

REPORT ON
TARGET MARKET CONDUCT EXAMINATION
OF
HEALTHKEEPERS, INC.
AS OF JUNE 30, 2008

Conducted from March 23, 2009

Through

June 25, 2010

By

Market Conduct Section

Life and Health Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 54-1356687

NAIC: 95169

COMMONWEALTH OF VIRGINIA

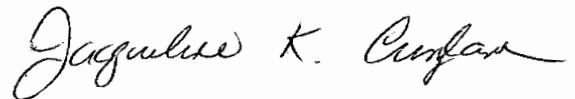
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I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Market Conduct Examination of HealthKeepers, Inc., conducted at the company's office in Richmond, VA as of June 30, 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-2012-00141.

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.



Jacqueline K. Cunningham
Commissioner of Insurance

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I. SCOPE OF EXAMINATION

The Market Conduct Examination of HealthKeepers, Inc. (hereinafter referred to as HealthKeepers), a Health Maintenance Organization (HMO), 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, 38.2-1809, 38.2-3407.15 C, 38.2-4315 and 38.2-5808 of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

A previous Market Conduct Examination covering the period of January 1, 2003, through December 31, 2003, was concluded on August 3, 2004. As a result of that examination, HealthKeepers made a monetary settlement offer, which was accepted by the State Corporation Commission on May 19, 2005, in Case No. INS-2005-00086.

A previous Market Conduct Examination covering the period of July 1, 1998, through June 30, 1999, was concluded on June 30, 2000. As a result of that examination, HealthKeepers made a monetary settlement offer, which was accepted by the State Corporation Commission on September 13, 2001, in Case No. INS010194 in which HealthKeepers agreed to the entry by the Commission of an order to cease and desist from any conduct which constitutes a violation of certain sections of the Code and regulations.

A previous investigation was conducted to review emergency claims settlement practices. As a result of that investigation, HealthKeepers agreed to the entry by the Commission of a final settlement order on January 14, 2008 in Case INS-2007-00225.

In addition to the areas examined during the current examination period, HealthKeepers' practices were reviewed for compliance with the recommendations made to HealthKeepers as a result of the examiners' findings during the previous examinations and investigation discussed above.

Although HealthKeepers had agreed after these earlier regulatory actions to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where HealthKeepers had not done so. In the examiners' opinion; therefore, HealthKeepers in some instances knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2008 through June 30, 2008. The on-site examination was conducted at HealthKeepers' office in Richmond, Virginia from March 23, 2009 through December 4, 2009 and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia 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 HealthKeepers was in compliance with various provisions of the Code and the regulations found in the Virginia Administrative Code. Compliance with the following was considered in the examination process:

- | | |
|-------------------------|---|
| 14 VAC 5-90-10 et seq. | Rules Governing Advertisement of Accident and Sickness Insurance; and |
| 14 VAC 5-211-10 et seq. | Rules Governing Health Maintenance Organizations |

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising
- Premium Notices
- Cancellations/Non-renewals
- Complaints
- Claim Practices

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

COPY

II. COMPANY HISTORY

HealthKeepers, Inc. (HealthKeepers), formerly known as HealthKeepers of Virginia, Inc., was incorporated on April 8, 1985, and on September 1, 1986, became licensed to furnish health maintenance care under Chapter 43, Title 38.2 of the Code.

HealthKeepers is a stock, for-profit HMO. On November 1, 1997, HMO Virginia, Inc., a wholly owned subsidiary of Trigon Administrators, Inc., and formerly known as Virginia Health Maintenance Organization, Inc., was merged into HealthKeepers. On November 1, 1998, Physicians Health Plan, Inc., a wholly owned subsidiary of Trigon Administrators, Inc., was also merged into HealthKeepers.

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. HealthKeepers became a wholly owned subsidiary of Anthem Southeast, Inc.

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.

Effective January 1, 2006, UNICARE Health Plan of Virginia, Inc. (UNICARE Health Plan), an affiliated HMO, merged into HealthKeepers. As a result of the merger, UNICARE National Services, Inc., UNICARE Health Plan's parent company, received 25 shares of HealthKeepers' common stock. Prior to the merger, HealthKeepers was a

wholly owned subsidiary of Anthem Southeast, Inc. After the merger and as of December 31, 2008, HealthKeepers was 88.89% owned by Anthem Southeast, Inc. and 11.11% owned by UNICARE National Services, Inc.

HealthKeepers' service area includes the Virginia cities of Alexandria, Bedford, Buena Vista, Charlottesville, Chesapeake, Colonial Heights, Danville, Emporia, Fairfax, Falls Church, Farmville, Franklin, Fredericksburg, Hampton, Hopewell, Lexington, Manassas, Manassas Park, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, South Boston, Suffolk, Virginia Beach, Williamsburg and Winchester; and the Virginia counties of Accomack, Albemarle, Amelia, Arlington, Bedford, Botetourt, Brunswick, Buckingham, Caroline, Charles City, Charlotte, Chesterfield, Clarke, Craig, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Greensville, Halifax, Hanover, Henrico, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Shenandoah, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Westmoreland, Wythe, and York. HealthKeepers' service area also extends beyond Virginia to include the District of Columbia and the Maryland cities and counties of Ann Arundel, Carroll, Charles, Howard, Montgomery, and Prince George.

Marketing efforts are carried out by account representatives, agents, and brokers. Effective April 10, 1999, HealthKeepers discontinued solicitation of the

individual market. Since that time, individual policies have been issued only as conversions from group plans.

Total enrollment as of December 31, 2008, was 284,828 members, including Medicaid members.

COPY

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

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

GENERAL PROVISIONS

Section 38.2-5801 C 2 requires that a request for an initial certificate of quality assurance be filed by HMOs, which were licensed on or before July 1, 1998, by December 1, 1998. The review revealed that HealthKeepers was in substantial compliance.

Section 38.2-5802 D states that no MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier. The review revealed that HealthKeepers was in substantial compliance.

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 HealthKeepers was in substantial compliance.

COMPLAINT SYSTEM

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

The examiners reviewed a sample of 21 from a population of 457 written pre-service, post-service and contractual appeals; a sample of 4 from a population of 11 expedited appeals; a sample of 5 from a population of 30 executive inquiries; and a sample of 15 from a population of 31 written complaints received during the examination time frame.

HealthKeepers' 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. HealthKeepers' 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.

The review revealed that HealthKeepers was in substantial compliance.

PROVIDER CONTRACTS

The examiners reviewed a sample of 54 provider contracts from a total population of 26,004 provider contracts in force during the examination time frame. The examiners also reviewed HealthKeepers' contracts negotiated with intermediary organizations for the purpose of providing health care services pursuant to an MCHIP.

Section 38.2-5805 C 9 of the Code states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. An HMO may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to covered persons. The review revealed that 6 of HealthKeepers' contracts with vision providers were in violation of this section. An example is discussed in Review Sheet EF04-HMO, where the provider contract included the following supplemental language to the hold harmless clause prescribed by § 38.2-5805 C 9 of the Code:

...that no change is effective until fifteen (15) days after the relevant Commissioner of Insurance or other government agency has been notified of the proposed change.

HealthKeepers disagreed with the examiners and stated, "The hold harmless clause in Section 15 of the contract has been reviewed by our legal team in reference to 38.2-5805 C 9." The examiners would respond that by amending the hold harmless

clause it no longer reads as essentially set forth in § 38.2-5805 C 9 of the Code, placing HealthKeepers in violation of this section.

COPY

IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

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

The examiners reviewed a sample of 26 professional, 10 facility, and 2 chiropractic provider contracts from a total population of 22,643 professional, 482 facility, and 274 chiropractic provider contracts in force during the examination time frame. The provider contracts were reviewed to determine whether they contained and complied with the 11 provisions required by § 38.2-3407.15 B of the Code.

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. The review revealed that each of the 38 sample provider 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 HealthKeepers' contract stated that the provider has 40 calendar days from the post mark date of the amendment to notify HealthKeepers of termination, while the Code specifically allows the provider a time frame of 30 calendar days from the *receipt* date to notify HealthKeepers of intent to terminate the contract. HealthKeepers responded in part that:

...In order to comply with the law, give providers their required notice of an amendment and allow the Company to implement systems changes, the Company 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, HealthKeepers 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 HealthKeepers of termination of the contract in the event that there is a delay in receiving notification.

Vision and Pharmacy

In addition to the contracts reviewed above, the examiners also reviewed a sample of 6 vision and 10 pharmacy provider contracts from a total population of 1,051 vision and 1,554 pharmacy provider contracts in force during the examination time

frame. The provider contracts were reviewed to determine whether they contained and complied with the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed 122 instances in which all 16 sampled 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	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 2	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 3	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 4	16	EF03-HMO, EF04-HMO, EF05-HMO
§ 38.2-3407.15 B 5	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 6	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 7	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 8	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 9	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 10	10	EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 11	16	EF03-HMO, EF04-HMO, EF05-HMO

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. HealthKeepers' failure to amend all of 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 HealthKeepers in violation of § 38.2-510 A 15 of the Code. In the prior Report, it was recommended that HealthKeepers 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 8 (formerly § 38.2-3407.15 B 7), and 38.2-3407.15 B 10 (formerly § 38.2-3407.15 B 9) of the Code were discussed in the prior Report, the current violations of these sections 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 38.2-3407.15 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.

The following samples were reviewed for compliance with the minimum fair business standards in the processing and payment of claims: a sample of 179 out of a total population of 6,832 in-network claims under the professional, facility and chiropractic provider contracts; a sample of 28 from a population of 190 in-network claims processed under the 6 sample vision provider contracts; and a sample of 13 from an unknown population of in-network claims processed under the 10 sample pharmacy provider contracts. Of the 13 sampled pharmacy claims, 4 were determined to be Medicaid claims and were not reviewed. Therefore, the 9 remaining claims in the pharmacy claims sample were reviewed

Section 38.2-3407.15 B 1 of the Code requires that a clean claim be paid within 40 days of receipt. The review revealed 6 instances where HealthKeepers failed to pay

a clean claim within 40 days, in violation of this section. An example is discussed in Review Sheet EFCL15-HK in which HealthKeepers took 377 days to pay a clean claim. HealthKeepers agreed that the claim was not paid within 40 days.

Section 38.2-3407.15 B 3 of the Code states that any interest due on a claim under § 38.2-4306.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. The review revealed 3 instances where HealthKeepers failed to pay interest as required, in violation of § 38.2-3407.15 B 3 of the Code. An example is discussed in Review Sheet EFCL12-HK in which HealthKeepers failed to pay the required interest. HealthKeepers agreed with the examiners' observations.

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 11 instances where HealthKeepers 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, HealthKeepers underpaid the provider by an amount that ranged between \$5 and \$15. An example is discussed in Review Sheet

EFCL22-HK in which HealthKeepers underpaid the contractual allowance by \$5. HealthKeepers 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, HealthKeepers 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. HealthKeepers 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 HealthKeepers' response to Review Sheet EFCL22-HK. The examiners sent Memo EFCLMEM01BW-HK on June 7, 2010, requesting that HealthKeepers 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 provider's contract. HealthKeepers 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 HealthKeepers' 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. HealthKeepers' 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, HealthKeepers underpaid the providers according to the fee schedules included with the provider contracts and failed to document that the vision provider contracts were amended to include the fee schedules provided in its response.

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. HealthKeepers’ failure in 20 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.

V. ADVERTISING/MARKETING COMMUNICATIONS

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

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of this regulation if it is determined by the Bureau of Insurance that the advertisement has the tendency or capacity to mislead from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-90-50)

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

Compliance as required. However, the examination revealed that HealthKeepers' advertisements were not in compliance with the Code and regulations in all instances.

A sample of 25 advertisements from a total population of 195 was selected for review. The review revealed that 2 of the 25 advertisements selected contained violations. In the aggregate, there were 2 violations, which are discussed in the following paragraph.

14 VAC 5-90-50 A sets forth the requirements that the format and content of an advertisement of an accident or sickness insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Review Sheets AD01A-HK and AD02A-HK refer to the 2 violations of this section. As discussed in Review Sheet AD01A-HK, HealthKeepers disseminated an invitation to inquire in the form of a flyer. The examiners originally observed that the flyer discussed benefits without disclosing that exclusions, reductions, or limitations may apply. HealthKeepers disagreed, stating that the identified service was part of a health program "...that provides non-insurance services." The examiners would respond that, although not advertising insurance benefits of the policy, this advertisement promotes services that are not available unless a policy is purchased. The advertisement does not specify that the services are not insurance and not covered benefits of the insurance plan and this omission has the capacity or tendency to mislead or deceive, in violation of this section.

SUMMARY

HealthKeepers violated 14 VAC 5-90 50 A, 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 HealthKeepers 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 shall file for approval explanation of benefits (EOB) forms. The review revealed 75 instances in which HealthKeepers used an EOB form that was not filed with or approved by the Commission, in violation of this section. Examples are discussed in Review Sheet CL02ASHN-HK where HealthKeepers used a denial letter as an EOB for chiropractic claims, but the denial letter was not filed with or approved by the Commission. HealthKeepers agreed with the examiners.

VII. PREMIUM NOTICES/REINSTATEMENTS

HealthKeepers' 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.

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.

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.

Individual

HealthKeepers' 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."

The entire population of 3 individuals receiving a premium increase of greater than 35% at renewal was reviewed. The review revealed that HealthKeepers was in substantial compliance.

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 HealthKeepers 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.

HealthKeepers informed the examiners that it does not track premium increases greater than 35% at renewal in the small group of 2-14 market, but it does send renewal notices to all groups prior to the 60 day notification period. For this reason, the examiners reviewed a sample of 100 from the population of 2,840 renewals in the small group of 2-14 market and found 3 small groups receiving a premium increase greater than 35% at renewal. For all other groups, the entire population of 13 groups receiving premium increases greater than 35% at renewal was reviewed.

The review revealed that HealthKeepers failed, in 4 instances, to provide the group with the required 60-day written notice of a premium increase greater than 35%, in violation of § 38.2-3407.14 B of the Code. An example is discussed in Review Sheet PB04-HK in which a group renewal with an increase in premium of 65.1% was to be effective on April 1, 2008. Written notice of such premium increase was required no later than February 1, 2008. The file included a renewal letter dated February 12, 2008. HealthKeepers agreed with the examiners.

REINSTATEMENTS

HealthKeepers' procedures indicate that a group or individual is reinstated upon written request within 90 days of cancellation for non-payment of premium if all delinquent payments are made to bring the account current.

Individual

A sample of 4 from a population of 7 reinstated individual policies was selected for review. The review revealed that HealthKeepers was in substantial compliance with its established procedures.

Group

A sample of 25 from a population of 154 reinstated groups was selected for review. The review revealed that HealthKeepers was in substantial compliance with its established procedures.

VIII. CANCELLATIONS/NON-RENEWALS

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

Individual

A sample of 18 from a population of 67 individual contracts terminated during the examination time frame was selected for review.

14 VAC 5-211-230 B 1 states that an HMO shall not terminate coverage for services provided under a contract without giving the subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that, for termination due to nonpayment of premium, the grace period as required in 14 VAC 5-211-210 B 17 shall apply. The review revealed that HealthKeepers was in substantial compliance.

Group

A sample of 50 from a population of 1483 groups terminated during the examination time frame was selected for review.

Section 38.2-3542 C of the Code requires an HMO to provide an employer, whose coverage is terminating due to nonpayment of premiums, with a written notice of termination 15 days before the date coverage will terminate, and that coverage shall not be permitted to terminate for at least 15 days after such notice has been mailed. The review revealed that HealthKeepers was in substantial compliance.

IX. COMPLAINTS

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

The examiners reviewed a sample of 21 from a population of 457 written pre-service, post-service and contractual appeals, a sample of 4 from a population of 11 expedited appeals, a sample of 5 from a population of 30 executive inquiries, and a sample of 15 from a population of 31 written complaints received during the examination time frame.

The review revealed that HealthKeepers was in substantial compliance.

X. CLAIM PRACTICES

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

GENERAL HANDLING STUDY

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

HealthKeepers has contracted with intermediaries for the processing of its claims for vision and chiropractic services. EyeMed processes vision claims and American Specialty Health Network (ASHN) processes chiropractic claims.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 365 was selected from a total population of 1,279,757 claims paid during the examination timeframe.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Review Sheet CL09B-HK discusses the 1 instance of non-compliance with these sections. HealthKeepers applied an incorrect deductible and coinsurance while processing a claim. In addition, HealthKeepers

placed inaccurate remarks on the EOB, which stated, “The payment for this service has already been included in the allowance for a related procedure. As such, a separate payment for this procedure could not be made,” resulting in a violation of § 38.2-3407.4 B of the Code, which requires that an EOB accurately and clearly set forth the benefits payable under the contract; and of § 38.2-503 of the Code, which prohibits the use of a statement which is untrue, deceptive or misleading. HealthKeepers agreed with the examiners that the claim was processed incorrectly and submitted documentation verifying that it re-processed the claim to pay the correct amount, with interest.

Mental Health & Substance Abuse

A sample of 120 was selected from a total population of 57,783 mental health and substance abuse claims paid during the examination time frame. Section 38.2-3412.1:01 C of the Code of Virginia requires that coverage for biologically based mental illnesses neither be different nor separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

The review revealed 33 violations of this section. An example is discussed in Review Sheet CL01-HK in which HealthKeepers applied a regular mental health copayment, instead of a specialist copayment, for a claim with a biologically based mental illness diagnosis. By applying a mental health copayment, HealthKeepers failed

to treat the biologically based mental illness as any other illness for determining the copayment factors. HealthKeepers disagreed, stating:

The Company treats all mental health diagnosis codes the same. It does not differentiate between biologically based mental illness and other mental illnesses. The mental health benefits are not subject to separate deductibles; benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits. The copayments for mental illness services are not greater than those for other illnesses. The copayments for mental health and substance abuse benefits are less than the copayments for specialists for other illnesses. HealthKeepers does not believe the intent of Section 38.2-3412.1:01 C of the Code of Virginia is to prohibit an HMO from providing a better benefit for its members than is required by law. The rationale for reducing the mental health copayment in HMO products with high specialist copayments is because of the concern over the cost of an episode of treatment for a behavioral health or biologically based mental illness over time as compared to that of a physical illness. In general behavioral health or biologically based mental illness tend to include more frequent and regular interventions than physical illness, so lower copayments help reduce any financial barrier to care that would be imposed if a specialist copayment were required with every regular mental health visit.

Although the examiners acknowledge the rationale expressed in HealthKeepers' response, the examiners would note that § 38.2-3412.1:01 C of the Code clearly states that coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, to include applicable copayment factors. In the claim referenced above, the member sought services for a diagnosis considered to be a biologically based mental illness according to § 38.2-3412.1:01 E of the Code. Therefore, the copayment should not have been different than if the member had sought services from another type of specialty provider. It remains the opinion of the examiners that HealthKeepers' practice is in violation of the Code. However, since the review did not reveal any instances in which a copayment greater than the copayment

for a service for any other illness was applied, no monetary penalty will be assessed for these violations.

Chiropractic

A sample of 24 was selected from an unknown population of chiropractic claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Ambulance

A sample of 28 claims, consisting of 21 air ambulance claims and 7 ground ambulance claims, was selected from an unknown population of ambulance claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Vision

A sample of 50 claims was selected from a total population of 130,417 vision claim lines paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Pharmacy

A sample of 98 was selected from an unknown population of pharmacy claims paid during the examination time frame. Of the 98 claims in the sample, 23 claims were determined to be Medicaid claims and were not reviewed. Therefore, the examiners reviewed 75 claims. The review revealed that the claims were processed in accordance with the contract provisions.

Dental

A sample of 9 was selected from a total population of 198 dental claim lines paid during the examination time frame. Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that HealthKeepers was in non-compliance with these sections in 2 instances. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. The review revealed that HealthKeepers was in non-compliance with this section in 1 instance. An example of HealthKeepers' non-compliance with these 3 sections is discussed in Review Sheet CL24B-HK. HealthKeepers incorrectly denied the second procedure code on the claim as invalid. Although HealthKeepers disagreed with the examiners observations, the company's response stated, "This claim was originally processed in error." HealthKeepers submitted documentation verifying that it re-processed the claim to pay the correct amount, with interest.

Interest on Claims

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof loss is received to the date of claim payment. The review revealed 2 violations of this section in which HealthKeepers failed to pay interest as required, in the amounts of \$2.84 and \$0.11. An example is discussed in Review Sheet CL10B-HK in which HealthKeepers failed to

pay interest due on the claim. HealthKeepers disagreed with the examiners' observations and provided documentation that interest was paid. However, the documentation confirmed that HealthKeepers paid \$2.84 less than the amount of interest due.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 229 was selected from a total population of 193,715 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 HMO contract, 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 6 instances in which HealthKeepers sent an EOB that failed to include all lines of the claim, in violation of these sections. An example is discussed in Review Sheet CL19B-HK, where HealthKeepers received a claim with 3 procedure codes listed separately by claim line. According to HealthKeepers' procedures, 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. For this claim, HealthKeepers approved payment for two procedure codes and denied

one procedure code. HealthKeepers suppressed the EOB that included the paid procedure codes for which a copay was collected. The only procedure included on the EOB sent to the member was the denied procedure. The denial reason on the EOB stated, "This procedure is incidental when performed with another procedure," but the EOB did not include the related procedures for which benefits were paid and it is not clear which other procedure HealthKeepers is referring to in the denial reason on the EOB. Therefore, HealthKeepers failed 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, in violation of the Code.

HealthKeepers disagreed, stating:

Explanations of Benefits are suppressed when Anthem pays the charges in full and there is no patient balance, when Anthem pays the allowable charge in full and there is no patient balance or when Anthem pays its full allowance and only a flat dollar co-payment remains. Members may request an EOB statement for the types of claims for which an EOB is not sent through an online application. Members may also access Anthem.com and view their claims information on-line. In addition, members can always request a copy of their EOB from a member services representative.

The examiners do not concur. The claim is split onto two separate EOBs, and one is suppressed. 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 HealthKeepers 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.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed 3 instances of non-compliance with these sections. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. The review revealed 1 instance of non-compliance with this section. An example of HealthKeepers' non-compliance with these 3 sections is discussed in Review Sheet CL03B-HK. HealthKeepers incorrectly denied several lines of a claim and the denial reason on the EOB stated, "This service is not covered if billed with another substantial procedure." According to the remarks in the claim file, the claim lines were later approved during a special project with HealthKeepers "at fault." In addition, the EOBs for this claim failed to clearly indicate the amount that was paid, resulting in a violation of § 38.2-3407.4 B of the Code, which requires that an EOB accurately and clearly set forth the benefits payable under the contract; a violation of § 38.2-514 B of the Code, which states that no person shall provide to an enrollee under an HMO contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount that has been or will be paid to the provider of services; and a violation of § 38.2-503 of the Code, which prohibits the use of a statement which is untrue, deceptive or misleading.

Although HealthKeepers disagreed with the examiners' observations, its response stated, "Originally this claim was denied by the Claims Check system. A special project was created in order to adjust all the claims affected and process the denied charges to pay...." HealthKeepers submitted documentation verifying that it re-processed the claim to pay the correct amount, with interest.

Mental Health & Substance Abuse

A sample of 75 was selected from a total population of 8,540 mental health and substance abuse claims denied or adjusted during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Chiropractic

A sample of 16 was selected from an unknown population of chiropractic claims denied or adjusted during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. As discussed in Review Sheet CL03ASHN-HK, the review revealed 1 instance of non-compliance with this section in which HealthKeepers failed to notify the member that a claim had been denied and, thus, failed to provide a reasonable explanation of the basis for the denial of the claim. Although HealthKeepers disagreed with the examiners' observations, its response stated, "However during an internal audit it was identified that this claim was denied incorrectly and adjusted on 4/15/2008...." HealthKeepers did not address the examiners'

observation regarding its failure to provide a reasonable explanation of the basis for the denial of the claim.

Ambulance

A sample of 11, consisting of 8 air ambulance claims and 3 ground ambulance claims, was selected from an unknown population of ambulance claims denied or adjusted during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Vision

A sample of 20 was selected from a total population of 1,910 vision claim lines denied or adjusted during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Pharmacy

A sample of 25 was selected from an unknown population of pharmacy claims denied or adjusted during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Dental

A sample of 13 was selected from a total population of 2,503 dental claim lines denied or adjusted during the examination time frame. Of the 13 claims in the sample, 1 claim was determined to be the claim of an employee and was not reviewed. Therefore, the examiners reviewed 12 claims.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. As discussed in Review Sheet CL22B-HK, the review revealed 1 instance of non-compliance with these sections. HealthKeepers incorrectly denied the claim and the denial reason on the EOB stated, "This service is not a covered benefit of the plan." The remarks in the claim file stated, "claim denied in error by system- auth on file." HealthKeepers submitted documentation verifying that it re-processed the claim to pay the correct amount, with interest.

SUMMARY

HealthKeepers' failure to comply with § 38.2-510 A of the Code did not occur with such frequency as to indicate a general business practice.

TIME SETTLEMENT STUDY

The time settlement study was performed to determine compliance with § 38.2-510 A 5 of the Code, which requires that coverage of claims be affirmed or denied within a reasonable time after proof of loss statements have been completed. The normally acceptable "reasonable time" is 15 working days from the receipt of proof

of loss to the date a claim is either affirmed or denied. The term “working days” does not include Saturdays, Sundays, or holidays.

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

Of the 111 claims reviewed by the examiners that were payable to the member or were denied and were the responsibility of the member, the review revealed 2 instances in which HealthKeepers failed to affirm or deny coverage within a reasonable time, in non-compliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL03ASHN-HK in which HealthKeepers failed to send an EOB informing the member that the claim had been denied. HealthKeepers’ failure to comply with § 38.2-510 A 5 of the Code did not occur with such frequency as to indicate a general business practice.

SETTLEMENT ORDER - CLAIMS FOR EMERGENCY SERVICES

The Commission entered a final settlement order in Case INS-2007-00225 on January 14, 2008. The order requires HealthKeepers to comply with the reimbursement plan and subsequent payment methodology specified in HealthKeepers’ letter of November 16, 2007, to the Bureau of Insurance.

The examiners reviewed a sample of 189 claims for emergency services from non-participating providers from an unknown population. Section 38.2-4312.3 B of the Code states that an HMO shall reimburse a hospital emergency facility and provider, less any applicable copayments, deductibles, or coinsurance, for medical screening and stabilization services rendered to meet the Federal Emergency Medical Treatment and

Active Labor Act and related to the condition for which the member presented in the hospital emergency facility. Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. Section 38.2 510 A 8 of the Code prohibits, as a general business practice, attempting to settle claims for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

In its letter dated November 16, 2007, to the Bureau of Insurance, HealthKeepers' procedure for reimbursement of claims for emergency services from non-participating providers states that, after January 1, 2008, such claims containing a diagnosis code included on the EMTALA diagnosis list developed by its medical staff will be reimbursed by HealthKeepers directly to the non-participating provider or facility in an amount that such provider or facility will accept as payment in full, less any applicable deductible, copayment, or coinsurance.

The review revealed that HealthKeepers did not pay claims for emergency services according to these procedures in 14 instances, placing it in non-compliance with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8; in violation of § 38.2-4312.3 B; and in non-compliance with the reimbursement plan and payment methodology required by the Order. Examples are discussed in Review Sheet CL01ER-HK. The claims for emergency services contained diagnosis codes that are included on the

EMTALA diagnosis list developed by HealthKeepers' medical staff; however, in each instance, the member was held liable for the amount over the allowable charge and HealthKeepers failed to pay the provider directly for services. HealthKeepers disagreed, stating:

Anthem's procedural guideline as of 1/2/2008 is to pay claims as EMTALA only when the primary diagnosis is on the EMTALA DX list. The following claims were all filed with primary diagnoses that are not on that list....

The examiners would respond that the payment methodology in the Order specifies that HealthKeepers will use diagnosis to identify EMTALA claims, but there is no requirement or limitation in the Order that the EMTALA diagnosis be primary. HealthKeepers disagreed, stating:

The reprocessing of EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance although we have no written documentation of this discussion. The EMTALA list of diagnoses was purposely made broad to capture EMTALA events. If a claim does not have an EMTALA diagnosis as the primary diagnosis it is less likely to have been an EMTALA event. No appeals were received from Providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis.

The examiners do not concur. HealthKeepers' specified payment methodology, which is included in the Order, contains no limitation or requirement that the EMTALA diagnosis be primary. In addition, the examiners would note that the EMTALA list developed by HealthKeepers' medical staff contains E codes (diagnosis codes that begin with the letter "E"). The Coding Fundamentals section of the ICD-9 manual states, "E codes are never to be recorded as a principal diagnosis (first-listed in a non-inpatient setting) and are not required for reporting to CMS." Since the ICD-9 coding manual clearly indicates that E codes are never to be used as primary diagnosis codes,

claims with E codes, which HealthKeepers included on its EMTALA list, will never be considered as EMTALA under HealthKeepers' current procedure.

Therefore, HealthKeepers is in violation of § 38.2-4312.3 B, and in non-compliance with the Order, in each and every instance in which a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc. HealthKeepers is in non-compliance with §§ 38.2-510 A 1, 38.2-510 A 6 and 38.2-510 A 8 of the Code in 14 instances.

HealthKeepers' failure to comply with §§ 38.2-510 A 1, 38.2-510 A 6 and 38.2-510 A 8 of the Code occurred with such frequency as to indicate a general business practice, placing HealthKeepers in violation of these sections.

THREATENED LITIGATION

There were no claims that involved threatened litigation during the examination time frame.

XI. CORRECTIVE ACTION PLAN

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

1. Review and revise its procedures to ensure that all provider contracts contain the required “hold harmless” clause and that it reads essentially as set forth in § 38.2-5805 C 9 of the Code;
2. As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;
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 HealthKeepers 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 the prior Report, 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;
5. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-50 A, as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code;
6. Establish and maintain procedures to ensure that all EOBs used by HealthKeepers are filed with and approved by the Commission, in their final form, as required by § 38.2-3407.4 A of the Code;

7. Review and revise its procedures to ensure that all renewals that result in more than a 35% increase in the annual premium charged for the coverage thereunder are notified in writing 60 days prior of such increase as required by § 38.2-3407.14 B of the Code;
8. Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contract holders were not notified in writing 60 days prior to such increase as required by § 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days' written notice to the contract holder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized;
9. Establish and maintain procedures, and revise existing practices, to ensure that all EOBs clearly and accurately set forth the benefits payable under the contract, the method of benefit calculation, and the actual amount which has been or will be paid to the provider of services, as required by §§ 38.2-514 B and 38.2-3407.4 B of the Code;

10. Revise and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;
11. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code;
12. Establish and maintain procedures to ensure compliance with § 38.2-4312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc; and
13. Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

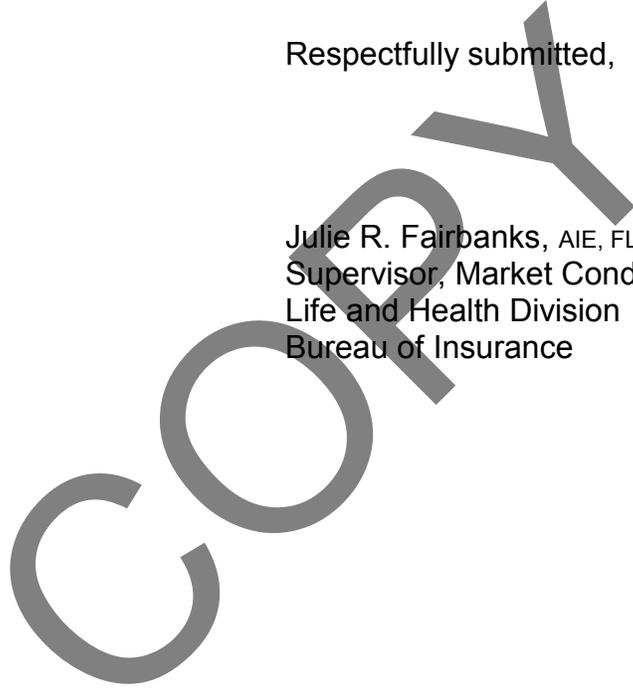
XII. ACKNOWLEDGMENT

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

Bryan Wachter FLMI, AIE, AIRC, Bill Benson, AIE, FLMI, ACS, Todd Bryant, HIA, MHP, 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, FLMI, AIRC
Supervisor, Market Conduct Section II
Life and Health Division
Bureau of Insurance



XIII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Provider Contracts
§ 38.2-5805 C 9, 6 violations, EF04HMO
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§ 38.2-3407.15 B 1, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 2, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 3, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 4, 16 violations, EF03-HMO, EF04-HMO, EF05-HMO
§ 38.2-3407.15 B 5, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 6, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 7, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 8, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 9, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 10, 10 violations, EF03-HMO, EF05-HMO
§ 38.2-3407.15 B 11, 16 violations, EF03-HMO, EF04-HMO, EF05-HMO
Provider Claims
§ 38.2-3407.15 B 1, 6 violations, EFCL01-HK, EFCL11-HK, EFCL13-HK, EFCL14-HK, EFCL15-HK, EFCL16-HK
§ 38.2-3407.15 B 3, 3 violations, EFCL01-HK, EFCL11-HK, EFCL12-HK
§ 38.2-3407.15 B 4 a ii c, 11 violations, EFCL21-HK, EFCL22-HK, EFCL23-HK, EFCL24-HK
§ 38.2-3407.15 B 4 a ii d, 11 violations, EFCL21-HK, EFCL22-HK, EFCL23-HK, EFCL24-HK

§ 38.2-3407.15 B 8, 11 violations, EFCL21-HK, EFCL22-HK, EFCL23-HK, EFCL24-HK
ADVERTISING/MARKETING COMMUNICATIONS
14 VAC 5-90-50 A, 2 violations, AD01A-HK, AD02A-HK
POLICY AND OTHER FORMS
§ 38.2-3407.4 A, 75 violations, CL01VISION-HK, CL02ASHN-HK
PREMIUM NOTICES
§ 38.2-3407.14 B, 4 violations, PB01-HK, PB02-HK, PB03-HK, PB04-HK
CLAIM PRACTICES
§ 38.2-503, 2 violations, CL03B-HK, CL09B-HK
§ 38.2-514 B, 7 violations, CL03B-HK, CL13B-HK, CL14B-HK, CL18B-HK, CL19B-HK, CL20B-HK, CL21B-HK
§ 38.2-3407.4 B, 8 violations, CL03B-HK, CL09B-HK, CL013B-HK, CL14B-HK, CL18B-HK, CL19B-HK, CL20B-HK, CL21B-HK,
§ 38.2-3412.1:01 C, 33 violations, CL01-HK
§ 38.2-4306.1 B, 2 violations, CL10B-HK, CL15B-HK
§ 38.2-4312.3 B, 14 violations, CL01ER-HK, CL02ER-HK
§ 38.2-510 A 1, 21 instances, CL03B-HK, CL06B-HK, CL07B-HK, CL09B-HK, CL22B-HK, CL23B-HK, CL24B-HK, CL01ER-HK, CL02ER-HK
§ 38.2-510 A 5, 2 instances, CL03ASHN- HK, CL10B- HK
§ 38.2-510 A 6, 21 instances, CL03B-HK, CL06B-HK, CL07B-HK, CL09B-HK, CL22B-HK, CL23B-HK, CL24B-HK, CL01ER-HK, CL02ER-HK
§ 38.2-510 A 8, 14 instances, CL01ER-HK, CL02ER-HK
§ 38.2-510 A 14, 4 instances, CL03ASHN-HK, CL03B-HK, CL22B-HK, CL24B-HK

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March 15, 2011

CERTIFIED MAIL 7005 1820 0007 5460 5558
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 HealthKeepers, Inc. (HealthKeepers) 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 HealthKeepers, 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. HealthKeepers 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

Legal Department

Anthem Blue Cross and Blue Shield
2015 Staples Mill Road
PO Box 27401
Richmond, VA 23279
Tel 804 354-7283
Fax 804 354-7281



May 13, 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
HealthKeepers, Inc., Priority Health Care, Inc. and Peninsula Health Care Inc.
Exposure Draft Corrective Action Item Response

Dear Ms. Fairbanks:

This letter is in response to the Market Conduct Examination Report Exposure Drafts issued by the Bureau for HealthKeepers, Inc, Priority Health Care, Inc. and Peninsula Health Care Inc.

Enclosed please find the responses to the Corrective Action Items identified in the Exposure Drafts. HealthKeepers, Inc. is responding on behalf of Priority Health Care, Inc. and Peninsula Health Care Inc.

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
HealthKeepers, Inc.

Enclosure
cc: Owen Hunt

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

- 1. Review and revise its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code.**

HealthKeepers has reviewed its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code. With respect to Review Sheet EF04-HMO, HealthKeepers believes that the addition of supplemental language to the "hold harmless" clause does not essentially change the meaning of the clause nor does it limit member rights.

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

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

HealthKeepers, Inc. maintains its position regarding its response to EF01-HMO 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 HealthKeepers of termination. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue include this corrective action in its Report.

EyeMed has advised that its contracts with providers were updated in December 2008 to include the provisions required by the Code.

- 3. As recommended in prior Report, 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.**

HealthKeepers, Inc. 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. The examiners commented that HealthKeeper's did not provide documentation that would verify the date that EyeMed mailed fee schedules to its providers. EyeMed advised HealthKeeper's, Inc. that it has updated its policies and procedures to document the date that fee schedules were mailed to its providers.

- 4. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-50 A, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.**

The examiners identified two instances that non insurance benefits were not identified as such. HealthKeepers, Inc. will review and revise its procedures to ensure that invitations to inquire identify that certain services are not insurance and not covered benefits under

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

the plans in order to comply with 14 VAC 5-90-50 A, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

- 5. Establish and maintain procedures to ensure that all EOBs used by HealthKeepers are filed with and approved by the Commission, in their final form, as required by Section 38.2-3407.4 A of the Code.**

The examiners identified two instances where vendor EOBs were not filed with and approved by the Commission in their final form. The denial letter identified in CL02ASHN-HK was inadvertently not filed for approval with the Commission. The denial letter was subsequently filed and approved in August, 2008. The EOBs identified in CL01VISION-HK were not filed for approval prior to use. The vendor has been advised that all EOBs and subsequent changes must be filed for approval for use. 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. Review and revise its procedures to ensure that all renewals that result in more than a 35% increase in the annual premium charged for the coverage thereunder are notified in writing 60 days prior of such increase as required by Section 38.2-3407.14 B of the Code.**

The small group 2-14 market example cited in the report on Review Sheet PB04-HK in which the renewal was dated February 12, 2008 for an April 1, 2008 effective date was one of a limited number of renewals that are produced each month outside of the normal production process. Reasons that renewals cannot be produced through the normal production process and schedule include: group is cancelled for non-payment and then later reinstated, renewal date is incorrect on the membership system, or other data entry errors in the membership system that must be corrected prior to producing the renewal.

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 of the 2008 Market Conduct Audit, Anthem instituted a process to 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.

- 7. Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contractholders were not notified in writing 60 days prior to such increase as required by Section 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts**

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days written notice to the contractholder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized.

HealthKeepers, Inc. has conducted a review of all the group renewals released outside of the standard 2-14 market renewal production process for each month in the time period on or after January 30, 2006. The review of these group renewals for refund of premium amounts collected in excess of the 35% increase is based on:

1. Groups receiving greater than a 35% increase excluding premium increases resulting from employees aging into a higher age band
2. Groups identified in #1 who then received less than 60 days notice
3. Groups whose coverage remained in force and paid premiums at the rate increases in excess of 35%.

A report will be created listing any groups due refunds and the amount of the premium to be refunded. HealthKeepers will refund any premium amounts affected by less than 60 days notice. Documentation of the refunds and letters will be furnished to the examiners no later than 90 days after the Report is finalized.

8. **Establish and maintain procedures, and revise existing practices, to ensure that all EOBS clearly and accurately set forth the benefits payable under the contract, the method of benefit calculation, and the actual amount which has been or will be paid to the provider of services, as required by Sections 38.2514 B and 38.2-3407.4 B of the Code.**

HealthKeepers will revise its procedures and existing practices to ensure that all EOBS clearly and accurately set forth the benefits payable under the contract, the method of benefit calculation, and the actual amount which has been or will be paid to the provider of services, as required by Sections 38.2514 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.

9. **Revise and strengthen its procedures for the payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.**

The two instances cited in Review Sheets cL-10B-HK and CL-15B-HK, were a result of human error. HealthKeepers believes that its procedures are adequate to ensure payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.

10. **Establish and maintain procedures to ensure that coverage for biologically based mental illnesses neither be different or separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits,**

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

copayment and coinsurance factors, and benefit year maximum for deductibles, as required by Section 38.2-3412.1:01 C of the Code.

HealthKeepers maintains its position taken in the response to Review Sheet CL01-HK and others that providing a better benefit than required by Section 38.2-3412.1:01 C of the Code is not violative of the law. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue to include this correction action in its Report.

11. Establish and maintain procedures to ensure compliance with Sections 38.2-510 A 1, 38.2-510 A 6, and 38.2 510 A 8 of the Code.

HealthKeepers acknowledges that the examiners determined that findings related to Sections 38.2-510 of the Code did not constitute a general business practice. HealthKeepers will review its procedures to ensure compliance with Section 38.2-510 of the Code.

12. Establish and maintain procedures to ensure compliance with Section 38.24312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.

HealthKeepers respectfully disagrees with this Corrective Action Item. Please refer to the Response to Corrective Action Item 13.

13. Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

HealthKeepers, on behalf of Peninsula, respectfully disagrees with this Corrective Action Item. As indicated in HealthKeepers' additional response to Review Sheet CL01ER-HK, the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance, although we have no written documentation of this discussion. The discussion centered around the supposition that if in fact an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. When a claim is submitted, the provider may bill up to 12 diagnosis codes. At the line level, there is a diagnosis pointer and that pointer advises which diagnosis from the claim level should be used for that claim line. The current HCFA claim form has this diagnosis pointer field and can only point to one diagnosis per claim line. The provider determines the appropriate diagnosis for each claim line.

As previously indicated, the EMTALA list of diagnoses was purposely made broad to capture to EMTALA events. If a claim does not have an EMTALA diagnosis as the

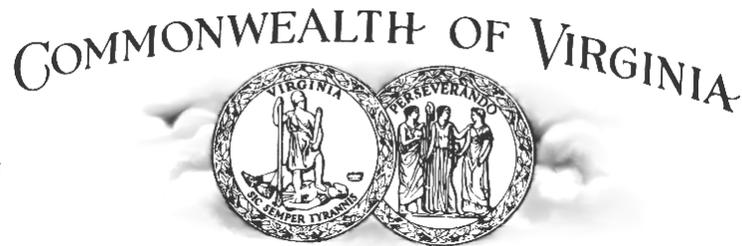
**Response to Recommendations
HealthKeepers, Inc.
Market Conduct Examination Report**

primary diagnosis it is less likely to have been an EMTALA event. An appeal process is set up to address any claim filed by a non-HMO provider for us to reconsider claims that are initially determined to be non-EMTALA. No appeals were received from Providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. However, if any appeals were received a review would have been done to determine if the claim was an EMTALA claim.

HealthKeepers, on behalf of Peninsula, requests an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

COPY

JACQUELINE K. CUNNINGHAM
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November 22, 2011

**CERTIFIED MAIL 7005 1820 0007 5460 5831
RETURN RECEIPT REQUESTED**

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
HealthKeepers, Inc.
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 13, 2011, response to the Market Conduct Examination Report of HealthKeepers, Inc. (HealthKeepers), sent with my letter of March 15, 2011.

Your response indicates that HealthKeepers has concerns regarding the writing of the Report. This letter addresses these concerns in the same order as presented in your May 13th response. However, since HealthKeepers' response will also be attached to the final Report, this response does not address those issues where HealthKeepers indicated agreement and/or action taken as a result of the Report. HealthKeepers should note that upon finalization of this exam, HealthKeepers will be given approximately 90 days to document compliance with **all** of the corrective actions in the Report.

In your response, HealthKeepers 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 HealthKeepers 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 HealthKeepers would like to schedule an informal conference here at the Bureau, HealthKeepers may submit a request, along with a list of all issues or items that it would like to discuss.

- 1. Review and revise its procedures to ensure that all provider contracts contain the required “hold harmless” clause and that it reads essentially as set forth in § 38.2-5805 C 9 of the Code.**

With respect to Review Sheet EF04-HMO, HealthKeepers maintains the position that the addition of supplemental language to the “hold harmless” clause does not essentially change the meaning of the clause nor does it limit member rights. However, § 38.2-5805 C 9 of the Code specifically states that the “hold harmless” clause required by this section shall read essentially as set forth in this subdivision. By amending the “hold harmless” clause with additional language referencing the effectiveness of changes to the language, the “hold harmless” clause no longer reads as essentially set forth in § 38.2-5805 C 9 of the Code, placing HealthKeepers in violation of this section. The examiners would also note that, although HealthKeepers states that it has reviewed its procedures, it has not indicated that it has taken steps to complete the corrective action. The Report appears correct as written.

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

In your response, you state that HealthKeepers maintains its position regarding its response to EF01-HMO. 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 HealthKeepers 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 HealthKeepers 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 HealthKeepers in violation of this section of the Code. The Report appears correct as written.

- 3. As recommended in the prior Report, 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.**

HealthKeepers states that it has procedures in place, but the examination revealed several violations. In order to comply with the corrective action, HealthKeepers 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.

- 4. Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-50 A, as well as subsection 1 of § 38.2-502 and § 38.2-503 of the Code.**

HealthKeepers has indicated that it has already complied with this Corrective Action; however, HealthKeepers has not documented that changes have been made to the sample advertisements cited for violations of 14 VAC 5-90-50 A 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.

- 7. Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contract holders were not notified in writing 60 days prior to such increase as required by § 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days' written notice to the contract holder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized.**

HealthKeepers' proposed plan of action states that it will identify groups receiving greater than a 35% increase excluding premium increases resulting from employees aging into a higher age band. The examiners would note that the Code does not appear to support HealthKeepers' exclusion of premium increases resulting from employees aging into a higher age band. In order for HealthKeepers to comply with the corrective action, it cannot exclude such groups from its review and plan of action.

- 8. Establish and maintain procedures, and revise existing practices, to ensure that all EOBs clearly and accurately set forth the benefits payable under the contract, the method of benefit calculation, and the actual amount which has been or will be paid to the provider of services, 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.

9. Revise and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code.

HealthKeepers states that the 2 instances cited in Review Sheets CL10B HK and CL15B-HK were a result of human error and that it believes that its procedures are adequate to ensure payment of interest due on claim proceeds. The examiners would note that, although HealthKeepers maintains that the violations are due to human error, the corrective action advises HealthKeepers to revise and strengthen its procedures to help mitigate further errors, whether the cause may be due to human error or other reasons. The Report appears correct as written.

10. Establish and maintain procedures to ensure that all coverage for biologically based mental illnesses neither be different or separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors, as required by § 38.2-3412.1:01 C of the Code.

Although HealthKeepers' procedures did not comply with the Code during the examination time frame, after taking into consideration subsequent changes in federal legislation, the Report has been revised to remove this Corrective Action item.

11. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code.

HealthKeepers states that it acknowledges that the examiners determined that findings related to § 38.2-510 of the Code did not constitute a general business practice. This is not correct in all instances. The review of claims for emergency services revealed that HealthKeepers' failure to comply with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code did occur with such frequency as to indicate a general business practice, placing HealthKeepers in violation of these sections. HealthKeepers has not fully complied with this corrective action until it establishes and maintains procedures that ensure that claims for emergency services are processed in accordance with the final settlement order in Case INS-2007-00225 and in accordance with the Code.

12. Establish and maintain procedures to ensure compliance with § 38.2-4312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.

HealthKeepers combined its response for Corrective Action Items #12 and #13. Please see the examiners' comments under Corrective Action Item #13 below.

- 13. Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.**

HealthKeepers indicates that the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau, and that the discussion centered around the supposition that if, in fact, an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. However, HealthKeepers has no written documentation of the discussion. The examiners would note that the written settlement agreement regarding the processing of claims for emergency services from non-participating providers specifies that HealthKeepers will use diagnosis to identify EMTALA claims. The settlement agreement does not include a requirement or limitation that the EMTALA diagnosis be primary and the Bureau does not recall a discussion where both parties agreed to this practice. In order for HealthKeepers to comply with the settlement agreement, all diagnosis codes submitted with a claim must be considered, both when processing the claim and when determining if the claim is an EMTALA claim. Further, the EMTALA list developed and used by HealthKeepers contains 1,172 E codes (diagnosis codes that begin with the letter "E"). E codes comprise roughly 25% of all of the diagnosis codes on the list. In the Coding Fundamentals section of the ICD-9 manual, it states that "E codes are never to be recorded as a principal diagnosis (first-listed in a non-inpatient setting) and are not required for reporting to CMS." Since the ICD-9 coding manual clearly indicates that E codes are never to be used as primary diagnosis codes, claims with these codes will never be considered as EMTALA under HealthKeepers' current procedure. If HealthKeepers' intent was to make the EMTALA list "...broad to capture EMTALA events," it has negated that intention by considering only the primary diagnosis code when determining if a claim is EMTALA and thereby excluding one quarter of all codes on its own list.

HealthKeepers states that an appeal process has been set up to address any claim filed by a non-HMO provider so that HealthKeepers can reconsider claims that are initially determined to be non-EMTALA. HealthKeepers also states that no appeals were received from providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. In response, the examiners would note that a standard operating procedure that requires a claimant to appeal before an insurer will process a claim correctly would be an unfair claims settlement practice and a violation of § 38.2-510 of the Code. In addition, the examiners would note that these providers are non-participating and, as such, are not privy to HealthKeepers' participating provider manual which discusses appeal procedures, and the provider remittances sent to these

non-participating providers do not alert the provider to the special appeal process. The Corrective Action items and the Report appear correct as written.

During the review of the response to the Report, the examiners discovered typos on p.45 of the Report. These typos have been corrected and a revised page is attached.

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, HealthKeepers 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 HealthKeepers 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 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 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: Althelia P. Battle

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December 29, 2011

Julie R. Fairbanks, AIE, AIRC, FLMI, ACS
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Richmond, Virginia 23218

Re: Market Conduct Examination Report
Exposure Draft – Additional Information

Dear Ms. Fairbanks:

This letter is in response to your November 22, 2011 communications regarding the Market Conduct Examination Report Exposure Drafts for HealthKeepers, Inc., Priority Health Care, Inc. and Peninsula Health Care Inc. HealthKeepers, Inc. is responding on behalf of Priority Health Care, Inc. and Peninsula Health Care Inc. with respect to the EMTALA claims corrective action.

Attached please find additional information for the examiners' consideration. If the examiners maintain the position that certain corrective action is required, HealthKeepers, Inc. 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" with "JD" written in smaller letters to the right.

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
HealthKeepers, Inc.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Review and revise its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code.

Original Response

HealthKeepers has reviewed its procedures to ensure that all provider contracts contain the required "hold harmless" clause and that it reads essentially as set forth in Section 38.2-5805 C 9 of the Code. With respect to Review Sheet EF04-HMO, HealthKeepers believes that the addition of supplemental language to the "hold harmless" clause does not essentially change the meaning of the clause nor does it limit member rights.

Additional Response

The Bureau in its 11/22/2011 response maintains that by amending the "hold harmless" clause with additional language referencing the effectiveness of changes to the language, the "hold harmless" clause no longer reads as essentially set forth in Section 38.2-5805 C 9 of the Code. The supplemental language is a holdover from the former HMO regulation (14VAC5-210-10 et seq.). In the former HMO regulation, that language was specifically required to be part of the hold harmless provision in provider contracts. If that specific hold harmless provision was not included in a provider contract, payments under those contracts would not have been considered covered expenses. HealthKeepers, Inc. maintains that inclusion of the supplemental language formerly required by the HMO regulation does not fundamentally change the meaning of the clause nor does it limit member rights.

As recommended in the prior Report, 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

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

HealthKeepers, Inc. maintains its position regarding its response to EF01-HMO 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 HealthKeepers of termination. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue include this corrective action in its Report.

EyeMed has advised that its contracts with providers were updated in December 2008 to include the provisions required by the Code.

Additional Response

HealthKeepers, Inc. will request an informal hearing to discuss this issue.

As recommended in prior Report, establish and maintain procedures to ensure adherence to the compliance with the minimum fair business standards in the

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

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

HealthKeepers, Inc. 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. The examiners commented that HealthKeeper's did not provide documentation that would verify the date that EyeMed mailed fee schedules to its providers. EyeMed advised HealthKeeper's, Inc. that it has updated its policies and procedures to document the date that fee schedules were mailed to its providers.

Additional Response

HealthKeepers, Inc. will review its current procedures and strengthen the procedures as necessary 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.

Review and revise its procedures to ensure that its advertisements are in compliance with 14 VAC 5-90-50 A, as well as subsection 1 of Section 38.2-502 and Section 38.2-503 of the Code.

Original Response

The examiners identified two instances that non insurance benefits were not identified as such. HealthKeepers, Inc. will review and revise its procedures to ensure that invitations to inquire identify that certain services are not insurance and not covered benefits under the plans in order to comply with 14 VAC 5-90-50 A, 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, HealthKeepers, Inc. will provide evidence of revisions made to the advertisements or evidence that these advertisements are no longer in use in Virginia.

Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contractholders were not notified in writing 60 days prior to such increase as required by Section 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days written notice to the contractholder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Original Response

HealthKeepers, Inc. has conducted a review of all the group renewals released outside of the standard 2-14 market renewal production process for each month in the time period on or after January 30, 2006. The review of these group renewals for refund of premium amounts collected in excess of the 35% increase is based on:

1. Groups receiving greater than a 35% increase excluding premium increases resulting from employees aging into a higher age band
2. Groups identified in #1 who then received less than 60 days notice
3. Groups whose coverage remained in force and paid premiums at the rate increases in excess of 35%.

A report will be created listing any groups due refunds and the amount of the premium to be refunded. HealthKeepers will refund any premium amounts affected by less than 60 days notice. Documentation of the refunds and letters will be furnished to the examiners no later than 90 days after the Report is finalized.

Additional Response

In the Bureau's 11/22/2011 response, the examiners state that the code does not appear to support HealthKeepers, Inc.'s exclusion of premium increases resulting from employees aging into a higher age band. Section 38.2-3407.14 of the Code only states "intent to increase by more than 35 percent the annual premium charged for coverage thereunder". It does not specify what is included or excluded. The renewal notice for the Anthem 2-14 market includes the chart of the renewal rates by age band, gender and membership type for any employee of that employer who is enrolled at the time the renewal is produced or who may be employed during the policy year. The rates displayed in this chart for the renewal effective date compared to the chart for the current policy year is the increase in the annual premium. An example of the age banded chart in the renewal package is attached.

Employees who age into a higher age band or change membership types (add dependents), and therefore are charged an increased premium, are outside of the annual premium setting determined by the insurer. Likewise, employee terminations or new hires that result in a higher premium for the employer are outside of the annual premium setting determined by the insurer. Therefore, HealthKeepers has excluded premium increases due to aging into a higher age band.

Revise and strengthen its procedures for the payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.

Original Response

The two instances cited in Review Sheets CL-10B-HK and CL-15B-HK, were a result of human error. HealthKeepers believes that its procedures are adequate to ensure payment of interest due on claim proceeds, as required by Section 38.2-4306.1 B of the Code.

Additional Response

HealthKeepers, Inc. will review and revise its procedures as necessary to mitigate future errors.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Establish and maintain procedures to ensure that coverage for biologically based mental illnesses neither be different or separate from coverage for any other illness, for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles, as required by Section 38.2-3412.1:01 C of the Code.

Original Response

HealthKeepers maintains its position taken in the response to Review Sheet CL01-HK and others that providing a better benefit than required by Section 38.2-3412.1:01 C of the Code is not violative of the law. HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue to include this corrective action in its Report.

Additional Response

HealthKeepers, Inc. acknowledges the removal of this Corrective Action item from the Report.

Establish and maintain procedures to ensure compliance with Sections 38.2-510 A 1, 38.2-510 A 6, and 38.2 510 A 8 of the Code.

Original Response

HealthKeepers acknowledges that the examiners determined that findings related to Sections 38.2-510 of the Code did not constitute a general business practice. HealthKeepers will review its procedures to ensure compliance with Section 38.2-510 of the Code.

Additional Response

The Bureau in its 11/22/2011 response clarified that its review of claims for emergency services revealed that HealthKeepers, Inc. failed to comply with Sections 38.3-510 A 1, 38.2-510 A 6 and 38.2 A 8 of the Code did occur with such frequency as to indicate a general business practice. Additionally, the Bureau stated that HealthKeepers has not fully complied with this Corrective Action until it established and maintains procedures that ensure claims for emergency services are processed in accordance with the final settlement order in Case INS-2007-00225 and in accordance with the Code. HealthKeepers, Inc. maintains that its procedures for processing emergency services are compliant and will request an informal hearing to discuss this issue if the Bureau maintains its position.

Establish and maintain procedures to ensure compliance with Section 38.24312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.

HealthKeepers respectfully disagrees with this Corrective Action Item. Please refer to the Response to Corrective Action Item 13.

Response to Recommendations HealthKeepers, Inc. Market Conduct Examination Report

Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

Original Response

HealthKeepers respectfully disagrees with this Corrective Action Item. As indicated in HealthKeepers' additional response to Review Sheet CL01ER-HK, the processing of the EMTALA claims based on the primary diagnosis was the subject of discussion with the Bureau of Insurance, although we have no written documentation of this discussion. The discussion centered around the supposition that if in fact an EMTALA claim was involved, the most "on point" diagnosis would be submitted as the primary diagnosis. When a claim is submitted, the provider may bill up to 12 diagnosis codes. At the line level, there is a diagnosis pointer and that pointer advises which diagnosis from the claim level should be used for that claim line. The current HCFA claim form has this diagnosis pointer field and can only point to one diagnosis per claim line. The provider determines the appropriate diagnosis for each claim line.

As previously indicated, the EMTALA list of diagnoses was purposely made broad to capture EMTALA events. If a claim does not have an EMTALA diagnosis as the primary diagnosis it is less likely to have been an EMTALA event. An appeal process is set up to address any claim filed by a non-HMO provider for us to reconsider claims that are initially determined to be non-EMTALA. No appeals were received from Providers regarding those claims identified above where an EMTALA diagnosis was not the primary diagnosis. However, if any appeals were received a review would have been done to determine if the claim was an EMTALA claim.

HealthKeepers requests an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

Additional Response

In its 11/22/2011 response, the Bureau reiterates that all diagnosis codes must be considered both when processing the claim and determining if a claim is an EMTALA claim. The ICD-9-CM Official Guidelines for Coding and Reporting Guidelines include the requirement that the provider list first the code for the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided. Adherence to the guidelines is required under the Health Insurance Portability and Accountability Act. If a claim is an EMTALA claim a provider would submit an EMTALA diagnosis first.

The Bureau also indicated that a standard operating procedure that requires a claimant to appeal before an insurer will process a claim correctly would be an unfair claim settlement practice and a violation of Section 38.2-510 of the Code. HealthKeepers

**Response to Recommendations
HealthKeepers, Inc.
Market Conduct Examination Report**

disagrees that its appeal process violates Section 38.2-510 of the Code. A provider is expected to bill with specificity as indicated above. In the event a provider did not list an EMTALA diagnosis as the diagnosis chiefly responsible for the services provided and the claim was processed as non-EMTALA, HealthKeepers appeals process allows for a review of the claim.

In addition, the Bureau indicated that HealthKeepers EMTALA diagnosis code list includes E-codes that are not to be used as primary diagnosis codes. HealthKeepers maintains that even without the inclusion of E-codes, the EMTALA diagnosis code list is broad enough to capture EMTALA events.

HealthKeepers, Inc. will request an informal hearing to discuss this issue should the Bureau continue to maintain that this corrective action is required.

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COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
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February 14, 2012

**CERTIFIED MAIL 7005 1820 0007 5460 6135
RETURN RECEIPT REQUESTED**

Marie Lough, JD, FLMI, AIRC, HIA
Regulatory Compliance Director
HealthKeepers, Inc.
3350 Peachtree Road NE
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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 December 29, 2011, additional response to the Market Conduct Examination Report of HealthKeepers, Inc. (HealthKeepers).

In your December 29th letter, HealthKeepers amended its May 13, 2011, response to include additional information for the examiners' consideration regarding the writing of the Report. This letter addresses HealthKeepers' additional responses in the same order as presented in your December 29th response. However, since HealthKeepers' response will also be attached to the final Report, this response does not address those issues where HealthKeepers indicated agreement and/or action taken as a result of the Report. HealthKeepers should note that upon finalization of this exam, HealthKeepers will be given approximately 90 days to document compliance with **all** of the corrective actions in the Report.

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

1. Review and revise its procedures to ensure that all provider contracts contain the required “hold harmless” clause and that it reads essentially as set forth in § 38.2-5805 C 9 of the Code.

With respect to Review Sheet EF04-HMO, HealthKeepers states that the added language was specifically required in the former HMO regulation 14 VAC 5-210-10 et seq.

However, the added language is not the same as the language found in the repealed regulation 14 VAC 5-210-60 H. The added language in HealthKeepers' contract states:

...that no change is effective until fifteen (15) days after the relevant Commissioner of Insurance or other government agency has been notified of the proposed change.

Whereas, the actual language in 14 VAC 5-210-60 H states:

Any modifications, additions or deletions to the provisions of this hold harmless clause shall become effective on a date no earlier than 15 days after the State Corporation Commission has received written notice of such proposed changes.

The language added to the hold harmless clause does not specify that the notification must be written and it does not specify that the notification must be sent to the State Corporation Commission.

Also, Chapter 210 of Title 14 was repealed and Chapter 211 of Title 14 was adopted to be effective on July 1, 2005. The language in 14 VAC 5-210-60 H mentioned above is not included in Chapter 211. HealthKeepers entered into an agreement with EyeMed in 2006 and transitioned all groups by 2008. Although Chapter 210 of Title 14 had already been repealed in 2005, HealthKeepers failed to ensure that all of its provider contracts were in compliance with § 38.2-5805 C 9 of the Code which specifically states that the “hold harmless” clause required by this section shall read essentially as set forth in this subdivision. By amending the hold harmless clause with additional language referencing the effectiveness of changes to the language, the hold harmless clause does not read as essentially set forth in § 38.2-5805 C 9 of the Code, placing HealthKeepers in violation of this section. The Report appears correct as written.

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

HealthKeepers 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.

7. **Review all renewals of group contracts issued in Virginia that occurred on or after January 30, 2006, that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which group contract holders were not notified in writing 60 days prior to such increase as required by § 38.2-3407.14 of the Code, and refund to the group policyholder all premium amounts collected in excess of the 35% increase for the entire contract period for which notice was not provided. Send checks for the required refunds along with letters of explanation stating specifically that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that HealthKeepers had failed to provide 60 days' written notice to the contract holder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount." Documentation of the refunds and letters should be furnished to the examiners no later than 90 days after the Report is finalized.**

HealthKeepers' additional response and clarification regarding the exclusion of increases resulting from employees aging into a higher band has been reviewed and the examiners find that HealthKeepers' plan seems appropriate. HealthKeepers has agreed to furnish documentation of refunds and letters to the examiners no later than 90 days after the Report is finalized.

11. **Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 1, 38.2-510 A 6, and 38.2-510 A 8 of the Code.**

HealthKeepers 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.

12. **Establish and maintain procedures to ensure compliance with § 38.2-4312.3 B of the Code and revise its existing procedures to process, as an EMTALA claim, a claim for emergency services from a non-participating provider with a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, etc.**

HealthKeepers combined its response for Corrective Action Items #12 and #13. Please see the examiners' comments under Corrective Action Item #13 below.

13. **Review all claims for emergency services from non-participating providers from July 1, 2006 to the current year. Determine those instances where a claim has not been processed as an EMTALA claim although it has a diagnosis that is on HealthKeepers' EMTALA diagnosis list, regardless of whether the EMTALA diagnosis is primary, secondary, tertiary, or otherwise. Reopen and reprocess those claims as EMTALA claims and reimburse affected members and/or providers according to the terms of the Order in**

Case INS-2007-00225 on January 14, 2008. HealthKeepers should provide the examiners with documentation that the required amounts have been paid within 90 days of the Report being finalized.

HealthKeepers states that if a claim is an EMTALA claim, a provider would submit an EMTALA diagnosis first. However, an EMTALA diagnosis code does not have to be the first code listed in order for the claim to be an EMTALA claim. The examiners would continue to note that the written settlement agreement regarding the processing of claims for emergency services from non-participating providers specifies that HealthKeepers will use diagnosis to identify EMTALA claims. The settlement agreement does not include a requirement or limitation that the EMTALA diagnosis be primary and the Bureau does not recall a discussion where both parties agreed to this practice. In order for HealthKeepers to comply with the settlement agreement, all diagnosis codes submitted with a claim must be considered, both when processing the claim and when determining if the claim is an EMTALA claim. An emergency services claim from a non-participating provider that has a diagnosis code on HealthKeepers' EMTALA list, whether it be primary, secondary, tertiary, or otherwise, should be processed as an EMTALA claim.

HealthKeepers disagrees that its appeals process violates § 38.2-510 of the Code, stating that in the event that a provider did not list an EMTALA diagnosis as the diagnosis chiefly responsible for the claim and the claim was processed as non-EMTALA, HealthKeepers' appeal process allows for a review of the claim. The examiners do not concur and would continue to note that a standard operating procedure, as described in HealthKeepers' previous response, that requires a claimant to appeal before an insurer will consider all information on the claim form and process a claim correctly would be an unfair claims settlement practice and a violation of § 38.2-510 of the Code. The examiners would also note that these providers are non-participating and, as such, are not privy to HealthKeepers' participating provider manual which discusses appeal procedures. In addition, the provider remittances sent to these non-participating providers do not indicate that the claim was processed as "non-EMTALA" and do not alert the provider to the special appeal process.

HealthKeepers states that even without the inclusion of E codes, HealthKeepers' EMTALA list is broad enough to capture EMTALA events. The examiners do not concur. The EMTALA list developed and used by HealthKeepers contains 1,172 E codes (diagnosis codes that begin with the letter "E"). E codes comprise roughly 25% of all of the diagnosis codes on the list. Since the ICD-9 coding manual clearly indicates that E codes are never to be used as primary diagnosis codes, claims with these codes will never be considered as EMTALA under HealthKeepers' current procedure. In the final Settlement Order, HealthKeepers agreed to use the diagnosis codes on its list to determine if a claim is an EMTALA claim. HealthKeepers developed its own EMTALA list and developed its own procedure to exclude all but primary diagnosis codes from consideration. When HealthKeepers submitted the proposed list of EMTALA codes to the Bureau, HealthKeepers did not disclose that 1 in 4 codes on its EMTALA list would not be eligible for EMTALA reimbursement when following HealthKeepers' intended procedure. The Report appears correct as written.

Once the matter has been concluded, HealthKeepers 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 orders issued by the State Corporation Commission.

On the basis of our review of this entire file, it appears that HealthKeepers 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 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 await further communication from you as to whether HealthKeepers wishes to schedule an informal conference or proceed with the settlement process. 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: 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

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STATE CORPORATION COMMISSION
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June 4, 2012

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Marie Lough
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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.

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
HealthKeepers, Inc.
3350 Peachtree Road NE
POB 30302-445
Mail Code GAG004-0002
Atlanta, GA 30326-1039

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

RE: Alleged Violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502 and §§ 38.2-503, 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-510 A 15, 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.

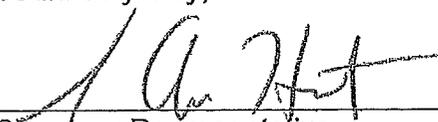
Dear Ms. Battle:

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

HealthKeepers 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 \$52,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement, it is entitled to a hearing in this matter and waives its right to such a hearing and agrees to cease and desist from future violations of §§ 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-514 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, 38.2-3407.15 B 11, and 38.2-4312.3 B of the Code, 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 **120830126**
STATE CORPORATION COMMISSION

AT RICHMOND, AUGUST 22, 2012

SCC-CLERK'S OFFICE
DOCUMENT CONTROL CENTER
2012 AUG 22 P 4: 25

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2012-00141

HEALTHKEEPERS, INC.,

Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that HealthKeepers, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance as a health maintenance organization 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 §§ 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-510 A 15, and 38.2-4306.1 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 §§ 38.2-3407.4 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 § 38.2-3412.1:01 C of the Code by failing to comply with the requirements of coverage for biologically based mental illness; violated § 38.2-4312.3 B of the Code by failing to comply with the requirements of patient access to emergency services; violated § 38.2-5805 C 9 of the Code by failing to comply with Managed Care Health Insurance Plan (MCHIP) requirements; and 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 5-90-50 A.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-4316 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 Fifty-two Thousand Dollars (\$52,000); waived its right to a hearing; agreed to cease and desist from future violations of §§ 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-514 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, 38.2-3407.15 B 11, or 38.2-4312.3 B of the Code; 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 HealthKeepers, Inc., in settlement of the matter set forth herein be, and it is hereby, accepted.

(2) HealthKeepers, Inc., shall cease and desist from any future violations of §§ 38.2-510 A 1, 38.2-510 A 6, 38.2-510 A 8, 38.2-514 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, 38.2-3407.15 B 11, or 38.2-4312.3 B of the Code.

(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, HealthKeepers, 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:

Joel H. Peck
Clerk of the
State Corporation Commission