

REPORT ON
TARGET MARKET CONDUCT EXAMINATION
OF
ANTHEM HEALTH PLANS OF VIRGINIA, INC.
AS OF JUNE 30, 2008

Conducted from March 12, 2009

through

June 25, 2010

By

Market Conduct Section

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-0357120

NAIC: 71835

COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
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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 Anthem Health Plans of Virginia, Inc., conducted at the company's Home office in Richmond, VA as of June 30, 2008, 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-2012-00138.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 11th day of September, 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

This Report addresses the findings of the second phase of the Target Market Conduct Examination of Anthem Health Plans of Virginia, Inc. (hereinafter referred to as "Anthem"). This phase was conducted at the company's office in Richmond, Virginia, 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, and 38.2-1809 of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

Previous Target Market Conduct Examinations covering the periods of January 1, 2002 through June 30, 2002, and January 1, 2006 through March 30, 2006, were concluded on September 9, 2002 and March 22, 2007, respectively. As a result of these examinations, Anthem made monetary settlement offers that were accepted by the State Corporation Commission on February 10, 2003, in Case No. INS-2002-01317 and on July 30, 2007, in Case No. INS-2007-00219.

A comprehensive Market Conduct Examination covering the period January 1, 2002 through December 31, 2002, was concluded on December 15, 2003. As a result of that examination, Anthem made a settlement offer that was accepted by the State Corporation Commission on November 19, 2004, in Case No. INS-2004-00302.

The current examination revealed violations that were also noted in previous Reports. Although Anthem had agreed after the earlier Reports to change its practices in these instances to comply with the Code and regulations, the current examination

revealed a number of instances where Anthem has not done so. In the examiners' opinion, therefore, while it is not alleged that Anthem's actions were willful in light of its prior notice of many of the problems revealed by this Report, it is reasonable to conclude that Anthem knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties which may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2008 through June 30, 2008. The on-site examination was conducted from March 12, 2009 through December 4, 2009, and completed at the office of the State Corporation Commission's Bureau of Insurance on June 25, 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 Anthem 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 5-130-10 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 5-170-10 et seq. | Rules Governing Minimum Standards for Medicare Supplement Policies; |

14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-234-10 et seq.	Rules Governing Essential and Standard Health Benefit Plan Contracts; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

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
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act/Insurance Replacement
- Premium Notices/Reinstatements
- Cancellations/Nonrenewals
- Complaints
- Claim Practices

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

II. COMPANY HISTORY

Trigon Insurance Company (Trigon) was chartered on October 14, 1935, as a health services plan under the name of Richmond Hospital Association. Its name was changed to Virginia Hospital Service Association in 1944 by charter amendment and again in 1968 to Blue Cross of Virginia.

The Associated Doctors of Virginia was chartered on October 21, 1944, as a health services plan providing medical/surgical and similar or related services. The following year, the name was changed to Virginia Medical Association. In 1968, the charter was amended to change the name to Blue Shield of Virginia. On March 31, 1982, Blue Shield of Virginia was merged into Blue Cross of Virginia, and the name was changed to Blue Cross and Blue Shield of Virginia. In 1986, Blue Cross and Blue Shield of Southwestern Virginia was reorganized and merged into Blue Cross and Blue Shield of Virginia.

On July 1, 1991, Blue Cross and Blue Shield of Virginia was granted authority under the provisions of § 38.2-4229.1 of the Code to convert to a domestic mutual insurer. Then on February 5, 1997, Blue Cross and Blue Shield of Virginia converted from a mutual insurance company to a stock insurance company. Blue Cross and Blue Shield of Virginia changed its name to Trigon Insurance Company, d/b/a Trigon Blue Cross Blue Shield and became a wholly-owned subsidiary of Trigon Healthcare, Inc. The membership interests of the company were converted into Class A common stock of Trigon Healthcare, Inc. or cash.

On July 31, 2002, Trigon Healthcare, Inc. and Anthem Inc. completed a merger in which Trigon Healthcare, Inc. merged into a wholly owned subsidiary of Anthem, Inc. that subsequently changed its name to Anthem Southeast, Inc. At that time, Trigon Insurance Company became a wholly owned subsidiary of Anthem Southeast, Inc. and its name was changed to Anthem Health Plans of Virginia, Inc. (Anthem)

On November 30, 2004, Anthem, Inc. and WellPoint Health Networks, Inc. completed a merger in which WellPoint Health Networks, Inc. and all WellPoint subsidiaries merged with and into Anthem Holding Corp., a direct and wholly owned subsidiary of Anthem, Inc., with Anthem Holding Corp. as the surviving entity. In connection with the merger, Anthem, Inc. amended its articles of incorporation to change its name to WellPoint, Inc.

Anthem markets group, individual, and Medicare supplement through brokers/agents, salaried employees, and direct mail in Virginia, with the exception of the cities of Fairfax, Arlington, Alexandria, the town of Vienna, and the eastern half of Fairfax County.

As of December 31, 2008, Anthem's annual statement reported net admitted assets totaling \$1,627,260,653, and direct accident and health insurance premiums totaling \$3,844,329,611.

COPY

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIP)

Chapter 58 of Title 38.2 was effective July 1, 1998. 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 sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

GENERAL PROVISIONS

Section 38.2-5801 C 3 requires that a health carrier request its initial certificate of quality assurance by December 1, 1998. The review revealed that Anthem was in substantial compliance with this section.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

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

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

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

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner. Section 38.2-5804 C of the Code requires each health carrier to submit to the Managed Care Ombudsman and the State Health Commissioner an annual report.

The examiners reviewed a sample of 81 from a population of 1,266 written pre-service, post-service and contractual appeals; a sample of 10 from a population of 35 expedited appeals; a sample of 16 from a population of 142 executive inquiries; and a sample of 21 from a population of 39 written complaints received during the examination time frame.

Anthem's approved complaint system provides mechanisms for reconsideration of adverse decisions and for pre-service, post-service, and expedited appeals. The procedures require written notification of the disposition of the pre-service or post-service appeals to the member within 30 calendar days from the receipt of the request to appeal. Anthem's goal is to provide written notification of the disposition within 14 working days from the receipt of all information regarding the request to appeal, but not more than 30 calendar days.

As discussed in Review Sheet CP06-AN, the review revealed 1 violation of § 38.2-5804 A of the Code for failure to maintain its approved complaint system. In this instance, Anthem took 34 days to resolve the appeal, which exceeds the 30 day time frame set forth in its approved complaint system.

PROVIDER CONTRACTS

Section 38.2-5805 B of the Code requires that every contract with a provider enabling an MCHIP to provide health care services shall be in writing. Section 38.2-5802 C of the Code states that the health carrier shall maintain a complete file of all contracts made with health care providers, which shall be subject to examination by the Commission.

The examiners selected a sample of 74 from a total population of 76,216 provider contracts in force during the examination time frame. The review revealed that Anthem was in substantial compliance with these sections.

PROHIBITED PRACTICES

Section 38.2-5806 of the Code prohibits the cancellation or refusal to renew basic health care coverage by an MCHIP licensee based on a person's health status.

The review did not reveal any indication that Anthem had conducted prohibited practices under this section.

IV. ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services. Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section.

PROVIDER CONTRACTS

Professional and Facility

The examiners reviewed a sample of 40 professional and 18 facility contracts from a total population of 72,964 professional and 668 facility provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

In 2004, § 38.2-3407.15 B of the Code was amended where former subdivisions B 7 through B 9 were re-designated as subdivisions B 8 through B 10 and a new subdivision B 7 was inserted. In 2005, §§ 38.2-3407.15 B 4 and 38.2-3407.15 B 9 of the Code were amended and § 38.2-3407.15 B 11 was added. The 2005 revisions to § 38.2-3407.15 B of the Code apply to provider contracts entered into, amended, extended or renewed on or after January 1, 2006.

The review revealed 6 instances where Anthem's provider contracts failed to contain 1 or more of the 11 specific 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 4	1	EF02-AN
§ 38.2-3407.15 B 7	1	EF02-AN
§ 38.2-3407.15 B 8	1	EF04-AN
§ 38.2-3407.15 B 9	2	EF02-AN, EF11-AN,
§ 38.2-3407.15 B 11	1	EF02-AN

Section 38.2-3407.15 B 9 of the Code states that no amendment to any provider contract shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract. During the provider contract review, the examiners noted that 56 sample professional and facility contracts contained language that was inconsistent with the notification requirements set forth in § 38.2-3407.15 B 9 of the Code. The Standard Terms and Conditions of Anthem's contracts stated that the provider has 40 calendar days from the post mark date of the amendment to notify Anthem of termination; while, the Code specifically allows the provider a time frame of 30 calendar days from the *receipt* date to notify Anthem of intent to terminate the contract.. Anthem responded in part that:

...In order to comply with the law, give providers their required notice of an amendment and allow Anthem to implement systems changes, Anthem has included in its provider contract a period of ten days to allow for the mail to be delivered ("If you are unwilling to accept the amendment, you may terminate this Agreement by

giving us written notice of termination within **forty (40) calendar days after the post mark date** of the amendment....”). Ten days is more than enough time for all mail to be delivered to providers in Virginia and, in fact, probably gives the vast majority of providers (if not all of them) more notice than is required by law...

While there may be instances in which the mail is not delivered within 10 days (i.e. late, lost, or stolen) of the postmark date, the examiners acknowledge that this would be an infrequent occurrence. However, in order to ensure future compliance with § 38.2-3407.15 B 9 of the Code in all instances, Anthem must establish and implement written procedures to ensure that a provider would be permitted the full 30 days from receipt of the amendment to notify Anthem of termination of the contract in the event that there is a delay in receiving notification.

Pharmacy and Vision

The examiners also reviewed a sample of 6 vision and 10 pharmacy provider contracts from a total population of 1,051 vision and 1,533 pharmacy provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed 122 instances in which all 16 sample provider contracts failed to contain 1 or more 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	10	EF02-AHPVATB
§ 38.2-3407.15 B 2	10	EF02-AHPVATB
§ 38.2-3407.15 B 3	10	EF02-AHPVATB
§ 38.2-3407.15 B 4	16	EF01-AHPVATB
§ 38.2-3407.15 B 5	10	EF02-AHPVATB
§ 38.2-3407.15 B 6	10	EF02-AHPVATB
§ 38.2-3407.15 B 7	10	EF02-AHPVATB
§ 38.2-3407.15 B 8	10	EF02-AHPVATB
§ 38.2-3407.15 B 9	10	EF02-AHPVATB
§ 38.2-3407.15 B 10	10	EF02-AHPVATB
§ 38.2-3407.15 B 11	16	EF01-AHPVATB

SUMMARY

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 B of the Code. Anthem'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 Anthem in violation of § 38.2-510 A 15 of the Code.

In the prior Report, it was recommended that Anthem establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code. Due to the fact that violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code were discussed in the prior Report, the current violations of this section could be construed as knowing. Section

38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

PROVIDER CLAIMS

Section 38.2-510 A 15 of the Code prohibits as a general business practice the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

Professional and Facility

A sample of 287 from a total population of 12,026 claims processed under the 58 sample professional and facility provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 1 of the Code states that every carrier shall pay any clean claim within 40 days of receipt. As discussed in Review Sheet EFCL38-AN, the review revealed 1 violation of this section, where Anthem took 370 days to pay a clean claim. In the company's response, Anthem disagreed with the examiners' observation, indicating that the delay was due to a system issue. However, the claim was clean upon initial receipt and Anthem failed to pay this claim within 40 days, as required by this section.

Section 38.2-3407.15 B 3 of the Code requires that any interest due on a claim under § 38.2-3407.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. Section 38.2-3407.1 of the Code requires interest to be paid on claim proceeds at the legal rate of interest from the date 15 working days from the receipt of the proof of loss to the date of claim payment. The review revealed 9 instances where Anthem failed to pay interest due within 60 days of the claim payment, in violation of § 38.2-3407.15 B 3 of the Code. An example is discussed in Review Sheet EFCL05-AN, where Anthem failed to pay 35 days of interest due. Anthem agreed with the examiners' observations.

Section 38.2-3407.15 B 8 of the Code requires the provider contract to include the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid. The review revealed 4 instances where Anthem failed to allow the contracted amount, in violation of § 38.2-3407.15 B 8 of the Code. These 4 instances involved a total of \$1,234.17 in underpayments, ranging from \$0.80 to \$806.00 per claim. An example is discussed in Review Sheet EFCL27-AN, where Anthem reimbursed the provider \$520.00 instead of the contracted amount of \$1,326.00. Anthem agreed with the examiners' observations.

The review also revealed that Anthem allowed more than the contracted amount in 7 instances. These 7 instances involved a total of \$54.63 in overpayments, ranging from \$.03 to \$20.00 per claim. While allowing more than the contracted amount is not considered to be a violation of the Code, this practice may result in an increase in the coinsurance owed by the member on a given claim. Anthem is cautioned to the potential for future violations.

Vision

A sample of 53 from a total population of 1,092 claims processed under the 6 sample vision provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 4 (ii) (c) of the Code requires every carrier to establish and implement reasonable policies to permit any provider with which there is a provider contract to confirm provider-specific payment and reimbursement methodology. Section 38.2-3407.15 B 4 (ii) (d) of the Code requires every carrier to establish and implement reasonable policies to permit any provider with which there is a provider contract to confirm other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract. Section 38.2-3407.15 B 8 of the Code requires the provider contract to include the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid.

The review revealed 17 instances where Anthem failed to allow the contracted amount, in violation of §§ 38.2-3407.15 B 4 (ii) (c), 38.2-3407.15 B 4 (ii) (d), and 38.2-3407.15 B 8. In each instance, Anthem underpaid the provider by an amount that ranged between \$5 and \$15. An example is discussed in Review Sheet EFCL04-AHPVATB where Anthem underpaid the contractual allowance by \$15. Anthem disagreed with the examiners' observations and stated, "The schedule used for audit reflected incorrect reimbursement. Proper fee schedules were supplied in response to the examiner." The examiners would note that, during April 8, 2010, through April 20, 2010, Anthem provided the examiners with fee schedules from

EyeMed that it indicated were included with the vision provider contracts. On April 20, 2010, the examiners requested clarification regarding how information contained in the claim files corresponded to the information in the fee schedules. Anthem provided additional clarifying information to the examiners on April 21, 2010. However, on May 25, 2010, the examiners received a different set of fee schedules attached to Anthem's response to Review Sheet EFCL01-AHPVATB. The examiners sent Memo EFCLMEM01BW-AN on June 4, 2010, requesting that Anthem provide documentation confirming the delivery date of these fee schedules to the providers, as well as documentation of each provider's acceptance of the fee schedule, as outlined in the terms and provisions of the providers' contract. Anthem responded on June 21, 2010, stating:

Attached are the schedules that were communicated to the VA Blue View Vision providers in April 2006. Also attached is a Screen-shot from the EyeMed System, the [sic] EyeMed advised shows the date the communications were posted to the system. They were posted the evening of 4/12/2006 – which schedules them for transmission the following day 4/13/2006.

The examiners would comment that Anthem's response failed to provide documentation that would verify the date that the fee schedules were mailed to the providers in accordance with the amendment provisions of the contracts. Anthem's response documenting the date that the documents "...were posted into the system," and a description of what is scheduled to happen once a document is posted, is not sufficient. Therefore, Anthem failed to document that the vision provider contracts were amended to include the fee schedules provided in its response.

Pharmacy

A sample of 80 from a population of 11,534 claims processed under the 10 sample pharmacy provider contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims. The review revealed that Anthem was in substantial compliance.

SUMMARY

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, failing to comply with § 38.2-3407.15, or to perform any provider contract provision required by that section. Anthem's failure in 31 instances to perform the provider contract provisions required by § 38.2-3407.15 B of the Code, occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code.

Due to the fact that violations of §§ 38.2-3407.15 B 3, and 38.2-3407.15 B 8 (formerly 38.2-3407.15 B 7) of the Code were discussed in prior Reports, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties for knowing violations.

V. ADVERTISING/MARKETING COMMUNICATIONS

A review was conducted of Anthem'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 the regulations if it is determined by the Bureau of Insurance that an advertisement has the capacity or tendency to mislead or deceive 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 Anthem was in substantial compliance.

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 company which states that, to the best of his/her knowledge, information, and belief, the advertisements complied, or were made to comply in all respects with the provisions of these rules and

insurance laws of this Commonwealth. A copy of the required Certificate of Compliance was furnished to the examiners and was in substantial compliance.

A sample of 50 advertisements from a total population of 465 was selected for review. The review revealed that 8 of the 50 advertisements selected contained violations. In the aggregate, there were 9 violations, which are discussed in the following paragraphs.

14 VAC 5-90-55 B requires an invitation to inquire to contain a prominent disclaimer 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. 14 VAC 5-90-40 sets forth the requirement that all information required to be disclosed by Chapter 90 shall be set out conspicuously and in close conjunction with the statements to which the information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous fashion. Review Sheets AD02C-AN, AD03B-AN, AD06B-AN, AD07C-AN, AD08D-AN, AD14C-AN and AD15C-AN discuss 7 violations of this section. In each of the 7 instances, the disclaimer required under 14 VAC 5-90-55 B was not prominent or set out conspicuously due to the use of a significantly smaller font size than the rest of the text in the advertisement. Anthem disagreed stating:

We use the footnote approach for all our required disclosures on our invitation to inquire advertisements, and we keep the disclosures on the front of these abbreviated advertisements for the reasons the regulations contemplate: it's conspicuous, it's in close conjunction with the related message, and it keeps this information from being intermingled with message copy – All of

these things help us avoid ambiguity. We do not see this as minimizing. Changing this approach would jeopardize our meeting the regulation's definition of an invitation to inquire: "an advertisement having as its objective the creation of a desire to inquire further."

By definition, conspicuous means obvious or eye catching. The text of the required disclosure is nearly half the size of the text in the rest of the advertisement and is located at the bottom of the page, both of which contribute to its being inconspicuous and illegible to the average person. Increasing the font size of the disclaimer would not change this advertisement's classification as an invitation to inquire.

14 VAC 5-90-60 A 1 prohibits the omission or use of information, words, or phrases if such omission or use would have the capacity or tendency to mislead as to the nature or extent of a premium payable. The two violations of this section are discussed in Review Sheets AD01A-AN and AD08A-AN. The advertisement discussed in Review Sheet AD01A-AN includes a letter, addressed to the recipient, that is incorporated into a packet of information about Anthem's KeyCare Flexible Choice product. This advertisement includes the statement "It's affordable," which implies that the coverage would be considered "affordable" by the person to whom the advertisement was mailed. Anthem failed to substantiate this statement within the advertisement.

Anthem disagreed with the examiners observations citing correspondence with the Bureau dating back to 2003 concerning the use of the word "affordable" in its advertisements and stated, in part, that "Use of affordable falls within the scope, intentions, and substance of the 2003 Bureau-Anthem discussions." The correspondence referred to in Anthem's response included discussions about how and

under what circumstances the use of the word “affordable” in an advertisement would be considered a violation. The Bureau indicated that it would depend upon the context of the advertisement, and should not assure the recipient that he or she would consider the plan being advertised to be “affordable”.

The use of the statement “It’s affordable” in the context of the direct mailing discussed in Review Sheet AD01A-AN indicates that the coverage will be considered affordable by the recipient, which does not fall within the guidelines presented in the discussions with Anthem in 2003. The monetary impact of the premium is relative to the affected individual’s ability to pay. Anthem’s use of the word “affordable” in the context of this advertisement is considered to have the capacity or tendency to mislead or deceive.

SUMMARY

Anthem violated 14 VAC 5-90 40 and 14 VAC 5-90-60 A 1 placing it in violation of Subsection 1 of § 38.2-502 and § 38.2-503, of the Code.

VI. POLICY AND OTHER FORMS

Although a formal review of policy forms was not performed, the examiners reviewed the policy forms contained in the claim files to determine if Anthem complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Section 38.2-3407.4 A of the Code requires that each insurer file its explanation of benefits (EOB) forms with the Commission for approval. Section 14 VAC 5-100-50 3 states, in part, that a form must be submitted in the final form in which it is to be marketed or issued. The examiners' review of 150 sample vision claims processed on Anthem's behalf by its vision intermediary revealed that the explanation of benefits (EOB) form issued to Anthem's members had been altered since it was filed for approval. These violations are discussed in Review Sheet CL02VISION-AN. Anthem's use of an EOB that had not been filed with and approved by the Commission, places Anthem in violation of § 38.2-3407.4 A of the Code in 150 instances. Anthem agreed with the examiners' observations.

Due to the fact that violations of § 38.2-3407.4 A of the Code were discussed in the prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties for knowing violations.

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

The examination included a review of Anthem'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 Anthem's underwriting guidelines were unfairly discriminatory, whether applications were underwritten in accordance with Anthem's guidelines, and whether correct premiums were being charged.

UNDERWRITING REVIEW

A sample of 100 from a population of 18,682 individual policies underwritten and issued during the examination time frame was selected for review. The review revealed that Anthem was in substantial compliance with its underwriting guidelines and no unfair discrimination was found.

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. Anthem was in substantial compliance with this section.

MECHANICAL RATING REVIEW

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

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. Anthem furnished a NIP form as part of the application and was in substantial compliance with this section.

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 substantial compliance with this section.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that in the event of an adverse underwriting decision, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission. Section 38.2-610 B of the Code requires the insurer, upon receipt of a written request within 90 business days from the date of mailing of the notice of AUD, to furnish to such person within 21 business days from the date of receipt of the request, the specific reasons for the AUD and the specific items of personal and privileged information that support those reasons. As discussed in Review Sheet UN08-AN, the review revealed that Anthem's AUD notice, and Anthem's procedures for providing the required AUD notice, failed to comply with this section. Anthem's AUD notice allows the applicant to submit written request for additional information within 90 business days of the "date of the letter attached to this notice." Anthem advised the examiners of the following in regards to its AUD mailing procedures:

Letters are created on a daily basis and are loaded in a queue to be printed each day. The letters print at 6:00 a.m. for all letters that were generated on the previous day.

The letters cannot be held where the difference between the date the letter was created and the date the letter was actually mailed is greater than one day. If this occurs for any reason, the letter is re-created with the current date so there is not more than one day (date) difference between letter creation and mailing.

Section 38.2-610 B of the Code requires that the applicant be given 90 business days from the date of the mailing of the notice. The AUD letter discussed in this review sheet was mailed two or more days after the letter was generated/dated, thereby allowing the recipient less than 90 days to submit a written request for the specific

reasons for the AUD, placing Anthem in violation of this section. Anthem agreed with the examiners' observations.

COPY

VIII. PREMIUM NOTICES/REINSTATEMENTS/POLICY LOANS AND LOAN INTEREST

Anthem's practices for the billing and collection of premiums and reinstatements were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM NOTICES

The examiners were provided with premium billing procedures used during the examination time frame. The procedures indicate that premium payment is due on or before the 1st of the coverage month. On as close to the 15th day of each month as possible, the Billing Supervisor runs a series of system reports and computer jobs during the bill generation process. The bills are printed, inserted and mailed. The review revealed that Anthem was in substantial compliance with its procedures.

Section 38.2-3407.14 A of the Code requires an insurer to provide prior written notice of intent to increase premiums by more than 35%. Section 38.2-3407.14 B of the Code requires that the notice be provided in writing at least 60 days prior to the proposed renewal of coverage.

Group

The examiners were informed that the standard process for group renewals in the 15-99 market is to deliver a copy of the renewal to the Agent of Record, via the Anthem Sales Representative, at least 3 weeks prior to the 60 day notification period to allow the Agent to deliver the renewal to the customer. The lead-time of 3 weeks is designed to provide the Agent adequate time to deliver and advise his client of the

renewal notification. In addition, Underwriting mails the legal notification directly to the customer 4 working days prior to the end of the month, preceding the 60-day notification date, to ensure that the customer has received notification as required by law.

The examiners reviewed the total population of 18 large group renewals and a sample of 100 from a total population of 10,696 small group renewals. The review revealed that Anthem failed, in 6 instances, to provide the group with the required 60-day advance written notice of a premium increase of greater than 35%, in violation of § 38.2-3407.14 B of the Code.

An example is discussed in Review Sheet PB15-AN where a group renewal with an increase in premium of 35.7% was to be effective on May 1, 2008. In this instance, Anthem failed to provide evidence that prior written notice of intent to increase premiums by more than 35% was sent to the group. Anthem disagreed with the examiners' observations and referred the examiners to an e-mail message from an agent dated March 9, 2009, stating that the agent did not have in his possession an e-mail from Anthem concerning the renewal (the previous year), but he would have mailed it to the client within 3 days. While this note in the file explains the agent's notification procedures, Anthem could not document that 60 days prior written notice of the premium increase greater than 35% was provided to the group, placing Anthem in violation of § 38.2-3407.14 B of the Code.

Individual

Anthem's renewal process is to generate letters that are:

"...printed with the month and year that is the 3rd month prior to the actual renewal. By mailing the [sic] before the end of the third month prior, it ensures at least 60 days of notification. An August 1st renewal requiring

60 day notification will mail, for example, in May. If that letter mails at ANY time in the month of May, it has beaten the 60 day requirement. System restraints prevent printing the specific date.”

A sample of 25 from a total population of 299 individuals receiving a premium increase greater than 35% at renewal was reviewed. The review revealed that Anthem was in substantial compliance with its procedures and § 38.2-3407.14 of the Code.

REINSTATEMENTS

The examiners reviewed a sample of 75 from a total population of 7,126 approved reinstatements and a sample of 25 from a total population of 242 denied reinstatements processed during the examination time frame.

Anthem’s billing procedures state that a Notice of Cancellation is produced 45 days after the due date; however, the review revealed 6 instances of non-compliance with Anthem’s established billing procedures. Review Sheets PB19-AN, PB20-AN, PB21-AN, PB22-AN and PB23-AN discuss 6 instances in which Anthem sent a Cancellation Notice more than 45 days after the due date. In each case, Anthem disagreed with the examiners’ observations and responded that coverage had previously been reinstated or a billing adjustment made, thereby changing the due date. Anthem advised the examiners of the “new” due dates, making each cancellation 45 days after the due date, in compliance with its procedures. In each case, however, Anthem failed to provide any documentation confirming the previous reinstatement or billing adjustment or the resulting new bill date. Therefore, Anthem was in non-compliance with its established procedures in each instance.

IX. CANCELLATIONS/NONRENEWALS

The examination included a review of Anthem's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions and the requirements of § 38.2-508 of the Code covering unfair discrimination.

Individual Cancellations

A sample of 100 from a total population of 5,197 individual contracts terminated during the examination time frame of was selected for review. The review revealed that Anthem was in substantial compliance with its established procedures and contract provisions.

Individual Rescissions

The total population of 40 individual policies rescinded during the examination time frame was reviewed. The review revealed substantial compliance with Anthem's established procedures.

X. COMPLAINTS

Anthem'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."

The examiners reviewed a sample of 81 from a population of 1,266 written pre-service, post-service and contractual appeals; a sample of 10 from a population of 35 expedited appeals; a sample of 16 from a population of 142 executive inquiries; a sample of 21 from a population of 39 written complaints; and the total population of 1 non-MCHIP complaint received during the examination time frame.

Section 38.2-508 2 of the Code states that no person shall unfairly discriminate or permit any unfair discrimination between individuals of the same class and of essentially the same hazard (i) in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance, (ii) in the benefits payable under such policy or contract, (iii) in any of the terms or conditions of such policy or contract, or (iv) in any other manner.

As discussed in Review Sheet CP01-AN, the review revealed 1 violation of this section. Two of the sample appeal files involved claim denials for dental services. Both members were within 1 month of meeting a contractually imposed waiting period. One

member's claim for simple/restorative services that was originally denied, was reversed upon appeal despite not having met the waiting period. The other member, who had also not satisfied the waiting period, but had received major restorative services, had his appeal denied. Anthem responded that appeal representatives are allowed to make exceptions based on each individual case. Anthem stated further that over the past year the Company has reviewed their guidelines on exceptions and subsequently written a guideline, related to waiting periods, to assure consistency. The guideline, when implemented, will limit members who receive dental services prior to satisfying a waiting period a 15-day grace period. Anything over 15 days will be denied.

The examiners have noted Anthem's efforts to ensure consistency in the future; however, in this instance, Anthem unfairly discriminated against the second member in determining the benefits payable under the policy or contract, placing Anthem in violation of this section.

XI. CLAIM PRACTICES

The examination included a review of Anthem's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of group, individual, essential and standard, Medicare supplement, mental health, dental, vision and pharmacy claims. All claims were processed internally, with the exception of claims for dental and vision services. Dental claims are processed in Colorado Springs by Anthem Dental Vision, another subsidiary of Wellpoint, Inc. Anthem has contracted with intermediaries for the processing of its claims for vision services. Anthem's contract with Davis Vision, Inc. terminated on December 31, 2007; however, Davis continued to process claims with dates of service prior to the contract termination date during the examination time frame. Anthem also contracts with EyeMed Vision Care, LLC.. A sample of vision claims processed by both Davis Vision, Inc. and EyeMed Vision Care, LLC were reviewed.

The review also included claims that had been processed through the "Inter-Plan Teleprocessing Services" (ITS), a nationwide electronic telecommunications system of Blue Cross Blue Shield Plans to handle out-of-area and national account claims. ITS claims were included in the samples selected for review.

Claim populations were requested by line of business and by the amount of the claim payment.

PAID CLAIM REVIEW

Group

Essential and Standard

Essential and standard plans as filed with the Commission are required to be offered to all small groups of 2-50 eligible employees.

A sample of 30 was selected from a total population of 171 essential and standard claims paid during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Small Groups

A sample of 110 was selected from a total population of 1,099,429 small group claims paid during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to a claimant or enrollee under an accident and sickness insurance policy, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code requires that an EOB shall accurately and clearly set forth the benefits payable under the contract. Review Sheet CL15L-AN discusses 1 violation of each of these sections. Within a 20-day time period, Anthem sent the member 2 EOBs for services provided on the same date by the same facility provider, but each EOB listed a different claim number. The first EOB indicated a total charge of \$96,340.00, an allowable charge of \$1,935.00, a paid amount of \$1,161.04, and member responsibility of

\$95,178.98. The second EOB listed the same allowable charge, but the total charge increased to \$98,390.00 and the amount paid increased by \$0.02. This EOB did not explain why the total charge was higher than on the original submission, why the allowable charge remained unchanged, or why the amount paid increased by \$0.02. The second EOB also showed the original claim number voided out, and informed the patient that \$2,080.00 is “WHAT YOU MAY OWE PROVIDER(S).” Based on the information provided on the EOB, the member could have reviewed the second EOB, thought it was a correction, and reasonably believed that the only member liability was \$2,080.00. However, based on Anthem’s processing of this claim, the member could in fact be held liable for a total of \$97,228.96. As such, Anthem failed to provide an EOB that clearly and accurately disclosed the method of benefit calculation and the benefits payable under the contract. Anthem agreed with the examiners’ observations and stated, in part,

Please note that the potential for such a misunderstanding was previously identified and, February 2009, Operations submitted a Small Systems Change Request (SSCR 5375) to modify the way patient liability is displayed on EOBs. Due to resource and SSCR funding constraints, the work has been deferred for this year – meaning it will not be completed in 2009. That said, a formal project to redesign VA’s EOB (targeting delivery sometime in 2010) is currently being sized/estimated. Enhancements would include correcting the display of patient liability.

To date, the examiners have not been advised of whether the referenced project has been scheduled or completed by Anthem.

Unfair claim settlement practices and additional violations related to Anthem’s EOBs revealed during the examiners’ review of paid small group claims are discussed in subsequent sections.

Large Groups

A sample of 65 was selected from a total population of 1,124,288 large group claims paid during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Individual

Personal Health Care

A sample of 100 was selected from a total population of 941,132 individual claims paid during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Medicare Supplement

A sample of 90 was selected from a total population of 2,055,826 Medicare Supplement claims paid during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to a claimant or enrollee under an accident and sickness insurance policy, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed 21 violations of this section. An example is discussed in Review Sheet CL53J-AN, where the EOB discloses the total charges and the amount Anthem paid to the provider, but fails to disclose the method of benefit calculation. The EOB also states that "the non-

covered amount is based upon a benefit plan or policy maximum;” however, the EOB does not notify the insured that he could be responsible for \$58.50 as a result. Based on the lack of information provided on the EOB, the insured could reasonably conclude that he is responsible for the difference between the charges and the paid amount, which would be \$4,652.26 more than he could actually be held responsible for. In response, Anthem argued that the EOB had been filed with and approved by the Commission. While the examiners confirmed that the EOB was approved by the Commission prior to use as required by § 38.2-3407.4 A of the Code, multiple sections of the EOB were marked as variable. Since Anthem allowed for variations of the form, the EOB must be reviewed in connection with different types of claims to determine compliance with § 38.2-514 B of the Code. The examiners’ review of the claim discussed in Review Sheet CL53J-AN revealed that Anthem failed to accurately and clearly disclose the method of benefit calculation in this instance, placing Anthem in violation of this section.

Unfair claim settlement practices are discussed in a subsequent section.

Mental Health

While the review revealed that the sample claims were processed according to the terms of the policy and Anthem’s established procedure, unfair claim settlement practices and additional violations related to Anthem’s explanations of benefits are discussed in subsequent sections.

Vision

A sample of 8 was selected from a total population of 16 vision claims processed and paid by Davis Vision Inc. during the examination time frame, and a sample of 100

was selected from a total population of 54,342 vision claims processed and paid by EyeMed Vision Care LLC during the examination time frame.

While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices are discussed in a subsequent section.

Dental

A sample of 130 was selected from a population of 95,881 dental claims paid during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Pharmacy

A sample of 77 was selected from a total population of 3,796,755 pharmacy claims paid during the examination time frame. The review revealed that the sample claims were processed according to the terms of the policy and established procedures.

Interest

Section 38.2-3407.1 of the Code requires that a company pay interest on claim proceeds from the 15th working day following receipt to the date of the claim payment. Interest is not payable on claims "for which payment has been or will be made directly to health care providers pursuant to a negotiated reimbursement arrangement requiring uniform or periodic interim payments to be applied against the insurer's obligation on such claims." In prior Reports it was recommended that Anthem strengthen its

procedures and controls to assure that all interest payable on claim proceeds is properly calculated and paid, for compliance with § 38.2-3407.1 of the Code.

Of the 1,244 claims reviewed by the examiners, there were 34 claims where statutory interest was required to have been paid. In 19 instances, Anthem paid the required amount of interest. In 15 instances, Anthem failed to pay interest as required, placing Anthem in violation of § 38.2-3407.1 B of the Code in each instance.

Due to the fact that violations of § 38.2-3407.1 B of the Code were discussed in prior Reports, the current violations of this section could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties for knowing violations. In addition, Anthem is in violation of the Commission’s Order to cease and desist issued November 19, 2004. Section 12.1-33 of the Code sets forth the penalties for such violations.

TIME PAYMENT STUDY

The time payment study computed by measuring the time it took Anthem, after receiving the properly executed proof of loss, to issue a check for payment. The term “working days” does not include Saturdays, Sundays, or holidays.

PAID CLAIMS			
<u>Claim Type</u>	<u>Working Days To Pay</u>	<u>Number of Claims</u>	<u>Percentage</u>
Essential and Standard	0-15	29	96.7%
	16-20	1	3.3%
	Over 20	-	-
Small Group	0-15	108	98.2%
	16-20	1	.9%
	Over 20	1	.9%

Large Group	0-15	62	95.4%
	16-20	1	1.5%
	Over 20	2	3.1%
Individual	0-15	100	100%
	16-20	-	-
	Over 20	-	-
Medicare Supplement	0-15	86	95.6%
	16-20	4	4.4%
	Over 20	-	-
Mental Health	0-15	43	86%
	16-20	4	8%
	Over 20	3	6%
Dental	0-15	123	94.6%
	16-20	3	2.3%
	Over 20	4	3.1%

Of the 760 claims reviewed for the time payment study, the review revealed that for the group claims, 3% were not paid within 15 working days; for individual claims, 0% were not paid within 15 working days; for Medicare Supplement claims, 4.4% were not paid within 15 working days; for mental health claims, 14% were not paid within 15 working days; and for the dental claims, 5.4% were not paid within 15 working days. Of the sample vision and pharmacy claims reviewed, 100% were paid within 15 working days.

DENIED CLAIM REVIEW

GROUP

Essential and Standard

A sample of 7 was selected from a total population of 48 essential and standard claims denied or adjusted during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy

and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Small Group

A sample of 41 was selected from a total population of 251,072 small group claims denied or adjusted during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Large Group

A sample of 49 was selected from a total population of 267,115 large group claims denied or adjusted during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide to a claimant or enrollee under an accident and sickness insurance policy, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code requires that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed 3 violations of each of these sections. An example is discussed in Review Sheet CL07BL-AN, involving the adjustment of a claim that was initially approved and paid. While the claim was denied during the reprocessing, the EOB sent to the member only showed Anthem's retraction of the claim payment. The EOB failed to provide any information describing how benefits payable under the contract were ultimately applied or the method of benefit calculation. Anthem agreed with the examiners' observations.

Section 38.2-3405 A prohibits subrogation of any person's right to recovery for personal injuries from a third person. As discussed in Review Sheet CL22BL-AN, the review revealed 1 violation of this section, where Anthem subrogated during the reprocessing of a previously paid claim. Anthem disagreed with the examiners' observations, stating the following:

The Host plan was advised that this claim was paid in full. It then advised Anthem to retract this claim. Due to an inadvertent error, Anthem retracted the claim. Yesterday, the the [sic] host plan was requested to reprocess this claim. There was no subrogation and no case was ever opened.

Anthem's response to CL07BL-AN, a previously submitted Review Sheet regarding this claim, included the statement "Claim retracted due to auto insurance paying the claim in full." The examiners would comment that no documentation was provided to indicate a different reason for the retraction, and that Anthem is ultimately responsible for the course of action taken despite instruction from the host plan. Based on this information, subrogation occurred within the processing of this claim, placing Anthem in violation of this section.

Unfair claim settlement practices and additional violations related to Anthem's EOBs are discussed in subsequent sections.

INDIVIDUAL

Personal Health Care

A sample of 35 was selected from a total population of 224,522 individual claims denied or adjusted during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Medicare Supplement

A sample of 71 was selected from a total population of 471,704 Medicare Supplement claims denied or adjusted during the examination time frame. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices and violations related to Anthem's EOBs are discussed in subsequent sections.

Mental Health

A sample of 40 was selected from a total population of 49,149 mental health claims denied or adjusted during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide an explanation of benefits that does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Section 38.2-3407.4 B of the Code states that an explanation of benefits shall accurately and clearly set forth the benefits payable under the contract. Review Sheet CL02BW-AN discusses 1 violation of each of these sections. After Anthem received this claim, and while the claim was being processed for payment, Anthem received notification that the group terminated its coverage prior to the date of service. Contrary to the eligibility information in Anthem's system, the claim was processed for payment and an EOB indicating such was mailed to the member. Several months later, Anthem re-opened and adjusted this claim to retract the payment. Anthem sent another EOB to the insured that did not provide the reason for the adjustment and subsequent denial. In addition, instead of showing that benefits were denied and that the member was responsible for the entire charge, the EOB showed negative amounts in each

column. As such, the second EOB did not clearly set forth the benefits payable under the contract or the method of benefit calculation. Anthem did not agree with the examiners' observations regarding this claim but failed to address this issue in its response.

Unfair claim settlement practices are discussed in a subsequent section.

Vision

The total population of 1 vision claim denied by Davis Vision Inc. during the examination time frame and a sample of 50 from a total population of 2,111 vision claims denied or adjusted by EyeMed Vision Care LLC during the examination time frame was selected for review. While the review revealed that the sample claims were processed according to the terms of the policy and Anthem's established procedures, unfair claim settlement practices are discussed in a subsequent section.

Dental

A sample of 142 was selected from a total population of 43,255 dental claims denied or adjusted during the examination time frame.

Section 38.2-514 B of the Code states that no person shall provide an explanation of benefits that does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. Review Sheet CL36J-AN discusses 1 violation of this section. In this instance, Anthem received a second claim submission from a provider for services that had already been considered for payment. Instead of processing the claim as a duplicate submission, Anthem denied the claim and sent the member an EOB stating

“This charge could not be covered, since this dental service is excluded under your Anthem benefit plan or policy.” The EOB also indicated that the member could be held responsible for the entire charge. As such, the EOB failed to accurately and clearly disclose the actual amount that had been paid to the provider for these services. Anthem agreed with the examiners’ observations.

Unfair claim settlement practices are discussed in a subsequent section.

Pharmacy

A sample of 48 was selected from a total population of 407,577 pharmacy claims denied or adjusted during the examination time frame. The review revealed that the sample claims were processed according to the terms of the policy and Anthem’s established procedures.

EXPLANATION OF BENEFITS (EOB)

The examiners’ review of sample claims for all lines of business revealed several business practices and procedures that do not support compliance with §§ 38.2-514 B and 38.2-3407.4 B of the Code. These violations are discussed in the following paragraphs.

Suppressed EOBs

Anthem has an established procedure to create 2 EOBs for a claim when the member could be held liable for all or part of the charge for certain procedures but is determined to either owe only a copay or has \$0 responsibility for the other procedures. The examiners reviewed 36 claims where Anthem’s procedure of suppressing EOBs did not comply with §§ 38.2-514 B and 38.2-3407.4 B of the Code. An example is discussed in Review Sheet CL06J-AN, where Anthem received a claim with 5

procedure codes listed separately by claim line. For this claim, Anthem approved payment for 4 procedure codes and denied one procedure code. Anthem suppressed the EOB that included the 4 procedures that were paid at 100% of the allowable charge. The only procedure included on the EOB sent to the member was the denied procedure. The denial reason on the EOB stated, "Payment for this procedure was included in the allowance for a related procedure performed on the same day," but the EOB did not include the related procedures for which benefits were paid, and it is not clear which other procedure Anthem is referring to in the denial reason on the EOB.

Anthem disagreed, stating:

Anthem considers each electronically submitted line (procedure code) a claim. In the instance referenced in CL06J-AN the member EOB did clearly and accurately show the benefits payable under the contract as required by Sections 38.2-3407.4 B because there was no separate benefit payable for the identified procedure code (claim/line). In addition, the denial code was reasonable because it accurately reflected the reason for the denial as required by 14 VAC 5-400-70 B. In addition, the EOB clearly and accurately disclosed the method of benefit calculation and the actual amount that was paid to the provider as required by Section 38.2-514 B of the Code because no separate benefit was payable and the procedure code (claim/line) was denied.

The observation that the examiners make involves claims filed by a provider, which are almost always filed electronically because of federal requirements. Providers file multiple claim lines in a single transaction called an 837 transaction. The provider, as the claimant, gets all claim line payment information on a remittance. Members get EOB's that tell them what their remaining liability is, if there is one. As a result, an EOB will only show denied claims and claims for which there is member liability because of denial or coinsurance. Members have the ability to see all claims lines, even those without member liability online, and can request paper copies of EOB information for all claim lines if they need to. Generally, members do not request this information because the provider bills reflect remaining balances which are consistent with the EOB's for the claim lines which are initially mailed.

While Anthem states that "Anthem considers each electronically submitted line (procedure code) a claim," only one claim number is assigned to all of the procedure

codes submitted by a provider on one claim form, regardless of whether the claim form is received electronically or on paper. Benefits are determined for each billed procedure based on several factors, to include consideration of the other procedures that were performed and submitted on the same claim form. The denial reason given for the claim discussed in Review Sheet CL06J-AN clearly indicates that one claim line was denied because Anthem approved payment for a related procedure performed on the same day. Neither EOB includes the entire claim, and neither EOB advises the member that a portion of the claim is on a different EOB. The member receives nothing showing the complete benefit calculation or the total benefits paid. Access to additional EOBs online or through a request made to a member services representative does not remedy the failure of the EOB that Anthem actually sent to the member to clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider, and the benefits payable under the contract.

Another example is discussed in Review Sheet CL68J-AN, where the EOB sent to the member includes the procedure for which 20% coinsurance is owed in the amount of \$6.90, and the EOB that was suppressed includes the procedure for which the \$30 copay is owed. The member was actually responsible for \$36.90, between the copay and coinsurance owed on this claim, but was only notified by Anthem of the \$6.90 of coinsurance owed. It is reasonable to assume that the member may believe that her responsibility is less than the \$30 copay, and is owed a refund from the provider. In addition, the EOB sent to the member did not disclose to the member that Anthem also paid \$127.08 for the consultation that was listed on the suppressed EOB. By failing to include both lines on the EOB, Anthem failed to clearly and accurately

disclose the method of benefit calculation and the amount paid to the provider and failed to accurately and clearly set forth the benefits payable under the contract.

Facility Claims

When Anthem processes a claim for health care services received at a facility, the EOB that is sent to the member does not display how the benefit payable was calculated, nor does it explain how the member's responsibility was determined. Due to this lack of information on the EOB, the examiners review of facility claims revealed 7 violations of §§ 38.2-514 B and 38.2-3407.4 B of the Code. An example is discussed in Review Sheet CL14BL-AN, involving a 15 line facility claim. Claim lines 1 through 7 and a portion of line 8 were paid at 80%, and the remaining lines were paid at 100% due to the member's out of pocket maximum being met; however, no breakdown was provided on the EOB as to which charges were paid at 80% and which were paid at 100%. Anthem disagreed with the examiners' observations, stating that the company's EOBs for facility service claim lines do not display the coinsurance percentage and that each policyholder receives a schedule of benefits outlining the percentage of payment applicable to the policy upon enrollment. The examiners responded that, as the Code requires an EOB to clearly and accurately disclose the method of benefit calculation, the failure of the EOB in question to break down any of the charges or show the coinsurance or benefit percentage paid on any of the lines places Anthem in violation of these sections.

Residential Treatment Facility (RTF) Claims

In response to complaints received by the Consumer Services Section of the Life and Health Division, a sample of claims for health care services received at Residential

Treatment Facilities (RTF) was selected for review. Through the examiners' review of 5 RTF claims, and subsequent correspondence and conversations with Anthem, it was revealed that Anthem has a procedure in place for calculating the "allowable charge" on claims submitted by non-participating facilities that is not disclosed in Anthem's policies or certificates of coverage. The examiners also determined that the EOBs sent by Anthem in these situations failed to clearly and accurately disclose the method of benefit calculation or the benefits payable under the terms of the contract, in violation of §§ 38.2-514 B and 38.2-3407.4 B of the Code. The examiners review of the 5 sample RTF claims revealed 4 violations of each section.

Anthem explained that the first step in its "allowable charge" calculation is the determination of the number of days for which inpatient treatment is covered under the member's policy. This number is then multiplied by a pre-determined per diem rate, which accounts for the covered services provided at the facility. From that amount, Anthem deducts the total charge for any non-covered services to determine Anthem's allowable charge. The allowable charge is then used as the basis for determining the member's responsibility and Anthem's payment. An example is discussed in Review Sheet CL82J-AN. In this instance, the \$724 per diem was multiplied by 60 days, equalling \$43,440. The charges for the 3 procedures that were determined to be non-covered totaled \$16,186, which was subtracted from the per diem amount. Based on this calculation, Anthem's allowable charge was \$27,254. Under the terms of her policy, the member was responsible for a \$500 deductible and \$4,000 in coinsurance, and because the services were received at a non-participating facility, the member is also responsible for the difference between the allowable charge of \$27,254 and the total

charges of \$171,581.53. Therefore, based on Anthem's calculation, the amount that the member could be held responsible for is \$148,827.53. While the EOB displays the allowable charge, the amount paid and the member responsibility, it does not accurately and clearly disclose the method of benefit calculation explained above or the benefits payable under the terms of the contract, in violation of §§ 38.2-514 B and 38.2-3407.4 B of the Code.

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 1,244 paid, adjusted and denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-30 - In 1 instance, the insurer's claim files did not contain all notes and work papers in such detail that events and dates of events could be reconstructed. This example is discussed in Review Sheet CL41BW-AN.

14 VAC 5-400-40 A - In 56 instances, Anthem misrepresented insurance policy provisions related to the coverage at issue.

An example is discussed in Review Sheet CL23J-AN, where Anthem denied a claim for an office visit with a family physician, and notified the member that "This charge could not be covered, since this dental service is excluded under your Anthem benefit plan or policy." While the physician diagnosed the patient as having an abscessed tooth, the service provided was a medical office visit for an evaluation and management of an established patient, which is a covered benefit under the terms of the member's policy. Anthem disagreed with the examiners' observations and provided

additional information regarding the processing of this claim. The claim was denied twice before the provider sent in additional notes that were sent to medical review. Based on these notes, it was determined that the claim should be processed as medical and not dental, and Anthem changed the diagnosis code accordingly in order to process the claim for payment. While the examiners acknowledge that Anthem re-opened and paid this claim, the initial denial misrepresented insurance policy provisions. The member's coverage excludes benefits for dental services, such as treatment of natural teeth due to diseases. However, the medical provider did not submit a claim for treatment of the abscessed tooth, only an office visit for the evaluation and management of an established patient, which is a covered benefit under the terms of the policy.

14 VAC 5-400-50 A - In 59 instances, claims were not acknowledged within 10 working days. Review Sheet CL17L-AN provides an example.

14 VAC 5-400-60 A - In 158 instances, Anthem failed to notify the member, who was the first party claimant in each instance, of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss. An example is discussed in Review Sheet CL05L-AN where Anthem took 17 working days to pay the claim and suppressed the EOB which would have advised the claimant that the claim was paid. As a result, the claimant was never notified of Anthem's acceptance of the claim. Anthem disagreed with the examiners' observations and referred to their internal guideline which permits the suppression of EOBs when the claim was paid at 100% or the member was only responsible for a copay. While Anthem complied with its established guideline in this instance, the procedure itself does not permit compliance

with the requirements set forth in 14 VAC 5-400-60 A. This section requires Anthem to notify all first party claimants of the acceptance of the claim within 15 working days of receipt of complete proof of loss and does not permit any exceptions to this requirement.

14 VAC 5-400-60 B - In 4 instances, a claim investigation was not completed within 45 days from the date of notification of the claim, and Anthem failed to send the claimant a letter setting forth the reason additional time was needed for investigation. Review Sheet CL25J-AN provides an example.

14 VAC 5-400-70 B - In 55 instances, Anthem failed to include a reasonable explanation of the basis for denial in the written denial. An example is discussed in Review Sheet CL33J-AN, where Anthem provided the member with an EOB stating the reason for the denial as "We have forwarded your routine dental claim to HMS." However, the dental services were performed as the result of injuries sustained during an accident, which are covered under the member's medical benefits and should have been processed for payment by Anthem upon initial receipt. The EOB also noted that the member may be responsible for the entire billed charge, in error. While Anthem did re-process and pay the claim several days later, the EOB that went to the member initially failed to include a reasonable explanation for the denial of the claim. Anthem agreed with the examiners' observations.

14 VAC 5-400-70 D - In 26 instances, Anthem failed to offer a claimant an amount which is fair and reasonable in accordance with policy provisions. An example is discussed in Review Sheet CL50BW-AN, where a claim was denied due to coverage not being in effect on the date of service. The member's coverage was subsequently

approved, with an effective date prior to the date of service of the claim, yet Anthem failed to reverse the denial and pay the claim.

The violations of 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice placing Anthem in violation of §§ 38.2-510 A 5 of the Code. These violations were also cited in a previous report and are considered knowing violations. Section 38.2-218 of the Code sets forth penalties that may be imposed for knowing violations. In addition, Anthem is in violation of the Commission's Order to cease and desist issued November 19, 2004. Section 12.1-33 of the Code sets forth the penalties for such violations.

THREATENED LITIGATION

The total population of 6 files involving threatened litigation was reviewed. The review revealed that Anthem handled the files in substantial compliance with its procedures and policy provisions.

XIII. CORRECTIVE ACTION PLAN

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

Anthem shall:

1. Review its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by § 38.2-5804 A of the Code;
2. As recommended in prior Reports, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;
3. Establish and implement written procedures to ensure that a provider will be allowed the full 30 days from receipt of an amendment to notify Anthem of intent to terminate the contract in the event that there is a delay in receiving notification, as required by § 38.2-3407.15 B 9 of the Code;
4. As recommended in prior Reports, establish and maintain procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;
5. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;

6. As recommended in the prior Report, establish and maintain procedures to ensure that its Explanation of Benefits forms are filed with and approved by the Commission, as required by §38.2-3407.4 A of the Code;
7. Revise its procedures and/or its adverse underwriting decision notices to ensure compliance with the requirements of § 38.2-610 B of the Code;
8. Establish and maintain procedures to comply with and to document compliance with § 38.2-3407.14 of the Code;
9. Establish and maintain procedures to ensure that all established billing procedures are followed and documented;
10. Establish and maintain procedures to ensure that no person unfairly discriminates or permits any unfair discrimination between individuals of the same class and of essentially the same hazard in the benefits payable under such policy or contract, to ensure compliance with § 38.2-508 2 of the Code;
11. Re-open and reprocess the denied claim discussed in Review Sheet CP01-AN. Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;
12. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;

13. As recommended in prior Reports, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 of the Code;
14. Review and reopen all adjusted dental claims where interest was due for the years 2006, 2007, 2008, 2009, 2010 and the current year and make interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send checks for the required interest along with letters of explanation stating, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been previously paid". After which, furnish the examiners with documentation that the required interest had been paid within 90 days of this Report being finalized;
15. Establish and maintain procedures to ensure compliance with § 38.2-3405 of the Code;
16. Review all claims submitted by non-participating facilities where the allowable charge was based on a per diem and then reduced by the charges for non-covered services during 2006, 2007, 2008, 2009, 2010 and the current year and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;

17. Immediately amend its policies to disclose Anthem's calculation for services received at a non-participating facility and reimbursed on a per diem basis to all affected policyholders and certificateholders;
18. As recommended in the prior Report, review its established procedures to ensure that its claim files contain all notes and work papers pertaining to a claim in such detail that pertinent events and dates can be reconstructed, as required by 14 VAC 5-400-30;
19. As recommended in the prior Report, review its established procedures to ensure that policy provisions, benefits or coverages are not obscured or concealed from a claimant, when such provisions are pertinent to a claim, as required by 14 VAC 5-400-40 A;
20. Revise its procedures to ensure that claims are processed in accordance with the terms of its policies and procedures, and that claim denials are not based solely on the diagnosis code submitted on the claim form;
21. Review all denied claims processed during 2006, 2007, 2008, 2009, 2010 and the current year where the diagnosis code submitted on the claim form was dental related and the only procedure code listed involved a medical office visit for the evaluation and management of an established patient and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of

22. the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;
23. As recommended in the prior Report, review its established procedures to acknowledge receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;
24. Revise its established procedures to ensure that each member is notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;
25. As recommended in the prior Report, review its established procedures to ensure that notification is sent every 45 days, as required by 14 VAC 5-400-60 B;
26. As recommended in the prior Report, review its established procedures to ensure that the claimant is provided a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B; and
27. As recommended in the prior Report, review its established procedures to ensure that it offers an amount which is fair and reasonable as shown by the investigation of the claim, as required by 14 VAC 5-400-70 D.

XIV. ACKNOWLEDGMENT

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

Julie Fairbanks, AIE, AIRC, FLMI, ACS, Bill Benson, FLMI, AIE, ACS, Todd Bryant, HIA, MHP, Daedre Holland, Brant Lyons, Bryan Wachter, FLMI, AIE, AIRC, and Laura Wilson, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Supervisor, Market Conduct Section II
Life and Health Division
Bureau of Insurance

IX. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED HEALTH CARE INSURANCE PLANS (MCHIPS)

§ 38.2-5804 A, 1 violation, CP06-AN

ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

Provider Contracts

§ 38.2-3407,15 B 1, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407,15 B 2, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407,15 B 3, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407,15 B 4, 17 violations, EF02-AN, EF01-AHPVATB (6), EF02-AHPVATB (10)

§ 38.2-3407,15 B 5, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407,15 B 6, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407,15 B 7, 11 violations, EF02-AN, EF02-AHPVATB (10)

§ 38.2-3407,15 B 8, 11 violations, EF04-AN, EF02-AHPVATB (10)

§ 38.2-3407,15 B 9, 12 violations, EF02-AN, EF11-AN, EF02-AHPVATB (10)

§ 38.2-3407.15 B 10, 10 violations, EF02-AHPVATB (10)

§ 38.2-3407.15 B 11, 17 violations, EF02-AN, EF01-AHPVATB (6),
EF02-AHPVATB (10)

Provider Claims

§ 38.2-3407.15 B 1, 1 violation, EFCL38-AN

§ 38.2-3407.15 B 3, 9 violations, EFCL05-AN, EFCL06-AN, EFCL07-AN, EFCL13-AN,
EFCL20-AN, EFCL22-AN, EFCL28-AN, EFCL30-AN, EFCL43-AN

§§ 38.2-3407.15 B 4 a ii c and d, 17 violations, EFCL01-AHPVATB (6),
EFCL02-AHPVATB (4), EFCL03-AHPVATB (2), EFCL04-AHPVATB (5)

§ 38.2-3407.15 B 8, 21 violations, EFCL15-AN, EFCL27-AN, EFCL28-AN,
EFCL32-AN, EFCL01-AHPVATB (6), EFCL02-AHPVATB (4), EFCL03-AHPVATB (2),
EFCL04-AHPVATB (5)

ADVERTISING/MARKETING COMMUNICATIONS

14 VAC 5-90-40, 7 violations, AD02C-AN, AD03B-AN, AD06B-AN, AD07C-AN,
AD08D-AN, AD14C-AN and AD15C-AN

14 VAC 5-90-60 A 1, 2 violations, AD01A-AN and AD08A-AN

POLICY AND OTHER FORMS
§ 38.2-3407.4 A, 150 violations, CL02VISION-AN (150)
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-610 B, 1 violation, UN08-AN
PREMIUM NOTICES
§ 38.2-3407.14 B, 6 violations, PB12-AN, PB14-AN, PB15-AN, PB16-AN, PB17-AN, PB18-AN
COMPLAINTS
§ 38.2-508 2, 1 violation, CP01-AN
CLAIM PRACTICES
§ 38.2-514 B, 72 violations, CL06J-AN, CL11J-AN, CL12J-AN, CL36J-AN, CL42J-AN, CL45J-AN, CL48J-AN, CL49J-AN, CL50J-AN, CL51J-AN (6), CL52J-AN, CL53J-AN, CL54J-AN, CL58J-AN, CL59J-AN (9), CL65J-AN, CL68J-AN, CL72J-AN, CL79J-AN, CL80J-AN, CL81J-AN, CL82J-AN, CL09L-AN, CL10L-AN, CL11L-AN, CL13L-AN (10), CL14L-AN, CL15L-AN, CL02T-AN, CL03T-AN, CL07T-AN, CL08T-AN, CL09T-AN, CL10T-AN, CL12T-AN, CL13T-AN, CL17T-AN, CL20T-AN, CL02BL-AN, CL04BL-AN, CL07BL-AN, CL14BL-AN, CL17BL-AN, CL18BL-AN, CL19BL-AN, CL20BL-AN, CL21BL-AN, CL02BW-AN, CL18BW-AN, CL25BW-AN
§ 38.2-3405 A, 1 violation, CL22BL-AN
§ 38.2-3407.1 B, 15 violations, CL17J-AN, CL25J-AN, CL28J-AN, CL40J-AN, CL41J-AN, CL42J-AN, CL49J-AN, CL67J-AN, CL71J-AN, CL83J-AN, CL02L-AN, CL16L-AN, CL07T-AN, CL01BL-AN, CL06BL-AN
§ 38.2-3407.4 B, 43 violations, CL06J-AN, CL11J-AN, CL12J-AN, CL42J-AN, CL45J-AN, CL48J-AN, CL65J-AN, CL68J-AN, CL72J-AN, CL79J-AN, CL80J-AN, CL81J-AN, CL82J-AN, CL13L-AN (10), CL15L-AN, CL02T-AN, CL03T-AN, CL07T-AN, CL08T-AN, CL12T-AN, CL13T-AN, CL17T-AN, CL20T-AN, CL02BL-AN, CL04BL-AN, CL07BL-AN, CL17BL-AN, CL18BL-AN, CL19BL-AN, CL20BL-AN, CL21BL-AN, CL02BW-AN, CL18BW-AN, CL25BW-AN,
14 VAC 5-400-30, 1 violation, CL41BW-AN

14 VAC 5-400-40 A, 56 violations, CL11J-AN, CL17J-AN, CL23J-AN, CL25J-AN, CL26J-AN, CL28J-AN, CL30J-AN, CL36J-AN, CL39J-AN, CL40J-AN, CL42J-AN, CL43J-AN, CL44J-AN, CL49J-AN, CL53J-AN, CL66J-AN, CL67J-AN, CL68J-AN, CL72J-AN, CL75J-AN, CL80J-AN, CL18T-AN, CL02BL-AN, CL04BL-AN, CL05BL-AN, CL07BL-AN, CL14BL-AN, CL02BW-AN, CL03BW-AN (5), CL04BW-AN, CL05BW-AN, CL10BW-AN, CL11BW-AN, CL12BW-AN, CL24BW-AN, CL29BW-AN, CL50BW-AN, CL53BW-AN, CL56BW-AN, CL61BW-AN, CL64BW-AN, CL73BW-AN, CL98BW-AN, CL04VISION-AN, CL05VISION-AN, CL06VISION-AN, CL07VISION-AN, CL08VISION-AN, CL10VISION-AN, CL11VISION-AN, CL12VISION-AN, CL13VISION-AN

14 VAC 5-400-50 A, 59 violations, CL15J-AN, CL18J-AN, CL21J-AN, CL25J-AN, CL29J-AN, CL32J-AN, CL34J-AN, CL37J-AN, CL39J-AN, CL47J-AN, CL49J-AN, CL52J-AN, CL54J-AN, CL55J-AN, CL58J-AN, CL60J-AN, CL61J-AN, CL62J-AN, CL63J-AN, CL69J-AN, CL73J-AN, CL01L-AN, CL06L-AN, CL07L-AN, CL08L-AN, CL12L-AN (6), CL17L-AN, CL07T-AN, CL12T-AN, CL16T-AN, CL21T-AN, CL11BL-AN, CL04BW-AN, CL05BW-AN, CL06BW-AN, CL15BW-AN (2), CL16BW-AN, CL21BW-AN, CL26BW-AN, CL34BW-AN, CL46BW-AN, CL57BW-AN, CL76BW-AN, CL77BW-AN, CL78BW-AN, CL80BW-AN, CL84BW-AN, CL85BW-AN, CL86BW-AN, CL87BW-AN, CL88BW-AN, CL92BW-AN, CL93BW-AN,

14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code, 158 violations, CL08J-AN, CL13J-AN (15), CL17J-AN, CL19J-AN, CL25J-AN, CL29J-AN, CL37J-AN, CL38J-AN, CL46J-AN, CL47J-AN, CL49J-AN, CL54J-AN, CL65J-AN, CL67J-AN, CL69J-AN, CL70J-AN, CL71J-AN, CL74J-AN, CL76J-AN, CL77J-AN, CL83J-AN, CL02L-AN, CL05L-AN, CL12L-AN (32), CL16L-AN, CL01T-AN (5), CL04T-AN, CL05T-AN, CL06T-AN (14), CL07T-AN, CL21T-AN, CL01BL-AN, CL03BL-AN, CL04BL-AN, CL06BL-AN, CL07BL-AN, CL08BL-AN, CL10BL-AN, CL11BL-AN, CL12BL-AN, CL13BL-AN, CL15BL-AN (6), CL16BL-AN (2), CL01BW-AN, CL06BW-AN, CL07BW-AN, CL11BW-AN, CL12BW-AN, CL13BW-AN (25), CL14BW-AN, CL15BW-AN (2), CL16BW-AN, CL22BW-AN, CL34BW-AN, CL57BW-AN, CL74BW-AN, CL80BW-AN, CL86BW-AN, CL87BW-AN, CL92BW-AN, CL01VISION-AN (5)

14 VAC 5-400-60 B, 4 violations, CL25J-AN, CL16BW-AN, CL87BW-AN, CL09VISION-AN

14 VAC 5-400-70 B, 55 violations, CL06J-AN, CL11J-AN, CL12J-AN, CL14J-AN, CL17J-AN, CL23J-AN, CL25J-AN, CL26J-AN, CL28J-AN, CL30J-AN, CL31J-AN, CL33J-AN, CL36J-AN, CL40J-AN, CL41J-AN, CL42J-AN, CL43J-AN, CL45J-AN, CL67J-AN, CL72J-AN, CL75J-AN, CL79J-AN, CL80J-AN, CL16L-AN, CL18T-AN, CL03BL-AN, CL05BL-AN, CL02BW-AN, CL03BW-AN (5), CL04BW-AN, CL05BW-AN, CL09BW-AN, CL10BW-AN, CL11BW-AN, CL12BW-AN, CL24BW-AN, CL29BW-AN, CL56BW-AN, CL61BW-AN, CL64BW-AN, CL73BW-AN, CL98BW-AN, CL04VISION-AN, CL05VISION-AN, CL06VISION-AN, CL07VISION-AN, CL08VISION-AN, CL10VISION-AN, CL11VISION-AN, CL12VISION-AN, CL13VISION-AN

14 VAC 5-400-70 D, 26 violations, CL17J-AN, CL23J-AN, CL26J-AN, CL30J-AN, CL36J-AN, CL39J-AN, CL41J-AN, CL70J-AN, CL72J-AN, CL75J-AN, CL16L-AN, CL03BL-AN, CL03BW-AN (5), CL04BW-AN, CL05BW-AN, CL10BW-AN, CL11BW-AN, CL12BW-AN, CL24BW-AN, CL29BW-AN, CL50BW-AN, CL53BW-AN

COPY

COMMONWEALTH OF VIRGINIA

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March 15, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5541
RETURN RECEIPT REQUESTED

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Lough:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Anthem Health Plans of Virginia, Inc. (Anthem) for the period of January 1, 2008 through June 30, 2008. 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 Anthem, 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. Anthem response(s) to the draft Report will be attached to and become part of the final Report.

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

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:mhh
Enclosure
cc: Althelia P. Battle



June 3, 2011

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report of
Anthem Health Plans of Virginia, Inc.
Exposure Draft Corrective Action Item Response

Dear Ms. Fairbanks:

This letter is in response to the Market Conduct Examination Report Exposure Draft issued by the Bureau for Anthem Health Plans of Virginia, Inc.

Enclosed please find the responses to the Corrective Action Items identified in the Exposure Draft.

Should you have any questions, please feel free to contact me at 404.842.8233 or 404. 357.4318.

Sincerely,

A handwritten signature in cursive script that reads "Marie Lough".

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Anthem Health Plans of Virginia, Inc.

Enclosure
cc: Owen Hunt

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

- 1. Review its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by Section 38.2-5804 A of the Code.**

Anthem has reviewed its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by Section 38.2-5804 A of the Code.

- 2. As recommended in prior Reports, establish and maintain procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407.15 B of the Code.**

Anthem has reviewed its procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407.15 B of the Code.

Anthem maintains its position regarding its response to EF03-AN that addresses the language found in the Standard Terms and Conditions of provider agreements that states the provider has 40 calendar days from the post mark date of an amendment to the agreement to notify Anthem of termination. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

EyeMed has advised that it updated its provider contracts to comply with Section 38.2-3407.15 B of the Code in December 2008. The pharmacy provider contracts addressed in the Report have been replaced by the current pharmacy vendor, Express Scripts, contracts. Express Scripts has advised that its contracts comply with Section 38.2-3407.15 B of the Code.

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

Anthem currently has procedures in place to ensure adherence to the compliance with the minimum fair business standards in the processing and payment of claims as required by Sections 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code. Anthem also has reporting tools it uses to ensure compliance.

EyeMed has advised that it is revising its procedures to ensure that it can provide documentation that would verify the date that the vision contract fee schedules are mailed to providers.

- 4. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.**

Anthem has reviewed and revised its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

5. **As recommended in the prior Report, establish and maintain procedures to ensure that its Explanation of Benefits forms are filed with and approved by the Commission, as required by Section 38.2-3407.4 A of the Code.**

The Explanation of Benefits (EOB) form identified in CL02VISION-AN was not filed for approval prior to use. Anthem understands that EyeMed made changes to a previously approved EOB. The vendor has been advised that all EOBs and subsequent changes must be filed for approval and that EOBS must not be used prior to approval. The subject EOB will be filed as required in Section 38.2-3407.4 A of the Code. The vendor has advised that it is developing procedures to ensure compliance with Section 38.2-3407.4 A.

6. **Revise its procedures and/or adverse underwriting decision notices to ensure compliance with the requirements of Section 38.2-610 B of the Code.**

Anthem has revised its procedures to ensure compliance with Section 38.2-610 B of the Code

7. **Establish and maintain procedures to comply with and to document compliance with Section 38.2-3407.14 of the Code.**

Anthem's standard monthly renewal production process for groups in the 2-14 market and the 15-99 market is to deliver the renewal to the Agent of Record approximately 90 days prior to the effective date. The pdf copies of renewals are delivered via the online broker renewal tools. System generated emails notify agents when the renewals are ready to view. The agent then has the ability to print, email, or fax the renewals to their customers. Approximately 64 days prior to the renewal effective date, the renewal packages are mailed to each small group.

Based on the feedback from the examiners during the recent Market Conduct Examination, Anthem instituted a process to formally document the actual date renewals are mailed each month. A copy of the released renewal schedule/checklist documenting the mailing date each month is available upon request.

8. **Establish and maintain procedures to ensure that all established billing procedures are followed and documented.**

Anthem will ensure that it will be able to provide documentation of certain events such as reinstatements, billing adjustments or new billing dates in order to show compliance with its established billing procedures regarding timely production of Notices of Cancellation.

9. **Establish and maintain procedures to ensure that no person unfairly discriminates or permits any unfair discrimination between individuals of the same class and of essentially the same hazard in the benefits payable under such policy or contract, to ensure compliance with Section 38.2-508 2 of the Code.**

Anthem has established procedures to ensure compliance with Section 38.2-508 2 of the Code. The examiners identified one dental claim where an exception was made by the appeals analyst in error. To ensure consistency regarding exceptions the procedures

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

were updated to include a guideline related to waiting periods. This guideline went into effect in June 2009.

- 10. Re-open and reprocess the denied claim discussed in Review Sheet CP01-AN. Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized.**

Anthem will re-open and reprocess the denied claim discussed in Review Sheet CP01-AN. Documentation of the review and any adjusted amounts paid will be provided to the examiners within 90 days of the Report being finalized.

- 11. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by Sections 38.2-514 B and 38.2-3407.4 B of the Code.**

Anthem will revise its established procedures for creating and sending EOBs to ensure that EOBs provided to an insured, claimant or subscriber clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by Sections 38.2-514 B and 38.2-3407.4 B of the Code. We would like to discuss with the Bureau how to accomplish this in a cost effective manner.

- 12. Review and revise its established procedures for compliance with Section 38.2-3412.1 C 2 of the Code when processing a claim for outpatient mental health and substance abuse services;**

Anthem respectfully disagrees with this corrective action. Anthem maintains that its established procedures for processing claims for outpatient mental health and substance abuse services comply with Section 38.2-3412.1 C 2 of the Code and that it processed the 2 claims identified by the examiners in compliance with the identified Code Section. The law requires that the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered under any policy or contract year shall be at least 50%. The coinsurance factor for the claims identified by the examiners is 100%. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

- 13. As recommended in prior Reports, establish and maintain procedures for the payment of interest due on claim proceeds, as required by Section 38.2-3407.1 of the Code.**

Anthem has specific procedures for the payment of interest due on claim proceeds, as required by Section 38.2-3407.1 of the Code. The examiners identified 18 claims where interest was not paid as required. Anthem disagrees with the examiners that because interest was not paid for these claims that Anthem knowingly violated either Section 38.2-3407.1 B of the Code and the Commission's Order to cease and desist issued November 19, 2004. Anthem believes that interest was not paid due to human error not to any deficiency in the procedure.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

14. Establish and maintain procedures to ensure compliance with Section 38.2-3405 of the Code.

Anthem has procedures to ensure compliance with Section 38.2-3405 of the Code. While an error may have been made in the processing of the claim identified in Review Sheet CL22BL-AN, it was not Anthem's intention nor does it believe it subrogated this claim.

15. Review all claims submitted by non-participating facilities where the allowable charge was based on a per diem and then reduced by the charges for non-covered services during 2006, 2007, 2008, 2009, 2010 and the current year and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized.

Anthem respectfully disagrees with this corrective action and maintains its position that claims submitted by non-participating facilities where the allowable charge was based on a per diem are processed according to plan provisions and that its EOBs for these type claims do not violate Sections 38.2-514 B and 38.2-3407. 4 B of the Code. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this correction action in its Report.

16. Immediately amend its policies to disclose Anthem's calculation for services received at a non-participating facility and reimbursed on a per diem basis to all affected policyholders and certificateholders.

Anthem respectfully disagrees with this corrective action and continues to maintain its position that policy provisions allow for the current way that claims are processed. Please see response to No. 15 above.

17. As recommended in the prior Report, review its established procedures to ensure that its claim files contain all notes and work papers pertaining to a claim in such detail that pertinent events and dates can be reconstructed, as required by 14 VAC 5-400-30.

The examiners identified one dental claim where the file did not contain copy of the EOB. Anthem will review its procedures to ensure that its dental claim files contain all notes and work papers pertaining to a claim as required by 14 VAC 4-400-30.

18. As recommended in the prior Report, review its established procedures to ensure that policy provisions, benefits or coverages are not obscured or concealed from a claimant, when such provisions are pertinent to a claim, as required by 14 VAC 5-400-40 A.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

Anthem believes that its established procedures are compliant with 14 VAC 5-400-40 A but will take this opportunity to review the procedures to identify any opportunities for improvement.

- 19. Revise its procedures to ensure that claims are processed in accordance with the terms of its policies and procedures, and that claim denials are not based solely on the diagnosis code submitted on the claim form.**

Anthem requests an informal hearing to explain its claims processing procedures and contract provisions as they relate to this corrective action and related corrective action #20 below.

- 20. Review all denied claims processed during 2006, 2007, 2008, 2009, 2010 and the current year where the diagnosis code submitted on the claim form was dental related and the only procedure code listed involved a medical office visit for the evaluation and management of an established patient and reopen and pay these claims in accordance with policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of the Report being finalized.**

Prior to agreeing to review the claims identified in this corrective action, Anthem requests an informal hearing to discuss the parameters of the review and to discuss the claims procedures and contract provisions as they relate to this corrective action and related corrective action #19 above.

- 21. As recommended in the prior Report, review its established procedures to acknowledge receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A.**

Anthem will review its established procedures to ensure that acknowledgement letters are sent as required by 14 VAC 5-400-50 A.

- 22. Revise its established procedures to ensure that each member is notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and Section 38.2-510 A 5 of the Code.**

Based on the examiners findings, Anthem was cited for violations of 14 VAC 5-400-60 A because it suppresses EOB lines when there is no member liability or only when a copayment is required. The examiners also identified that this occurred with such frequency as to indicate a general business practice placing Anthem in violation of Section 38.2-510 A 5 of the Code. Anthem respectfully disagrees with this corrective action item and maintains its original response. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

- 23. As recommended in the prior Report, review its established procedures to ensure that notification is sent every 45 days, as required by 14 VAC 5-400-60 B.**

As identified by the examiners, Anthem did not send the notification every 45 days as required by 14 VAC 5-400-60 B in only 4 instances. Anthem believes that its established procedures are sufficient to comply with 24 VAC 5-400-60 B but will review the process to determine if improvements can be made.

- 24. As recommended in the prior Report, review its established procedures to ensure that the claimant is provided a reasonable explanation of the basis for the denial of a claim in the written denial, as required by 14 VAC 5-400-70 B.**

Anthem's EOB remark codes were created to ensure that they are clearly written and to provide a reasonable explanation of the basis for the denial of the claim. Anthem will review its established procedures to determine if there are any opportunities to improve the procedures to enhance compliance with 14 VAC 5-400-70 B.

- 25. As recommended in the prior Report, review its established procedures to ensure that it offers an amount which is fair and reasonable as shown by the investigation of the claim, as required by 14 VAC 5-400-70 D.**

Anthem maintains that its established procedures ensure that it offers an amount which is fair and reasonable as shown by the investigation of the claim as required by 14 VAC 5-400 70 D. However, Anthem will take this opportunity to review its procedures to determine if improvements can be made to the process.

COMMONWEALTH OF VIRGINIA

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



P.O. BOX 1157
RICHMOND, VIRGINIA 23218
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December 8, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5947
RETURN RECEIPT REQUESTED

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

Re: Market Conduct Examination Report
Exposure Draft

Dear Ms. Lough:

The Bureau of Insurance (BOI) has completed its review of your June 3, 2011, response to the Market Conduct Examination Report of Anthem Health Plans of Virginia, Inc. (Anthem), sent with my letter of March 15, 2011.

Your response indicates that Anthem has concerns regarding the writing of the Report. This letter addresses these concerns in the same order as presented in your June 3rd response. However, since Anthem's response will also be attached to the final Report, this response does not address those issues where Anthem indicated agreement and/or action taken as a result of the Report. Anthem should note that upon finalization of this exam, Anthem will be given approximately 90 days to document compliance with **all** of the corrective actions in the Report.

In your response, Anthem requested an informal hearing to discuss several issues in the event that the Bureau maintains the position presented in the Draft Report. However, additional information was not provided with your response for the examiners to consider. If Anthem would like to provide the examiners with additional documentation or information pertinent to these issues, the examiners will readily consider such items. After any additional documentation or information has been considered, if Anthem would like to schedule an informal conference here at the Bureau, Anthem may submit a request, along with a list of all issues or items that it would like to discuss.

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

In your response, you state that Anthem maintains its position regarding its response to EF03-AN. The language found in the provider contracts states that the provider has 40 calendar days from the post mark date of the addendum to notify Anthem of termination. The Code specifically allows the provider a timeframe of 30 calendar days from the **receipt date** to accept the proposed amendment or terminate the contract. The language used by Anthem in the provider contracts does not satisfy the Code's requirements in all instances and since the timeframe given to the provider would be less favorable than that of the Code in certain situations, the inclusion of this language in the provider contracts places Anthem in violation of this section of the Code. The Report appears correct as written.

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

Anthem states that it has procedures in place to ensure compliance with these sections; however, the examination revealed several violations. In order to comply with the corrective action, Anthem needs to revise and strengthen its current procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code going forward.

- 4. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;**

Anthem has indicated that it has already complied with this Corrective Action; however, Anthem has not documented that changes have been made to the sample advertisements cited for violations of 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 in order to bring them into compliance with these sections. Evidence of revisions made to these advertisements or evidence that these advertisements are no longer in use in Virginia will be required in order to document compliance with this Corrective Action.

- 11. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;**

The Bureau is willing to review proposed revisions to Anthem's EOBs before Anthem formally files these EOBs with the Commission seeking approval.

12. Review and revise its established procedures for compliance with § 38.2-3412.1 C 2 of the Code when processing a claim for outpatient mental health and substance abuse services;

Upon further review, the examiners have removed the 2 violations of § 38.2-3412.1 C 2 of the Code cited in the Report. This Corrective Action has been removed as well. The revised pages are attached for your review.

13. As recommended in prior Reports, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 of the Code;

As noted in the Report, the examiners identified 36 claims where interest was due, and Anthem failed to pay interest in accordance with § 38.2-3407.1 B of the Code in 18, or half, of those instances. Of the 18 violations cited, 9 were observed during the review of adjusted dental claims. It was observed in the prior 2 Reports that violations of § 38.2-3407.1 B of the Code occurred during the processing of adjusted dental claims. In light of this, it appears that Anthem did not put substantial controls in place after the prior 2 exams to ensure future compliance with this section. As such, the violations could be construed as knowing, which is accurately stated in the current Report. In addition, Anthem agreed to cease and desist from future violations of this section upon issuance of the Settlement Order dated November 19, 2004. However, both the prior and the current exam revealed that Anthem has not complied with that Settlement Order. While the examiners acknowledge that human error may have contributed, it does not justify Anthem's repeat violations of this section. The Report appears correct as written.

After further review, one addition has been made to the Corrective Action Plan regarding interest. The following language has been added:

Review and reopen all adjusted dental claims where interest was due for the years 2006, 2007, 2008, 2009, 2010, and the current year and make interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send checks for the required interest along with letters of explanation stating, "As a result of a Target Market Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been previously paid". Afterwhich, furnish the examiners with documentation that the required interest had been paid within 90 days of this Report being finalized;

14. Establish and maintain procedures to ensure compliance with § 38.2-3405 of the Code;

To date, Anthem has not provided documentation to show that this claim was re-opened and paid in accordance with the terms of the policy. In addition, Anthem informed the examiners that the reason for the claim denial was "Claim retracted due to auto insurance paying the claim in full.," and has not yet provided any evidence to the contrary. As such, the Report appears correct as written.

15. Review all claims submitted by non-participating facilities where the allowable charge was based on a per diem and then reduced by the charges for non-covered services during 2006, 2007, 2008, 2009, 2010 and the current year and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;

Anthem continues to disagree with this corrective action; however, Anthem has not provided any additional information for consideration. The Report appears correct as written.

16. Immediately amend its policies to disclose Anthem's calculation for services received at a non-participating facility and reimbursed on a per diem basis to all affected policyholders and certificateholders;

Anthem continues to disagree with this corrective action; however, Anthem has not provided any additional information for consideration. The Report appears correct as written.

19. Revise its procedures to ensure that claims are processed in accordance with the terms of its policies and procedures, and that claim denials are not based solely on the diagnosis code submitted on the claim form;

20. Review all denied claims processed during 2006, 2007, 2008, 2009, 2010 and the current year where the diagnosis code submitted on the claim form was dental related and the only procedure code listed involved a medical office visit for the evaluation and management of an established patient and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment

amount.” Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;

Upon receipt, the examiners will review and consider any documentation provided to explain Anthem’s claims processing procedures as they relate to the violations cited in the Report. After the examiners have had an opportunity to review the relevant documentation, and respond to Anthem, Anthem may request an informal conference at the Bureau to discuss.

22. Revise its established procedures to ensure that each member is notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;

Anthem continues to disagree with this corrective action; however, Anthem has not provided any additional information for consideration. The Report appears correct as written.

Copies of the revised pages of the Report are attached and are the only substantive revisions we plan to make before it becomes final. Once the matter has been concluded, Anthem will receive a final copy of the Report, which will include the revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that Anthem has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-508 2, 38.2-510 A 5, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-610 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 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, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

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

Marie Lough
December 8, 2011
Page 6

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter. The Report will not become a public document until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:
Enclosures
cc: Bob Grissom
Althelia P. Battle

COPY



January 20, 2012

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report
Exposure Draft – Additional Information

Dear Ms. Fairbanks:

This letter is in response to your December 8, 2011 communications regarding the Market Conduct Examination Report Exposure Draft for Anthem Health Plans of Virginia, Inc. ("Anthem").

Attached please find additional information for the examiners' consideration. If the examiners maintain the position that certain corrective action is required, Anthem will submit a request for an informal conference along with a list of all issues or items that it would like to discuss.

Should you have any questions, please feel free to contact me at 404.357.4318.

Sincerely,

A handwritten signature in cursive script that reads "Marie Lough".

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Anthem Health Plans of Virginia, Inc.

Attachment

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

- 1. Review its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by Section 38.2-5804 A of the Code.**

Anthem has reviewed its procedures to ensure that the approved complaint system is followed in the processing of written complaints, as required by Section 38.2-5804 A of the Code.

- 2. As recommended in prior Reports, establish and maintain procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407. 15 B of the Code.**

Original Response

Anthem has reviewed its procedures to ensure that all provider contracts contain the provisions required by Section 38.2-3407.15 B of the Code.

Anthem maintains its position regarding its response to EF03-AN that addresses the language found in the Standard Terms and Conditions of provider agreements that states the provider has 40 calendar days from the post mark date of an amendment to the agreement to notify Anthem of termination. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

EyeMed has advised that it updated its provider contracts to comply with Section 38.2-3407.15 B of the Code in December 2008. The pharmacy provider contracts addressed in the Report have been replaced by the current pharmacy vendor, Express Scripts, contracts. Express Scripts has advised that its contracts comply with Section 38.2-3407.15 B of the Code.

Additional Response

Anthem requests an informal hearing to discuss this issue.

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

Original Response

Anthem currently has procedures in place to ensure adherence to the compliance with the minimum fair business standards in the processing and payment of claims as required by Sections 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code. Anthem also has reporting tools it uses to ensure compliance.

EyeMed has advised that it is revising its procedures to ensure that it can provide documentation that would verify the date that the vision contract fee schedules are mailed to providers.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

Additional Response

While Anthem believes that its procedures are adequate to ensure compliance we will review the current procedures and strengthen the procedures as deemed necessary.

- 4. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.**

Original Response

Anthem has reviewed and revised its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

Additional Response

As requested by the examiners, Anthem will provide evidence of revisions made to the advertisements or evidence that these advertisements are no longer in use in Virginia.

- 5. As recommended in the prior Report, establish and maintain procedures to ensure that its Explanation of Benefits forms are filed with and approved by the Commission, as required by Section 38.2-3407.4 A of the Code.**

The Explanation of Benefits (EOB) form identified in CL02VISION-AN was not filed for approval prior to use. Anthem understands that EyeMed made changes to a previously approved EOB. The vendor has been advised that all EOBs and subsequent changes must be filed for approval and that EOBs must not be used prior to approval. The subject EOB will be filed as required in Section 38.2-3407.4 A of the Code. The vendor has advised that it is developing procedures to ensure compliance with Section 38.2-3407.4 A.

- 6. Revise its procedures and/or adverse underwriting decision notices to ensure compliance with the requirements of Section 38.2-610 B of the Code.**

Anthem has revised its procedures to ensure compliance with Section 38.2-610 B of the Code.

- 7. Establish and maintain procedures to comply with and to document compliance with Section 38.2-3407.14 of the Code.**

Anthem's standard monthly renewal production process for groups in the 2-14 market and the 15-99 market is to deliver the renewal to the Agent of Record approximately 90 days prior to the effective date. The pdf copies of renewals are delivered via the online broker renewal tools. System generated emails notify agents when the renewals are ready to view. The agent then has the ability to print, email, or fax the renewals to their customers. Approximately 64 days prior to the renewal effective date, the renewal packages are mailed to each small group.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

Based on the feedback from the examiners during the recent Market Conduct Examination, Anthem instituted a process to formally document the actual date renewals are mailed each month. A copy of the released renewal schedule/checklist documenting the mailing date each month is available upon request.

8. Establish and maintain procedures to ensure that all established billing procedures are followed and documented.

Anthem will ensure that it will be able to provide documentation of certain events such as reinstatements, billing adjustments or new billing dates in order to show compliance with its established billing procedures regarding timely production of Notices of Cancellation.

9. Establish and maintain procedures to ensure that no person unfairly discriminates or permits any unfair discrimination between individuals of the same class and of essentially the same hazard in the benefits payable under such policy or contract, to ensure compliance with Section 38.2-508.2 of the Code.

Anthem has established procedures to ensure compliance with Section 38.2-508.2 of the Code. The examiners identified one dental claim where an exception was made by the appeals analyst in error. To ensure consistency regarding exceptions the procedures were updated to include a guideline related to waiting periods. This guideline went into effect in June 2009.

10. Re-open and reprocess the denied claim discussed in Review Sheet CP01-AN. Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized.

Anthem will re-open and reprocess the denied claim discussed in Review Sheet CP01-AN. Documentation of the review and any adjusted amounts paid will be provided to the examiners within 90 days of the Report being finalized.

11. Revise its established procedures for creating and sending EOBs to ensure that every EOB provided to an insured, claimant or subscriber clearly and accurately discloses the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by Sections 38.2-514 B and 38.2-3407.4 B of the Code.

Anthem will revise its established procedures for creating and sending EOBs to ensure that EOBs provided to an insured, claimant or subscriber clearly and accurately disclose the method of benefit calculation, the actual amount which has been or will be paid to the provider of services and the benefits payable under the contract, as required by Sections 38.2-514 B and 38.2-3407.4 B of the Code. We would like to discuss with the Bureau how to accomplish this in a cost effective manner.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

12. Review and revise its established procedures for compliance with Section 38.2-3412.1 C 2 of the Code when processing a claim for outpatient mental health and substance abuse services;

Anthem respectfully disagrees with this corrective action. Anthem maintains that its established procedures for processing claims for outpatient mental health and substance abuse services comply with Section 38.2-3412.1 C 2 of the Code and that it processed the 2 claims identified by the examiners in compliance with the identified Code Section. The law requires that the coinsurance factor applicable to any outpatient visit beyond the first five of such visits covered under any policy or contract year shall be at least 50%. The coinsurance factor for the claims identified by the examiners is 100%. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

Additional Response

Anthem acknowledges the removal of the violations of Section 38.2-3412.1 C 2 of the Code and the removal of this Corrective Action item from the Report.

13. As recommended in prior Reports, establish and maintain procedures for the payment of interest due on claim proceeds, as required by Section 38.2-3407.1 of the Code.

Anthem has specific procedures for the payment of interest due on claim proceeds, as required by Section 38.2-3407.1 of the Code. The examiners identified 18 claims where interest was not paid as required. Anthem disagrees with the examiners that because interest was not paid for these claims that Anthem knowingly violated either Section 38.2-3407.1 B of the Code and the Commission's Order to cease and desist issued November 19, 2004. Anthem believes that interest was not paid due to human error not to any deficiency in the procedure.

Additional Response

In the Bureau's December 8, 2011 correspondence, the examiner's indicated that 9 of 18 claims identified as having interest due were adjusted dental claims. The Bureau stated that violations were observed to have occurred in 2 prior reports and that Anthem appeared not to have substantial controls in place to ensure compliance and as such the violations could be construed as knowing. In addition, the examiners indicated that Anthem had not complied with the November 19, 2004 Settlement Order.

The adjusted claims identified by the examiner are claims that were processed under an Anthem Major Medical Plan. Thus these are not dental claims. The November 19, 2004 Settlement Order related to dental claims processed under a dental plan by Anthem Dental. Anthem asserts that it did not violate the Settlement Order. Notwithstanding, Anthem believes that it does have procedures in place to ensure compliance, and that processing claims incorrectly due to human error does not constitute a knowing violation of law nor a violation of a Settlement Order. Anthem requests an informal hearing to discuss this issue if the Bureau continues to maintain its position.

The examiners also added a Corrective Action item that requires Anthem to review and reopen adjusted "dental" claims where interest is due and make interest payments as

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

necessary. Anthem will review and reopen subject adjusted claims processed under the major medical plan and will make any required interest payments.

14. Establish and maintain procedures to ensure compliance with Section 38.2-3405 of the Code.

Anthem has procedures to ensure compliance with Section 38,2-3405 of the Code. While an error may have been made in the processing of the claim identified in Review Sheet CL22BL-AN, it was not Anthem's intention nor does it believe it subrogated this claim.

Additional Response

As requested by the examiners, Anthem will provide documentation that the claim identified in Review Sheet CL22BL-AN was processed according to the terms of the plan.

15. Review all claims submitted by non-participating facilities where the allowable charge was based on a per diem and then reduced by the charges for non-covered services during 2006, 2007, 2008, 2009, 2010 and the current year and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized.

Anthem respectfully disagrees with this corrective action and maintains its position that claims submitted by non-participating facilities where the allowable charge was based on a per diem are processed according to plan provisions and that its EOBs for these type claims do not violate Sections 38.2-514 B and 38.2-3407.4 B of the Code. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this correction action in its Report.

Additional Response

Based on the responses provided to the Bureau as part of the Market Conduct Examination, Anthem's discussion with the Bureau and subsequent correspondence with the Bureau, Anthem believes that it has provided documentation necessary to demonstrate that claims submitted by non-participating facilities where the allowable charge was based on a per diem rate are processed according to plan provisions and that its EOBs for these type claims do not violate Sections 38.2-514 B and 38.2-3407.4 B of the Code. Anthem requests an informal hearing to discuss this issue.

16. Immediately amend its policies to disclose Anthem's calculation for services received at a non-participating facility and reimbursed on a per diem basis to all affected policyholders and certificateholders.

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

Anthem respectfully disagrees with this corrective action and continues to maintain its position that policy provisions allow for the current way that claims are processed. Please see response to No. 15 above.

Additional Response

Please see Additional Response to No. 15 above.

- 17. As recommended in the prior Report, review its established procedures to ensure that its claim files contain all notes and work papers pertaining to a claim in such detail that pertinent events and dates can be reconstructed, as required by 14 VAC 5-400-30.**

The examiners identified one dental claim where the file did not contain copy of the EOB. Anthem will review its procedures to ensure that its dental claim files contain all notes and work papers pertaining to a claim as required by 14 VAC 4-400-30.

- 18. As recommended in the prior Report, review its established procedures to ensure that policy provisions, benefits or coverages are not obscured or concealed from a claimant, when such provisions are pertinent to a claim, as required by 14 VAC 5-400-40 A.**

Anthem believes that its established procedures are compliant with 14 VAC 5-400-40 A but will take this opportunity to review the procedures to identify any opportunities for improvement.

- 19. Revise its procedures to ensure that claims are processed in accordance with the terms of its policies and procedures, and that claim denials are not based solely on the diagnosis code submitted on the claim form.**

Anthem requests an informal hearing to explain its claims processing procedures and contract provisions as they relate to this corrective action and related corrective action #20 below.

Additional Response

See response to No. 20 below.

- 20. Review all denied claims processed during 2006, 2007, 2008, 2009, 2010 and the current year where the diagnosis code submitted on the claim form was dental related and the only procedure code listed involved a medical office visit for the evaluation and management of an established patient and reopen and pay these claims in accordance with policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount." Documentation of the review and**

Response to Recommendations Anthem Health Plans of Virginia, Inc. Market Conduct Examination Report

adjusted amounts paid should be provided to the examiners within 90 days of the Report being finalized.

Prior to agreeing to review the claims identified in this corrective action, Anthem requests an informal hearing to discuss the parameters of the review and to discuss the claims procedures and contract provisions as they relate to this corrective action and related corrective action #19 above.

Additional Response

For the diagnosis identified in Review Sheet CL23J-AN Anthem maintains that the services would not be covered under major medical unless medical documentation submitted met the contractual requirements for coverage of dental services. Anthem requests an informal hearing to discuss this issue.

- 21. As recommended in the prior Report, review its established procedures to acknowledge receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A.**

Anthem will review its established procedures to ensure that acknowledgement letters are sent as required by 14 VAC 5-400-50 A.

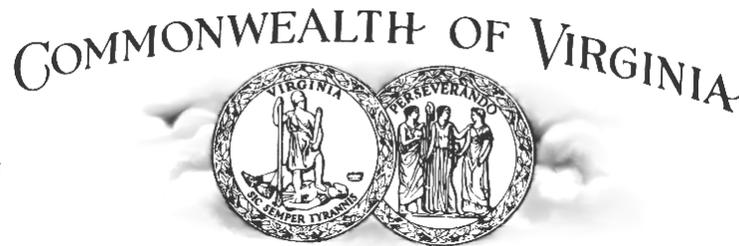
- 22. Revise its established procedures to ensure that each member is notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and Section 38.2-510 A 5 of the Code.**

Based on the examiners findings, Anthem was cited for violations of 14 VAC 5-400-60 A because it suppresses EOB lines when there is no member liability or only when a copayment is required. The examiners also identified that this occurred with such frequency as to indicate a general business practice placing Anthem in violation of Section 38.2-510 A 5 of the Code. Anthem respectfully disagrees with this corrective action item and maintains its original response. Anthem requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

Additional Response

Anthem maintains its original response and requests an informal hearing to discuss this issue.

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



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February 14, 2012

**CERTIFIED MAIL 7005 1820 0007 5460 6128
RETURN RECEIPT REQUESTED**

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

**Re: Market Conduct Examination Report
Exposure Draft**

Dear Ms. Lough:

The Bureau of Insurance (Bureau) has completed its review of your January 20, 2012, additional response to the Market Conduct Examination Report of Anthem Health Plans of Virginia, Inc. (Anthem).

In your January 20th letter, Anthem amended its June 3, 2011, response to include additional information for the examiners' consideration regarding the writing of the Report. This letter addresses Anthem's additional responses in the same order as presented in your January 20th response. However, since Anthem's letter will also be attached to the final Report, this response does not address those issues where Anthem indicated agreement and/or action taken as a result of the Report. Anthem should note that upon finalization of this exam, Anthem will be given approximately 90 days to document compliance with **all** of the corrective actions in the Report.

Anthem has indicated that it plans to request an informal conference in the event that the Bureau maintains the position that certain corrective action is required. If upon receipt and review of this response, Anthem decides to request an informal conference to discuss its concerns, Anthem may submit such a request, along with a list of all issues or items that it would like to discuss to julie.fairbanks@scc.virginia.gov. Upon receipt, I will coordinate with you and Bureau staff to schedule a meeting at everyone's earliest convenience.

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

Anthem has not provided any additional information and has expressed its intent to request an informal hearing to discuss this matter in the event that the Bureau maintains its position. Based on the documentation provided and reviewed to date, the Report appears correct as written.

13. As recommended in prior Reports, establish and maintain procedures for the payment of interest due on claim proceeds, as required by § 38.2-3407.1 of the Code;

Anthem argues that the adjusted dental claims cited in the current Report were processed under an Anthem Major Medical Plan; whereas the adjusted dental claims cited in previous reports were processed under a dental plan by Anthem Dental. Therefore, Anthem asserts that it did not violate the Settlement Order. While the examiners acknowledge that the claims were processed in different locations and under different plans, Anthem is ultimately responsible for the proper payment of interest on all claims processed under the terms of its insurance contracts. There are differences between dental and medical claims and the coverage under which they are processed; however, § 38.2-3407.1 B of the Code is applied consistently to all health insurance claims subject to the requirements of this section.

The examiners acknowledge that the example discussed in the 2004 Report and all of the claims referred to in the Report finalized on July 30, 2007, involved claims processed under Anthem's dental plan by Anthem Dental; however, 85 additional violations of this section were cited in the 2004 Report, all of which were not adjusted dental claims. The Report also noted that based upon these findings, Anthem was in violation of the Commission's Order to cease and desist issued October 14, 1999. Anthem agreed upon finalization of the 2004 exam to cease and desist from future violations of this section; however, subsequent market conduct examinations have revealed that Anthem continues to violate this statute. While our prior response regarding the current Report focused on the 9 adjusted dental claims, the examiners would emphasize that out of 36 claims where interest was due, Anthem failed to pay the required amount of interest on half of these claims. As such, it appears that Anthem did violate the Commission's Order to cease and desist and the Report appears correct as written.

15. Review all claims submitted by non-participating facilities where the allowable charge was based on a per diem and then reduced by the charges for non-covered services during 2006, 2007, 2008, 2009, 2010 and the current year and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that "As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission's Bureau of Insurance, this claim was not processed

in accordance with the policy provisions. Please accept this additional payment amount.” Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;

Anthem has not provided any additional information and has expressed its intent to request an informal hearing to discuss this matter in the event that the Bureau maintains its position. Based on the documentation provided and reviewed to date, the Report appears correct as written.

16. Immediately amend its policies to disclose Anthem’s calculation for services received at a non-participating facility and reimbursed on a per diem basis to all affected policyholders and certificateholders;

Anthem has not provided any additional information and has expressed its intent to request an informal hearing to discuss this matter in the event that the Bureau maintains its position. Based on the documentation provided and reviewed to date, the Report appears correct as written.

19. Revise its procedures to ensure that claims are processed in accordance with the terms of its policies and procedures, and that claim denials are not based solely on the diagnosis code submitted on the claim form;

20. Review all denied claims processed during 2006, 2007, 2008, 2009, 2010 and the current year where the diagnosis code submitted on the claim form was dental related and the only procedure code listed involved a medical office visit for the evaluation and management of an established patient and reopen and pay these claims in accordance with the policy provisions. Send a letter of explanation along with each payment stating that “As a result of a Target Market Conduct Examination conducted by the Virginia State Corporation Commission’s Bureau of Insurance, this claim was not processed in accordance with the policy provisions. Please accept this additional payment amount.” Documentation of the review and adjusted amounts paid should be provided to the examiners within 90 days of this Report being finalized;

Anthem has not provided any additional information and has expressed its intent to request an informal hearing to discuss this matter in the event that the Bureau maintains its position. Based on the documentation provided and reviewed to date, the Report appears correct as written.

22. Revise its established procedures to ensure that each member is notified of the acceptance or denial of a claim within 15 working days of receipt of complete proof of loss or why additional time is needed to make that determination, as required by 14 VAC 5-400-60 A and § 38.2-510 A 5 of the Code;

Anthem has not provided any additional information and has expressed its intent to request an informal hearing to discuss this matter in the event that the Bureau maintains

its position. Based on the documentation provided and reviewed to date, the Report appears correct as written.

Once the matter has been concluded, Anthem will receive a final copy of the Report, which will include any revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that Anthem has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-508 2, 38.2-510 A 5, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-610 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 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, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

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

We will wait further communication from you as to whether Anthem wishes to schedule an informal conference or proceed with the settlement process.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:

Enclosures

cc: Bob Grissom
Althelia P. Battle



May 11, 2012

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Life and Health Division
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Re: Market Conduct Examination Report
Exposure Draft – Informal Conference
Additional Information

Dear Ms. Fairbanks:

This letter is in response to your April 23 and April 25, 2012 email communications related to the information requested of Anthem Health Plans of Virginia, Inc. ("Anthem") and its HMOs as a result of the April 23, 2012 Informal Conference.

Provider Contract Language

The Bureau asked that Anthem document when the 40 calendar day language was first included in Anthem and its HMOs provider contracts. The 40 calendar day language was first included in the contracts on January 1, 2007. Attached please find the pertinent amendments.

Interest on Claims

The Bureau asked that Anthem provide documentation to show that the majority of the 18 situations of unpaid interest cited in the Report were due to human error and calculations, and not due to a systemic problem. Subsequent to your email, Anthem provided additional documentation regarding Review Sheet CL76J-AN. After reviewing the additional information you advised that the Bureau will remove the interest violation from the Final Report.

Anthem maintains that the claims identified in Review Sheets CI23J-AN and CL26J-AN were processed appropriately based on member and provider contract provisions, and as such no interest was due because the claims were not clean claims as submitted initially. Medical providers are to bill for medical services using the appropriate medical diagnosis codes.

Interest was not paid on the remaining claims due to various human errors including the following:

- Interest not calculated and paid when a claim was processed after receipt of Coordination of Benefits information;
- Keying of incorrect re-receipt date of claims;
- TriMed record identified member as child not policyholder, when claim reprocessed interest inadvertently not paid; and

- Interest not paid on one claim reprocessed as part of a rework project due to incorrect provider number. Interest payments were generated for the other claims in the project but the identified claim was inadvertently excluded.

Claims analysts receive comprehensive claims adjudication training as new hires and receive additional training as regulatory and claims processing system changes occur. Claims are routinely audited to determine compliance with the adjudication procedures. Any follow-up refresher discussions are accomplished at team meetings.

Basis for Determining a Per Diem

The Bureau requested that we provide the basis for determining a per diem rate. The rate for non-participating inpatient behavioral health facilities is derived by the Company actuaries by calculating the weighted average per diem rate paid to all participating inpatient behavioral health facilities across the state. The Company used a state-wide weighted average to arrive at the non-participating per diem rate because each of our participating behavioral health facility contracts is individually negotiated.

The derivation of per diem rates for non-participating facilities follows the same "gross" rate methodology as would be applicable to any participating facility. In other words, if we paid all in-state, participating RTFs at a "gross" rate of \$500 per day, the per diem rate for non-participating RTFs would also be \$500 (the state-wide average of in-network rates).

In the case of a participating facility, the "gross" per diem rate has historically represented the total amount collectible by the facility from both the payer and the patient. The facility is then obligated under contract to write-off the difference, if any, between the "gross" per diem rate and their charge (i.e. the contractual discount). The same methodology has historically been applied to the setting of non-participating rates and claim processing functions. The only difference is that in the absence of a contract with the provider, there is nothing which would preclude the facility from collecting the difference between the "gross" per diem and the facility's charge from the patient.

EOB Suppression

The Bureau asked that Anthem provide an estimate of the number of complaints or inquiries that have been received regarding EOB Suppression. Anthem has determined that there have been no written complaints. Anthem does not track the reasons for EOB requests that come through customer service from either the member or providers.

During the Informal Conference several options were discussed for adding language to Anthem's policies and both company's EOBs in order to resolve the Bureau's concerns regarding EOB suppression. Anthem agrees to update its policies and contracts. But changing EOBs typically involves a significant amount of programming. While Anthem cannot commit to making changes because of unknown costs at this point, we can look at making language changes the next time the EOBs are slated for modification for other business reasons that might make the cost of this effort absorbed into those changes.

Should you have any questions, please feel free to contact me at 404.357.4318.

Sincerely,

Marie Lough

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
Anthem Health Plans of Virginia, Inc.

Attachments

COPY

COMMONWEALTH OF VIRGINIA

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



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June 4, 2012

**CERTIFIED MAIL 7005 1820 0007 5460 6395
RETURN RECEIPT REQUESTED**

Marie Lough
Blue Cross Blue Shield of Georgia
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

**Re: Market Conduct Examination Report
Exposure Draft**

Dear Ms. Lough:

The Bureau of Insurance (Bureau) has completed its review of your May 11, 2012, letter providing the information requested of Anthem Health Plans of Virginia, Inc. (Anthem), HealthKeepers, Inc., Priority Health Care Inc. and Peninsula Health Care Inc. (collectively referred to as "the Company") during the April 23, 2012, informal conference. This letter addresses each item in the same order as presented in your May 11th response.

Provider Contract Language (all 4 reports)

After further discussion, the Bureau has determined that while the language in the Company's provider contracts allowing the provider 40 days from the postmark date of an amendment to notify the Company of intent to terminate the contract is inconsistent with the notification requirements set forth in § 38.2-3407.15 B 9 of the Code, the contract language is not in violation of this section. However, in order to ensure that every provider is afforded the rights under this section of the Code, the Company must establish and implement written procedures specifying that providers will be allowed the full 30 days from receipt of an amendment to notify the Company of intent to terminate the contract in the event that there is a delay in receiving notification.

The violations cited in each of the 4 Reports have been revised; however, the discussion regarding the contract language remains. A corrective action has also been added to address the establishment and implementation of the written procedures referenced above.

Interest on Claims (Anthem report only)

The examiners removed 1 violation of § 38.2-3407.1 B of the Code cited in Review Sheet CL76J-AN based on additional documentation provided by Anthem on April 26th. Upon receipt of your May 11th letter, the examiners reviewed Review Sheets CL23J-AN and CL26J-AN again, and have also removed the interest violations discussed in these two review sheets. The

violations of 14 VAC 5-400-40 A, 14 VAC 5-400-70 A and 14 VAC 5-400-70 D cited in these 2 review sheets will remain, in that the examiners maintain the position that policy provisions were misrepresented and Anthem failed to provide a reasonable explanation for the denial of the claim in these instances. It should be noted that in addition to removing these 2 interest violations, the number of instances where statutory interest was required to have been paid was reduced from 36 to 34.

Based on these revisions, Anthem failed to pay the required interest in 15 of the 34 instances where interest was due. In other words, interest violations were observed in 44% of the sample claims where interest was required to have been paid. Anthem continues to argue that these violations resulted from various human errors and should not be considered knowing violations and the Report should not reflect that Anthem is in violation of the Commission's Order to cease and desist. While the examiners acknowledge that these 15 claims were manually processed, 14 of the violations resulted from the claims processor's failure to document the date that complete proof of loss was received during the re-adjudication of a claim in order to determine the appropriate amount of interest due. The failure of each claims processor to gather the information necessary to determine if interest was due indicates a lack of training, procedures and proper file documentation. Anthem has been advised of the interest requirements set forth in § 38.2-3407.1 of the Code in several reports, and the application of these requirements does not vary based on the type of claim or how it is processed. Therefore, these violations could be considered knowing and Anthem is in violation of the Commission's Order to cease and desist. The Report appears correct as written.

Basis for Determining a Per Diem (Anthem report only)

Your explanation of the basis for determining a per diem has been reviewed, as well as the contract language provided during the April 23rd informal conference. While the information is appreciated, it does not warrant revisions to the Report. The revised contract language still does not explain to the insured that Anthem's procedure for calculating the allowed amount for non-participating facility claims involves subtracting charges for non-covered services from the per diem amount. Therefore, the corrective action remains. The Bureau is willing to discuss potential revisions to the contract language upon finalization of the Report.

EOB Suppression (all 4 reports)

While we understand that some of the changes required may be costly, we cannot allow the Company an indefinite amount of time to make these corrections. The Company will be permitted 120 days from the finalization of these Reports to document compliance with the Corrective Action Plan. The Bureau is willing to discuss options for complying with the Corrective Action Plan with the Company during that time.

We have attached a copy of each report incorporating the revisions discussed above for your review. If you have additional questions, please feel free to contact us.

Once the matter has been concluded, a final copy of each Report will be provided, which will include any revisions, copies of any additional responses you care to make, and copies of relevant correspondence up to and including any order issued by the State Corporation Commission.

On the basis of our review, it appears that Anthem has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-508 2, 38.2-510 A 5, and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-610 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 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, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

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

On the basis of our review, it appears that HealthKeepers, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8 and 38.2-514 B of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 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, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

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

On the basis of our review, it appears that Peninsula Health Care, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code of Virginia.

In addition, there were violations of §§ 38.2-3407.4 A, 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, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A, 14 VAC 5-90-90 C, and 14 VAC 5-90-130 A.

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

On the basis of our review, it appears that Priority Health Care, Inc. has violated the Unfair Trade Practices Act, specifically subsection 1 of 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, and 38.2-514 B of the Code of Virginia.

Marie Lough
June 4, 2012
Page 4

In addition, there were violations of §§ 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 C, 38.2-4306.1 B, 38.2-4312.3 B, and 38.2-5805 C 9 of the Code, as well as 14 VAC 5-90-50 A.

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

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of these matters. The Reports will not become public documents until the settlement process has been completed.

Very truly yours,

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
Principal Insurance Market Examiner
Market Conduct Section II
Life and Health Division
Bureau of Insurance
(804) 371-9385

JRF:
Enclosures
cc: Bob Grissom
Althelia P. Battle

Marie Lough
Anthem Health Plans of Virginia, Inc.
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

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

RE: Alleged Violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, and §§ 38.2-503, 38.2-508 2, 38.2-510 A 5, 38.2-510 A 15, and 38.2-514 B of the Code of Virginia. In addition, there were violations of §§ 38.2-610 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 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, and 38.2-5804 A of the Code, as well as 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1 Rules Governing Advertisement of Accident and Sickness Insurance and 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B and 14 VAC 5-400-70 D, Rules Governing Unfair Claim Settlement Practices.

Dear Ms. Battle:

This will acknowledge receipt of your letter dated June 15, 2012, concerning the above-captioned matter.

Anthem 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 \$129,000 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 §§ 38.2-508 2, 38.2-510 A 5, 38.2-514 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code, as well as 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, and 14 VAC 5-400-70 B, and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2008.

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

7/19/12

Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA 120830124
STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 22, 2012 SCC-CLERK'S OFFICE
DOCUMENT CONTROL CENTER

2012 AUG 22 P 4: 24

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2012-00138

ANTHEM HEALTH PLANS OF VIRGINIA, INC.,

Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Anthem Health Plans of Virginia, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Commonwealth"), in certain instances, violated § 38.2-502 (1) of the Code of Virginia ("Code") by misrepresenting the benefits, advantages, conditions or terms of an insurance policy; violated § 38.2-503 of the Code by making, publishing, disseminating, circulating, or placing before the public an advertisement, announcement or statement containing an assertion, representation or statement relating to the business of insurance which was untrue, deceptive or misleading; violated § 38.2-508 (2) of the Code by failing to comply with practices to prevent unfair discrimination; violated §§ 38.2-510 A 5, 38.2-510 A 15, and 38.2-3407.1 B of the Code by failing to comply with claim settlement practices; violated § 38.2-514 B of the Code by failing to make proper disclosures; violated § 38.2-610 B of the Code by failing to accurately provide the required notices to insureds; violated § 38.2-3405 A of the Code by allowing provisions for subrogation of any person's right to recovery for personal injuries from a third person in contracts for insurance; violated §§ 38.2-3407.4 A and 38.2-3407.4 B of the Code by failing to comply with explanation of

benefits practices; violated § 38.2-3407.14 B of the Code by failing to comply with the requirements regarding notice of premium increases; violated §§ 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 by failing to comply with ethics and fairness requirements for business practices; violated § 38.2-5804 A of the Code by failing to comply with procedures to establish and maintain a complaint system for each of its Managed Care Health Insurance Plans (MCHIPs); violated the provisions of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.*, specifically 14 VAC 5-90-40 and 14 VAC 5-90-60 A 1; violated the provisions of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, specifically 14 VAC 5-400-30, 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, 14 VAC 5-400-60 B, 14 VAC 5-400-70 B, and 14 VAC 5-400-70 D.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke 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 the sum of One Hundred Twenty-nine Thousand Dollars (\$129,000), waived its right to a hearing, agreed to cease and desist from any future violations of §§ 38.2-508 (2), 38.2-510 A 5, 38.2-514 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1,

38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, or 38.2-3407.15 B 11 of the Code, or 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, or 14 VAC 5-400-70 B, and agreed to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of June 30, 2008.

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

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

Accordingly, IT IS ORDERED THAT:

(1) The offer of Anthem Health Plans of Virginia, Inc., in settlement of the matter set forth herein be, and it is hereby, accepted.

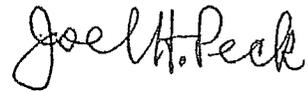
(2) Anthem Health Plans of Virginia, Inc., shall cease and desist from any future violations of §§ 38.2-508 (2), 38.2-510 A 5, 38.2-514 B, 38.2-3405 A, 38.2-3407.1 B, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, or 38.2-3407.15 B 11 of the Code of Virginia, or 14 VAC 5-400-40 A, 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, or 14 VAC 5-400-70 B.

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

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:
Marie Lough, Anthem Health Plans of Virginia, Inc., 3350 Peachtree Road, N.E., POB 30302-

445, Mail Code GAG004-0002, Atlanta, Georgia 30326-1039; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy
Teste:



Clerk of the
State Corporation Commission

COPY