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 15 of the Code.

It also appears that GHMSI has violated §§ 38.2-316 B, 38.2-316 C 1, 38.2-610 A 2, 38.2-1812 A, 38.2-1833 A 1, 38.2-3407.1 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3542 C and 38.2-5804 A of the Code and 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-80 A, 14 VAC 5-90-100 A, 14 VAC 5-90-100 B and 14 VAC 5-90-110 of Rules Governing Advertisement of Accident and Sickness Insurance.

Violations of the above sections of the Code can subject Group Hospitalization and Medical Services, Inc. to monetary penalties of up to \$5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter.

Very truly yours,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division
Bureau of Insurance

CBD/mhh
cc: Althelia Battle

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
www.carefirst.com

March 22, 2011

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Virginia Bureau of Insurance
Market Conduct Section I
Life and Health Market Regulation Division
Tyler Building
1300 East Main Street
Richmond, VA 23219



Re: Additional Response to Proposed GHMSI Action Plans 12 and 13

Dear Ms. Daniel:

Thank you for the opportunity to provide further information with respect to proposed corrective action plans 12 and 13. Both corrective action plans would require GHMSI to reopen all claims that were denied from October 1, 2007 through December 31, 2010 because additional medical records were required and all claims that were denied during that same time period on account of a pre-existing condition. Corrective action plan 12 would require GHMSI to readjudicate every denial based upon a preexisting condition to determine whether documentation received subsequent to the claim showed that the claim was not, in fact, preexisting. Corrective action plan 13 would require GHMSI to pay any claims denied for preexisting condition if a certificate of credible coverage was received after the claim was adjudicated. VBOI cites only three specific claim examples in its report as the alleged basis for corrective action plans 12 and 13. These corrective action plans go far beyond any legal requirements, they are not possible to implement, and they are disproportionate to the few alleged violations on which they are based.

As an initial matter, both of these corrective action plans are based on an assumption that GHMSI is required, every time that it receives medical information or a certificate of credible coverage, to revisit all previous claims for a particular subscriber and readjudicate those claims based on additional information. There is no legal support for this assumption, and the general claims payment laws cited by VBOI do not contain any requirement that an insurer reopen previously settled claims. GHMSI is required to adjudicate each claim that it receives within the appropriate window of time, based on the information available to it at the time the adjudication is made. If additional information is received for a claim originally denied for that information, and the claim is subsequently processed according to the results of that information, the decision made regarding the processing of the claim at that time of review, can only be made based on the information available at the time of that claim review. Likewise, if a member or a provider wishes to submit additional information, the member or provider may exercise the appeal rights provided with respect to that claim. Even if additional information is provided to GHMSI during an appeal, and the claim is paid, the initial denial was correctly decided on the basis of the information submitted at the time. There is no legal basis upon which GHMSI may be compelled to reopen claims that were properly decided at the time of their adjudication.

The same legal reasoning applies to certificates of credible coverage. The burden of presenting a certificate of credible coverage lies with the member, and GHMSI cannot possibly know at the time of claim adjudication whether or not a member has a certificate of credible coverage that has not been submitted. To the contrary, GHMSI is entitled to assume that the member has provided GHMSI with full and complete information, which would include any available certificate of credible coverage. There is no legal basis for corrective action plans 12 and 13, because they seek to require GHMSI to go back three years and pay claims that were properly denied at the time they were adjudicated.

Daniel Letter Dated 3/22/11
Re: Additional Response to Proposed GHMSI Action Plans 12 & 13
Page 2 of 2

In addition, it is not possible for GHMSI to reopen the claims specified in corrective action plans 12 and 13 for several reasons:

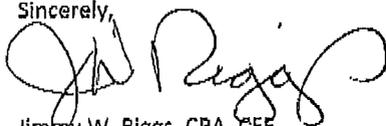
1. GHMSI cannot identify claims that have been denied because additional medical records are required without re-opening all claims that were denied because additional information was needed. GHMSI is attempting to determine how many such claims may exist during the nearly three-year period specified, but anticipates that thousands of claims would be involved.
2. Even if GHMSI were able to use a cumbersome manual process to isolate all claims that were denied because of a need for additional medical records, it is not possible to conduct any search of GHMSI's claim system that could assess whether such denial for additional medical records or medical information is related to a preexisting condition. It would be necessary to send every such claim and the member's subsequent history back through medical review to conduct an individualized medical assessment of each member.
3. GHMSI cannot conduct an automated search of its claims system to isolate claims denied for a preexisting condition in which a certificate of credible coverage was received after claims adjudication. GHMSI does not track when such certificates are received, post enrollment. As you know, the certificate of coverage is requested and required at the time of enrollment, in order to properly assign member coverage that would NOT include a pre existing waiting period. The burden of providing this certificate and/or communicating that this certificate exists, lies with the member or member's broker. Moreover, even if GHMSI did record such information, it would require GHMSI to open many thousands of claim files to medical readjudication. GHMSI is attempting to determine how many such files may exist during the specified time period.

Corrective action plans 12 and 13 are particularly unwarranted, given the extensive changes that GHMSI has recently made with respect to how it handles requests for additional information. Since the prior audit spanning the period of 2005 to 2009, GHMSI has moved its operations to a new claims processing platform, created enhanced operational reporting to monitor cycle times and quality on a routine and regular basis, and has enhanced its quality control capabilities. The extensive manual work required by proposed corrective action plans 12 and 13 would cause significant expense that is wholly disproportionate to the few violations alleged, while providing no benefit whatsoever to members receiving services from GHMSI.

As noted above, GHMSI is attempting to conduct an automated search of its systems to estimate how many claims may be have to be reopened if GHMSI were to attempt to comply with corrective action plans 12 and 13 (even though full compliance would be literally impossible). GHMSI expects that it will have that information for you by Monday, March 28.

Again, thank you for the opportunity to provide this additional information for your consideration in our request that these two impossible action plans be removed from the report.

Sincerely,



Jimmy W. Riggs, CPA, CFE
Assistant General Auditor

COMMONWEALTH OF VIRGINIA

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



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

June 1, 2011

**CERTIFIED MAIL 7005 1820 0007 5460 5718
RETURN RECEIPT REQUESTED**

Emery Hill
Manager, External Audit
Group Hospitalization and Medical Services, Inc. (GHMSI)
10455 Mill Run Circle
Owings Mills, Maryland 21117

RE: Additional Response to Proposed GHMSI Action Plans 12 and 13

Dear Mr. Hill:

The examiners have reviewed GHMSI's additional response to the Draft Report dated March 22, 2011 and have prepared a response.

Corrective Actions #12 and #13 do not require GHMSI to "...go far beyond any legal requirements". The findings of the examination indicate that, in the instances where GHMSI received subsequent documentation demonstrating that a diagnosis was not preexisting or the subscriber had creditable coverage, the company failed to timely reconsider the affected claims and "...facilitate reprocessing of the impacted claims" in accordance with the Standard Operating Procedures (SOPs) attached to GHMSI's May 10th email.

Under a contract of adhesion, the responsibility for determining eligibility and administering benefits in accordance with provisions of the insurance contract rests primarily with the insurer, not the contract holder. GHMSI's assertion that a member is required to "exercise the appeal rights provided with respect to..." claims denied as preexisting is not supported by the terms of the certificate of coverage which gives the subscriber "...15 months after the date the services were rendered..." to submit "claims for covered services." It logically follows that a subscriber has a reasonable period of time to submit any proof of loss associated with a claim for covered services. This would include documentation related to eligibility. *Proof of loss* is defined in § 38.2-3407.1 E of the Code as "all necessary documentation reasonably required by the insurer to make a determination of benefit coverage."

GHMSI informed the examiners in its March 22nd letter, that:

...both of these corrective actions plans are based on an assumption that GHMSI is required, every time that it receives medical information or a certificate of creditable coverage, to revisit all previous claims for a particular subscriber and re-adjudicate those claims based on additional information. There is no legal support for this assumption...

The company in its May 10th, email stated that:

The reconsideration of a claim for a pre existing condition or for a post enrollment submission of a certificate of credible coverage, equates to an appeal procedure for these types of denied claims. The appeals description and procedure is attached for your reference, as administered by the Central Appeals Unit. The procedure in place to identify the contracts where a pre existing limitation exists, the review of the relevant and related clinical and medical information to determine if a condition is pre existing to enrollment (within contract guidelines) and the appeal process to reconsider new information related to a denied claim, has been appropriately and correctly applied by CareFirst.

Effective March 21, 2000, the company implemented the Appeal Procedure it attached to its May 10th email, which requires GHMSI to take the following actions "...upon receipt of an appeal for a pre-existing condition," to include reviewing its system and reprocessing relevant claims that were impacted.

1. Ensure the application is in the file. If not, obtain the application: MD accounts obtain via SIR and for DC contact the medical Underwriting area.
2. Note and confirm the effective date of the policy or contract.
3. Note and confirm the date of service.
4. Check the medical underwriting application for Preexisting Condition Waiver Rider form and/or Exclusionary Amendment form.
5. Check to see if condition was disclosed on application.
6. For **Maryland** contracts verify if member signed pre-existing condition waiver rider form.
7. Research and determine if documentation of creditable coverage was submitted with the application or noted on the application.
8. If needed, contact member to inquire about HIPPA eligibility for creditable coverage and /or reduction of waiting period pending the total months of creditable coverage.
9. If member has creditable coverage requests the documentation and send to Enrollment to have the days credited to their policy.
10. Ensure that the appropriate contract is attached to the database and print cover sheet and appropriate pages from the contract for the file record.
11. Copy and paste to the case documentation, the specific verbiage of the definition of Pre-existing Condition, the waiting period and creditable coverage.
12. Acquire all medical records from appropriate providers to ensure a thorough review of the pre-existing condition.

13. Perform a thorough review of claims payments system to identify all relevant claims.
14. Prepare case for Medical Director review.
15. Medical Director renders the final internal appeal decision
16. Appeal decision is communicated in writing to the member and provider
17. If needed, notify claims regarding the appeal decision and facilitate reprocessing of the impacted claims.

GHMSI's assertion that the burden of presenting a certificate of creditable coverage lies with the "member or member's broker" is not supported by the language of the certificate of coverage and group contract which clearly imply that the subscriber, group contract holder, and health service plan, all share responsibility for providing the documentation required to determine a subscriber's eligibility for coverage. The examiners would refer GHMSI to subsections 2.4 and 2.5 of the Policy Form CCH/NCA CERT-5/95, titled PART 2 ELIGIBILITY AND ENROLLMENT, which state the following:

2.4 Clerical or Administrative Errors. If you are ineligible for coverage, you cannot become eligible because we or the Group made a clerical or administrative error in recording or reporting information. *Likewise, if you are eligible for coverage, you will not lose your coverage because we or the group made an administrative error in recording or reporting information.*

2.5 Cooperation and Submission of Information. We may require you and/or your Group to verify your eligibility. You and the Group are required to cooperate with and assist us, including allowing us to review your and/or the Group's records upon request. If our request is sent to the Group and the Group fails to respond within 31 days, we will send you a copy of the request and allow you an additional 31 days to submit the information or documents directly to us.

In addition, Section VIII of GHMSI's group contract titled, Cooperation, states that "The Group agrees that clerical errors...will not invalidate coverage which would otherwise be in effect" and that "The Group agrees to provide such information as necessary to verify compliance with the enrollment guidelines...."

The examination revealed that GHMSI violated §§ 38.2-510 A 2, 38.2-510 A 3, 38.2-510 A 5 and 38.2-510 A 6 of the Code with such frequency as to indicate a general business practice. The examiners can find no reasonable basis to exclude GHMSI from the requirements of the Unfair Claim Settlement Practices Act. Section 38.2-218 D 1 c of the Code states that the Commission may require an insurer to make restitution in the amount of direct financial loss for failing to pay amounts explicitly required by the terms of the insurance contract.

Review Sheets CL03, CL04, CL05, CL11, CL12, CL13, CL14, CL15, CL16, CL18, CL24, CL26, CL27, CL28, CL35, CL37, CL38 and CL42 document the 18 instances where GHMSI took greater than 15 working days to affirm a claim after

medical records had been received. Review Sheets CL29 and CL31 document the 2 instances where a claim remained denied even after medical records had been received and GHMSI's medical review department had determined that the diagnosis was not preexisting. In 3 instances (Review Sheets CL04, CL12 and CL14), GHMSI failed to pay the appropriate amount of statutory interest. In 9 of the claims files reviewed (CL05, CL12, CL13, CL14, CL15, CL16, CL24, CL28 and CL42); there was no documentation in the files indicating that the Claims Department was notified and that claims were reprocessed in accordance with GHMSI's SOPs.

The failure to timely affirm claims previously denied as possibly preexisting upon receipt of a Certificate of Creditable Coverage was documented in 12 instances (Review Sheets CL17, CL19, CL21, CL22, CL25, CL30, CL32, CL44, CL45, CL46, CL49 and CL50). In 7 instances (Review Sheets CL17, CL19, CL21, CL22, CL30, CL45 and CL46), GHMSI failed to pay the appropriate amount of statutory interest. In 4 instances (CL25, CL32, CL45 and CL46), there was no documentation in the files indicating that the Claims Department was notified and that the claims were reprocessed in accordance with GHMSI's SOPs. In all 4 instances, the claims remained denied.

GHMSI can identify claims that have been denied because medical records were required to determine if the diagnosis was preexisting by isolating the common reject codes used to deny these claims. Claims denied with these reject codes that have been subsequently adjusted to pay could be excluded from the target population of claims. The examiners would remind GHMSI that we are only concerned with claims that were denied under health service plan contracts issued in Virginia.

The corrective actions do not require GHMSI to "...send every such claim and the member's subsequent history back through medical review to conduct an individualized medical assessment of each member." The Corrective Action only requires GHMSI to "...pay those claims with interest *where subsequent documentation received by GHMSI indicated that the diagnosis associated with the covered health care services was not preexisting.*"

GHMSI's assertion that it does not track when certificates of creditable coverage are received post enrollment is incorrect. The examiners found such records on the company's Inquiry Analysis and Control System (IACS) system and used this data to document the company's failure to comply with the Unfair Claim Settlement Practices Act.

Corrective Actions 12 and 13 are not unwarranted. We are simply requiring that GHMSI comply with its Standard Operating Procedures, which state that GHMSI will ***"if needed, notify claims regarding the appeal decision and facilitate reprocessing of the impacted claims."*** The current status of the company's claims processing system is immaterial to this discussion. The examiners cannot permit unjust enrichment on the part of GHMSI for its failure to timely affirm claims for covered health care services. To do so, would create a perverse incentive for other health insurers operating in the Commonwealth. The Corrective Actions will remain in the Report.

Please let the examiners know within the next 10 working days whether GHMSI would like to settle this matter in accordance with the Deputy Commissioner's letter of

March 11, 2011. Questions or concerns regarding the proposed settlement should be communicated to Carly Daniel at the above address or to (804) 371-9492.

Very truly yours,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division

CBD:mhh

COPY

August 22, 2011



Ms. Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Virginia Bureau of Insurance
Market Conduct Section 1
Life and Health Market Regulation Division
Tyler Building
1300 East Main Street
Richmond, VA 23219

Dear Ms. Daniel:

Thank you for the opportunity to discuss the proposed Corrective Action Plans 12 and 13 on July 8, 2011.

In follow-up to the meeting and our subsequent conversation of August 10, we are providing the summary below of the 21 claims used by the VBOI to support their Corrective Action Plan request. During our call, we were informed that VBOI was relying on the claim files cited in their June 1 letter. We agreed to review these additional claim files, and we have found that they do not support the VBOI's proposed plan, that they do not show any pattern by CareFirst of improperly handling certificates of credible coverage or denials for pre-existing conditions. If anything, these citations demonstrate that the scope of Corrective Action Plans 12 and 13 extends far beyond the alleged violations upon which VBOI relies. CareFirst's Clinical Medical Review staff reviewed the 24 claims cited in your June 1 letter, and our summary is as follows:

Corrective Action Plan 12 - Corrective Action Plan 12 would require GHMSI to manually review every claim that was denied between October 1, 2007 and December 31, 2010 either for a pre-existing condition or because additional medical records were needed. GHMSI would have to "re-open" every such claim "to determine whether the services provided were for a preexisting condition." **Report at REVISED 45.** As we have discussed, one of our concerns is that, by its language, this corrective action plan would require GHMSI to conduct a new medical review of every such claim.

It is our view that the claims cited by VBOI in the June 1 Letter do not support this proposed plan. VBOI only cites two claims (CL 29 and 31) as "the 2 instances where a claim remained denied even after medical records had been received and GHMSI's medical review department had determined that the diagnosis was not preexisting." *June 1 Letter* at 4. The other claims cited to support Corrective Action Plan 12 in the June 1 Letter do not really apply:

- Nine claims (CL 05, 12, 13, 14, 15, 16, 24, 28 and 42) are cited for the proposition that "there was no documentation in the files indicating that the Claims Department was notified and that claims were reprocessed in accordance with GHMSI's SOPs." VBOI did not cite any of these claims during the audit for an alleged failure to refer the claim for adjustment following medical review. We have looked at these claims and believe that VBOI is in error. Based on the GHMSI records produced during the examination, each of these nine claims was sent to the adjustment area for processing following medical review as confirmed by CareFirst's Central Medical Review staff. In instances

where denials for pre-existing were made and certificates of creditable coverage were received after the fact, documentation is present to again show that adjustments were made. We can supply the documentation again, if you wish, or discuss that documentation with you at your convenience.

- Two of the nine claims cited above (CL 12 and 15) do not relate to preexisting conditions at all, but involve a cosmetic review.
- VBOI also cites three other claims that it concedes were paid (CL 04, 12, and 14), and where the only disagreement is over the payment of interest, an issue addressed by other parts of VBOI's report and not corrective action plan 12.

Corrective Action Plan 13 – Corrective Action Plan 13 would require GHMSI to manually review every claim which was denied as preexisting or because additional medical records were needed “to determine whether the health care services provided were for a preexisting condition,” and for each such claim to manually review GHMSI's file to determine if a certificate of creditable coverage had been received. There is no way to electronically search for certificates of creditable coverage in GHMSI's claim system.

In its June 1 Letter, VBOI cites 12 claims (CL 17, 19, 21, 22, 25, 30, 32, 44, 45, 46, 49, and 50) as its basis for Corrective Action Plan 13. GHMSI respectfully submits that these claims do not support this broad and burdensome corrective action plan:

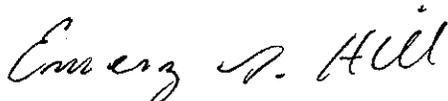
- GHMSI does not believe that VBOI has identified any claim that was not adjusted following receipt of a certificate of credible coverage. One claim (CL50) was adjusted 3 months late, due to a manual error. However, the claim was adjusted and paid before the VBOI's examination. If anything, this claim demonstrates that it was CareFirst's policy to adjust pending claims after receipt of a certificate of credible coverage, and that reopening and reviewing all such claims again would be unwarranted.
- GHMSI believes that for CL49 the claim in question was processed as not being pre-existing based upon the medical records that were received in the company on March 12, 2009. While the claims were being adjusted, the member sent in the Certificate of Creditable coverage on March 17, 2009 to the Customer Service area. The member called on April 6, 2009 to review claims with the Customer Service area and an additional 11 claims were sent for adjustment. To complete the Customer Service case, a letter was sent on April 11, 2009 stating that the waiting period had been removed.
- VBOI's objection with seven of those claims (CL 17, 19, 21, 22, 30, 45, and 46) is over the payment of interest, which is addressed by other portions of the Report and not Corrective Action Plan 13. CareFirst agrees with the VBOI assessment that interest was due, but these claims do not support Corrective Action Plan 13.
- VBOI cites four claims (CL 25, CL 32, CL 45 and CL 46) for the proposition that “there was no documentation in the files indicating that the Claims Department was notified and the claims were reprocessed in accordance with GHMSI's SOPs.” In each case, CareFirst confirmed that the documentation submitted to VBOI shows that the claims were referred for adjustment.

- In two cases (CL 45 and 46), problems arose with the provider tax ID number on readjustment and the provider was required to resubmit information, an issue that has no bearing on Corrective Action Plan 13.
- Two claims cited by VBOI (CL 19 and 32) did not have certificates of creditable coverage on file, and cannot support a review intended to look for such certificates.¹

In order to provide you with the potential impact on resources of fulfilling the two corrective action plans, we collected data for the years 2005 through 2010. During this time period, there were 96,568 claims that had requests for additional information, and an additional 9,588 claims that were denied during the initial review of the claim as pre-existing. These numbers represent claims for all jurisdictions. CareFirst would have to open 106,156 claims to perform a new review to determine if the appropriate decision was made. An RN can perform 100 reviews per day on the FLEXX platform. This would take 1062 days to perform the reviews required. Using 20 working days per month, it would take 53 months to perform this type of review using one RN. The process is further impacted because there is no identifiable indicator for Certificates of Creditable Coverage (COC), which would necessitate that CareFirst would need to perform manual research on the 106,156 cases that it either requested Medical Records on or rejected as pre-existing and rejected as pre-existing and determine if the Cert is available. In some instances, CareFirst would have to reach out to the DBE (Broker) who handles all enrollment activities to determine if the COC is on file with them.

We welcome the opportunity to discuss this information with you at your convenience.

Sincerely,



Emery S. Hill, Manager
External Audit Coordination

- c: P. Todd Cioni, Vice President, Corporate Compliance
Patricia Hodney-Gould, Manager, Central Medical Review
Tonya Kinlow, Vice President, Government Affairs
Randolph S. Sergeant, Sr. Director & Assistant General Counsel

¹ In CL 19, the member did not identify that he had come off of his parent's policy and CL 32 involved a coordination of benefits issue; neither is germane to Corrective Action Plan 13.

September 13, 2011



Ms. Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Virginia Bureau of Insurance
Market Conduct Section 1
Life and Health Market Regulation Division
Tyler Building
1300 East Main Street
Richmond, VA 23219

Dear Ms. Daniel:

This is in follow-up to our conversations of August 30 and September 7 regarding VBOI's draft report of the GHMSI Market Conduct Examination, in which we discussed proposed Corrective Action Plans 12 and 13 and CareFirst's subsequent proposal.

During our August 30 conversation, you provided clarification to a number of observations that CareFirst made in our August 22 letter, and proposed modifications to the original VBOI corrective action plans 12 & 13. Specifically, you proposed to combine the two plans and to utilize a specified set of denial codes, based on a set of codes that the VBOI examiners had seen used in conjunction with denials for pre-ex or lack of medical records. These codes are FO82, CM0D, CM02, PM0A, CM0A, CM12, and CM0L. Based on these codes, you proposed that CareFirst should review the claims with these denials. You also emphasized that you were not expecting CareFirst to conduct a medical review on claims that were denied, if a previous medical review had been conducted. The population in question would be drawn from claims denied during the period 10/01/07 – 12/31/10.

In reviewing the seven denial codes, CareFirst determined that those codes go beyond claims involving potential pre-existing conditions, but represent all circumstances in which medical records have been requested, for any reason. During the period of 2007 through 2010, approximately 58,000 claims were denied using these codes in both DC and Virginia. We believe that there are tens of thousands of such claims for Virginia members alone during the relevant period.

To address the concerns to which corrective action plans 12 & 13 directed, we have proposed an alternative that is intended to identify any claims that are similar to the two claims that serve as the primary basis for corrective action plan 12, and which we also believe will address the VBOI's concern with respect to corrective action plan 13. Those two claims involved instances in which CareFirst attempted to manually adjust claims that had been previously denied for pre-ex, after additional medical records were received or a certificate of credible coverage was received. In the two claims identified by VBOI, several such adjustments that were made at the same time to a set of multiple claims, and one claim in each set was missed due to human error, while the other claims were properly adjusted.

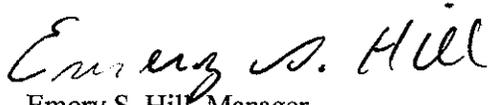
We have determined that we can conduct a search of the claims system to ensure that there are no other such claims during the period. The search would be for all claims where: (1) the claims were denied for pre-ex during the relevant period of time, (2) some of those claims were later adjusted to pay according to benefits, and (3) there is a claim or claims for which a pre-ex denial was not adjusted, but continues to be within the claim resolution. These claims would be reviewed to determine if they should

Carly B. Daniel
September 13, 2011
Page 2 of 2

be adjusted. We believe this approach would cover both corrective action plans 12 and 13, because it would include pre-ex claims where the manual adjustment was triggered by new medical records as well as those claims where a manual adjustment was triggered by receipt of a certificate of credible coverage.

Thank you again for the opportunity to continue our discussions around this issue.

Sincerely,



Emery S. Hill, Manager
External Audit Coordination

c: P. Todd Cioni, Vice President, Corporate Compliance
Tonya Kinlow, Vice President, Government Affairs
Randolph S. Sergeant, Sr. Director & Assistant General Counsel
Sheila Wilson-doby, Supervisor, Central Medical Review

COPY

COMMONWEALTH OF VIRGINIA

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



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
TELEPHONE: (804) 371-9741
TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

November 3, 2011

**CERTIFIED MAIL 7005 1820 0007 5460 5930
RETURN RECEIPT REQUESTED**

Emery Hill
Manager, External Audit
Group Hospitalization and Medical Services, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

RE: Additional Response to Proposed GHMSI Action Plans 12 and 13

Dear Mr. Hill:

The Bureau of Insurance (the Bureau) has completed its review of your September 13, 2011, supplemental response to the Target Market Conduct Examination Report of Group Hospitalization and Medical Services, Inc. (GHMSI) regarding Corrective Actions #12 and #13. The follow-up conversations to gain clarification were also taken into consideration.

For a pre-existing denial that has been overturned, the Company's established procedures require a thorough review of the claims payment system to identify relevant claims and to send the claims department notification to reprocess impacted claims. These Corrective Actions call for GHMSI to ensure this practice is upheld by reviewing and reopening denied claims that were impacted by a subsequent decision. They do not require GHMSI to perform new medical reviews.

GHMSI has noted that, when the decision is made to request medical records, the previous codes used internally to identify the reason for the request are lost and no accompanying denial codes are used that would further narrow the scope of claims in its legacy systems or the new Facets system. Therefore, GHMSI has proposed that it could review claims during the stated period that were denied for pre-ex under specified codes, which were later adjusted to be paid, and review each member's claims to ensure that relevant claims which remain denied are adjusted.

Although GHMSI indicated that its search will be based on its understanding that the Corrective Actions were a result of two instances where adjustments were made to multiple claims and some were missed due to human error, GHMSI later confirmed that this approach will also include those where no review of prior claims was performed, as was furthermore revealed by the examiners' review. The examiners are willing to

accept this approach and Corrective Actions #12 and #13 will be revised to read as follows:

12. Strengthen its established procedures to review its claims payment system to identify claims relevant to a pre-existing decision and notify the claims department to reprocess impacted claims;
13. From October 1, 2007, through December 31, 2010, review all claims adjusted upon receipt of documentation that resulted in a determination that a condition was not pre-existing or that credible coverage existed and the waiting period should have been waived. Review all relevant claims for the members and re-open and pay with interest those that were not adjusted based on the aforementioned determinations. Send reimbursement checks along with letters of explanation to the member and provider stating specifically that, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that GHMSI should have paid this claim based on a subsequent decision that the condition was not pre-existing. This check represents the additional payment due.";

The Bureau will continue to work with GHMSI to determine the Codes that should be incorporated into the review. In addition, GHMSI should ensure that it records the steps taken and its methodology used as it drills down within the system to further document that the necessary claims are reviewed.

As a result of the limitations that carried over to the new system, the examiners would encourage GHMSI to explore its options to further enhance its capabilities to enable the Company to efficiently perform audits, to include internal audits, and effectively re-adjudicate necessary claims. Such enhancements may also allow company service units and Central Medical Review to better match medical records to related claims, in light of its current manual process.

The revised page is enclosed for your review. If GHMSI wishes to settle this matter in accordance with the Deputy Commissioner's letter of June 9, 2011, a signed copy of the prepared settlement offer along with GHMSI's check must be received within 10 business days of receipt of this letter. Please feel free to contact me at (804) 371-9492 or carly.daniel@scc.virginia.gov should you have any questions.

Very truly yours,

Carly B. Daniel, AIE, AIRC
Principal Insurance Market Examiner
Market Conduct Section 1
Life and Health Market Regulation Division

CBD:mhh
Enclosures

Emery S. Hill
Manager, External Audit Coordination
Group Hospitalization and Medical Services, Inc.
10455 Mill Run Circle
Owings Mills, Maryland 21117

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

RE: Alleged Violations of Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and § 38.2-503 of the Code, and §§ 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 15 of the Code, as well as §§ 38.2-316 B, 38.2-316 C 1, 38.2-610 A 2, 38.2-1812 A, 38.2-1833 A 1, 38.2-3407.1 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3542 C and 38.2-5804 A of the Code and 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-80 A, 14 VAC 5-90-100 A, 14 VAC 5-90-100 B and 14 VAC 5-90-110 of Rules Governing Advertisement of Accident and Sickness Insurance.

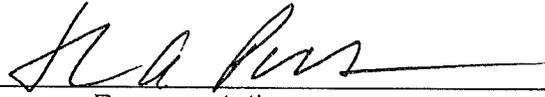
Dear Ms. Battle:

This will acknowledge receipt of your letter dated June 9, 2011, concerning the above-captioned matter.

Group Hospitalization and Medical Services, Inc. wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of \$53,000, payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to cease and desist from future violations of §§ 38.2-510 A 6, 38.2-3407.14 A, 38.2-3407.14 B, and 38.2-5804 A of the code, and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of March 31, 2009.

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

Yours very truly,



Company Representative

1/23/12

Date

Enclosure (check)

COPY

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

120220274

AT RICHMOND, FEBRUARY 22, 2012

CLERK'S OFFICE

COMMONWEALTH OF VIRGINIA, *ex rel.*

2012 FEB 22 P 2:14

STATE CORPORATION COMMISSION

DOCUMENT CONTROL

v.

CASE NO. INS-2011-00047

GROUP HOSPITALIZATION AND
MEDICAL SERVICES, INC.,

Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance, it is alleged that the Defendant, duly licensed by the State Corporation Commission ("Commission") to transact the business of a health services plan in the Commonwealth of Virginia, in certain instances, has violated §§ 38.2-316 B and 38.2-316 C 1 of the Code of Virginia by failing to comply with policy and form filing requirements; violated subsection 1 of § 38.2-502 and § 38.2-503 of the Code of Virginia, as well as 14 VAC 5-90-55 A, 14 VAC 5-90-55 B, 14 VAC 5-90-60 A 1, 14 VAC 5-90-60 A 2, 14 VAC 5-90-60 B 3, 14 VAC 5-90-60 B 4, 14 VAC 5-90-80 A, 14 VAC 5-90-100 A, 14 VAC 5-90-100 B, and 14 VAC 5-90-110 of the Rules Governing Advertisement of Accident and Sickness Insurance by failing to comply with advertising requirements; violated §§ 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 15 of the Code of Virginia by failing to comply with claim settlement practices; violated § 38.2-610 A 2 of the Code of Virginia by failing to give to applicants for insurance written notice of an adverse underwriting decision in the form approved by the Commission; violated §§ 38.2-1812 A and 38.2-1833 A 1 of the Code of Virginia by failing to comply with agent licensing requirements; violated § 38.2-3407.1 B of the

Code of Virginia by failing to pay interest at the legal rate of interest from the date of fifteen (15) working days from the Defendant's receipt of proof of loss to the date that the claim was paid; violated §§ 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code of Virginia by failing to comply with premium notice requirements and ethics and fairness requirements for business practices; violated § 38.2-3542 C of the Code of Virginia by failing to provide adequate notice of termination of coverage; and violated § 38.2-5804 A of the Code of Virginia by failing to comply with complaint system requirements.

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

The Defendant has been advised of its right to a hearing in this matter, whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth of Virginia the sum of Fifty-three Thousand Dollars (\$53,000), waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order from future violations of §§ 38.2-510 A 6, 38.2-3407.14 A, 38.2-3407.14 B or 38.2-5804 A of the Code of Virginia, and agreed to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of March 31, 2009.

The Bureau of Insurance 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 of Virginia.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau of Insurance, 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 be, and it is hereby, accepted;
- (2) The Defendant cease and desist from any future conduct that constitutes a violation of §§ 38.2-510 A 6, 38.2-3407.14 A, 38.2-3407.14 B or 38.2-5804 A of the Code of Virginia; and
- (3) The papers herein be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Emery S. Hill, Manager, External Audit Coordination, GHMSI, 10455 Mill Run, Owings Mills, Maryland 21117; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:

Joel H. Peck

Clerk of the
State Corporation Commission