

**PROCEEDING BEFORE THE HONORABLE MICHAEL D. RILEY
INSURANCE COMMISSIONER OF THE
STATE OF WEST VIRGINIA**

**IN RE:
HIGHMARK WEST VIRGINIA, INC.**

**ADMINISTRATIVE PROCEEDING
16-MAP-02001**

**AGREED ORDER ADOPTING REPORT OF
MARKET CONDUCT EXAMINATION AND DIRECTING
CORRECTIVE ACTION**

NOW COMES, The Honorable Michael D. Riley, Insurance Commissioner of the State of West Virginia, and issues this Order which adopts the Report of Market Conduct Examination for the statutory examination of Highmark West Virginia, Inc. hereinafter referred to as "Company" for the examination period ending May 31, 2015 based upon the following findings, to wit:

PARTIES

1. The Honorable Michael D. Riley, is the Insurance Commissioner of the State of West Virginia (hereinafter the "Insurance Commissioner") and is charged with the duty of administering and enforcing, among other duties, the provisions of Chapter 33 of the West Virginia Code of 1931, as amended.
2. Company operates under the provisions of Chapter 33, of the West Virginia Code as Highmark West Virginia, Inc.
3. Company is licensed and domiciled in West Virginia and operates throughout the State of West Virginia.
4. The Statutory Market Conduct Examination was instituted pursuant to the statutory obligation of the Insurance Commissioner's Office to examine

each West Virginia domestic insurance company every five (5) years.

The purpose of this Statutory Examination was to determine the Company's compliance with all parts of the ACA; Federally Facilitated Marketplace (FFM) requirements, as well as compliance with West Virginia Insurance laws relating to treatment of policyholders and claimants and the examination information contained in the Market Conduct Report should serve only these purposes. The conclusions and findings of the Market Conduct Examination are public record.

FINDINGS OF FACT

1. The examination was conducted in accordance with West Virginia Code Section 33-2-9(c) by examiners duly appointed by the West Virginia Offices of the Insurance Commissioner. The examination fieldwork began on September 28, 2015 and concluded on December 11, 2015. Additional work continued off-site through February 4, 2016.

2. The Statutory Market Conduct Examination included a review of the following mandates:

Federally Facilitated Marketplace (FFM)

Guaranteed Availability

Guaranteed Renewability

Patient Protections and Essential Health Benefits coverage

Clinical Trials nondiscrimination

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Genetic Information Nondiscrimination Act of 2008 (GINA)

Women's Health and Cancer Rights Act of 1998

Newborns' and Mothers' Health Protection Act of 1996

3. A total of eighty-two (82) standards were tested during this examination; the Company was found to be compliant with seventy-seven (77), predominantly compliant with three (3) and non-compliant with two (2) standards.

4. The Company failed to be in compliance with 45CFR §156.340 because producers failed to complete the producer registration prior to selling QHP plans in the federally facilitated marketplace.

5. The Company failed to be in compliance with federal regulation 45CFR §156.1010(d) for timely resolution as it failed to adequately resolve HICS cases within 15 calendar days. The majority of the delays were during open enrollment periods.

6. The Company was compliant or predominantly compliant with eighty (80) standards tested, which is fully set forth in the adopted Report attached here to.

7. On February 11, 2016, the examiner filed with the Insurance Commissioner, pursuant to West Virginia Code Section 33-2-9(j)(2), a Report of Market Conduct Examination.

8. Company waives notice of administrative hearing, any and all rights to an administrative hearing, and to judicial review of this matter.

9. Any Finding of Fact that is more properly a Conclusion of Law is hereby adopted as such and incorporated in the next section.

CONCLUSIONS OF LAW

1. The Insurance Commissioner has jurisdiction over the subject matter and the parties to this proceeding.
2. This proceeding is pursuant to and in accordance with W. Va. Code §33-2-9.
3. The Insurance Commissioner is charged with the responsibility of verifying continued compliance with West Virginia Code and the West Virginia Code of State Rules by Company as well as all other provisions of regulation that Company is subjected to by virtue of their Certificate of Authority to operate in the State of West Virginia.
4. The Company failed two standards, one pertained to producers failing to complete the registration process prior to selling QHP Plans in the federally facilitated marketplace and the other pertained to failing to timely resolve HICS cases. The company was compliant or predominately compliant with the other standards tested.
5. There does not appear to be any intentional misconduct exhibited by Company in this examination findings and scope.
6. Any Conclusion of Law that is more properly a Finding of Fact is hereby incorporated as such.

ORDER

Pursuant to West Virginia Code Section 33-2-9(j)(3)(A), following the review of the Report of Market Conduct Examination, the examination work papers, and Company response thereto, the Insurance Commissioner and Company have agreed to enter into this Agreed Order adopting the Report of

Market Conduct Examination.

It is accordingly **ORDERED** as follows:

(A) The Report of Market Conduct Examination of Company for the period ending May 31, 2015 is hereby **ADOPTED** and **APPROVED** by the Insurance Commissioner;

(B) It is further **ORDERED** that Company shall continue to monitor its Compliance with state and federal laws applicable to the operation of its business in the State of West Virginia.

(C) It is further **ORDERED** that within thirty (30) days of the next regularly scheduled meeting of its Board of Directors, Company shall file with the West Virginia Insurance Commissioner, in accordance with West Virginia Code Section 33-2-9(j)(4), affidavits executed by each of its directors stating under oath that they have received a copy of the adopted Report of Market Conduct Examination and a copy of this **ORDER ADOPTING REPORT OF MARKET CONDUCT EXAMINATION AND DIRECTING CORRECTIVE ACTION**;

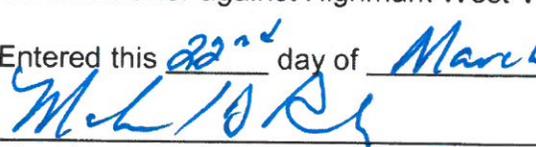
(D) It is further **ORDERED** that Company shall ensure compliance with the West Virginia Code and the Code of State Rules and the Patient Protection and Affordable Care Act (ACA). Company shall specifically cure those violations and deficiencies identified in the Report of Market Conduct Examination; and

(E) It is further **ORDERED** that **COMPANY SHALL FILE** a Corrective Action Plan which will be subject to the approval of the Insurance Commissioner. The Corrective Action Plan shall detail Company changes to its procedures and/or internal policies to ensure compliance with the West Virginia Code and the ACA and incorporate all recommendations of the Insurance Commissioner's examiners and

address all violations specifically cited in the Report of Market Conduct Examination. The Corrective Action Plan outlined in this Order must be submitted to the Insurance Commissioner for approval within thirty (30) days of the entry date of this Agreed Order. Company shall implement reasonable changes to the Corrective Action Plan if requested by the Insurance Commissioner within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan. The Insurance Commissioner shall provide notice to Company if the Corrective Action Plan is disapproved and the reasons for such disapproval within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan.

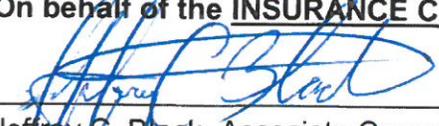
(F) It is finally **ORDERED** that all such statutory notices, administrative hearings and appellate rights are herein waived concerning this Report of Market Conduct Examination and Agreed Order. All such rights are preserved by the Parties regarding implementation or further action taken on such Order by the Commissioner against Highmark West Virginia, Inc.

Entered this 22nd day of March, 2016


The Honorable Michael D. Riley
Insurance Commissioner

REVIEWED AND AGREED TO BY:

On behalf of the INSURANCE COMMISSIONER:


Jeffrey C. Black, Associate Counsel
Attorney Supervisor

Dated: 3/22/16

On Behalf of HIGHMARK WEST VIRGINIA, INC.

By: J. FRED EARLEY, II
Print Name

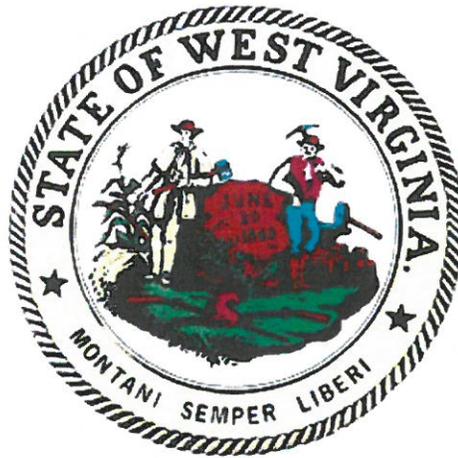
Its: PRESIDENT

Signature: J. Fred Earley, II

Date: March 17, 2016

Report of Market Conduct Examination

As of May 31, 2015



Highmark WV, Inc.
624 Market Street
Parkesburg, WV 26102

NAIC COMPANY CODE 54828
Examination Number WV014-M46

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February 11, 2016

The Honorable Michael D. Riley
West Virginia Insurance Commissioner
1124 Smith Street
Charleston, West Virginia 25301

Dear Commissioner Riley:

Pursuant to your instructions and in accordance with W.Wa. Code §33-2-9, an examination has been made as of May 31, 2015 of the business affairs of

HIGHMARK WEST VIRGINIA, INC.
624 Market Street
Parkersburg, WV 26102

Hereinafter referred to as the "Company" or "HMWV." The following report of the findings of this examination is herewith respectfully submitted.

EXECUTIVE SUMMARY

This is the report of examination for the Market Conduct Examination of Highmark West Virginia, Inc. (Company) conducted by the state of West Virginia, under the authorization of W.Va. Code §33-3-11 and 45 CFR §156.1010. The period covered by the examination was January 1, 2010 through May 31, 2015 with primary focus on the enrollment periods of 2013 and 2014 following the enactment of the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA) as this was the Company's first examination since PPACA was enacted.

The purpose of the examination was to determine the Company's compliance with all parts of the ACA; Federally Facilitated Marketplace (FFM) requirements, as well as West Virginia Statutes and Rules. The examination included a review of the following mandates:

- Federally Facilitated Marketplace (FFM);
- Guaranteed Availability;
- Guaranteed Renewability;
- Patient Protections and Essential Health Benefits coverage;
- Clinical Trials nondiscrimination;
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
- Genetic Information Nondiscrimination Act of 2008 (GINA);
- Women's Health and Cancer Rights Act of 1998; and,
- Newborns' and Mothers' Health Protection Act of 1996.

The examination fieldwork commenced on September 28, 2015 and concluded on December 11, 2015. Additional work continued off-site through February 4, 2016. The examination covered all applicable areas of Chapters XVI, XX, and XXa of the NAIC *Market Regulation Handbook* (including recently adopted ACA standards) and the 2015 *Review of Compliance with Qualified Health Plan Minimum Standards* protocols developed by CMS/CCIIO. Eighty-two (82) standards were reviewed. The Company was determined to be compliant with 77 standards, predominantly compliant with three (3) standards, and non-compliant with two (2) standards.

The major areas of concern are listed below:

- Failure to resolve cases with fifteen (15) calendar days (FFM Standard); and,
- Failure to ensure all producers are registered with CMS to sell marketplace products (FFM Standard).

SCOPE OF EXAMINATION

The basic business areas examined were:

- Company Operations/Management
- Complaint Handling/Grievances/Appeals
- Marketing and Sales
- Producer Licensing
- Policyholder Services
- Underwriting and Rating
- Claims
- Utilization Review
- External Review
- Network Adequacy
- Federally Facilitated Marketplace (FFM) Compliance

Each business area has standards that were measured during the examination process. Although most standards have statutory guidance, others are specific to the Company and contractual guidelines.

The focus of the examination was on the methods used by the Company to manage its operations for each of the business areas subject to this examination. Those areas deemed material were tested to determine if the Company is in compliance with West Virginia statutes and rules. The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify or comment on, or criticize specific Company practices does not constitute an acceptance of the practices by the West Virginia Offices of the Insurance Commissioner.

The examination also included the verification of compliance with regulatory requirements related to the *FFM Qualified Health Plan Minimum Certification Standards* identified in 45 CFR Part 156, Subpart C.

The FFM compliance standards are incorporated within the NAIC standards as follows:

- Company Operations/Management – Standards A.5, A.6, A.7, and A.15
- Producer Licensing – Standard C.1
- Policyholder Service – Standard D.2
- Underwriting and Rating – Standard E.1
- Claims – Standard F.11
- Complaints/Grievances/Appeals – Standard G.3, G.4, G.5
- Network Adequacy – Standard I.1, I.6, I.7

The following additional FFM standards are included as follows:

- Underwriting and Rating – Standard E.17, E.18
- Network Adequacy – Standard H.6

HISTORY AND PROFILE

Highmark Blue Cross Blue Shield West Virginia (Highmark West Virginia) is the only health insurance company operating under the Blue Cross and Blue Shield logos in West Virginia. Highmark West Virginia has been writing insurance since 1932. Highmark West Virginia serves a myriad of commercial and governmental customers through its diverse products. The company maintains a comprehensive network of providers and offers a choice of many hospitals, physicians and medical professionals to both its traditional and managed care customers. Highmark West Virginia offers health insurance plans to individuals, families, small businesses and large corporations.

In April 1999, Highmark West Virginia (then known as Mountain State Blue Cross Blue Shield West Virginia) entered into an affiliation agreement with Highmark Blue Cross Blue Shield, a Pennsylvania based Blue Cross and Blue Shield plan.

In 2004, Highmark West Virginia entered into a Closer Affiliation Agreement which further integrated the two companies, including Highmark being designated the sole corporate member of Highmark West Virginia. In 2009, the affiliation of the two companies was further solidified. Additionally, at this time Highmark and Highmark West Virginia entered into a reciprocal Administrative Services Agreement, with the approval of the West Virginia Offices of the Insurance Commissioner, to better provide for the framework, and flexibility needed to maximize efficiencies and streamline workflows between the respective companies. In January of 2011, Mountain State Blue Cross Blue Shield West Virginia officially changed its “doing business as” name to Highmark Blue Cross Blue Shield West Virginia (Highmark West Virginia.)

Highmark West Virginia serves approximately 280,000 customers through the company’s health care benefits business and also serves tens of thousands of additional members through the Blue Card program. Highmark West Virginia is an independent licensee of the Blue Cross and Blue Shield Association.

The Company’s 2014 market share is reflected in the table below.

MARKET	PREMIUMS	MARKET SHARE
Individual Health	\$137,560,01	87.26%
Small Group	\$198,494,769	70.13%
Large Group	\$606,968,560	80.97%

METHODOLOGY

The examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and West Virginia's applicable statutes and regulations. The examiners conducted file reviews and interviews of company management. The examination report is a report by test, rather than a report by exception.

Tests designed to measure the level of compliance with all Federal ACA/QHP statutes and regulations, along with West Virginia's statutes, rules and regulations were applied to the files selected for review. All standards tested and related results are described this report.

In the results tables, a "pass" response indicates compliance and a "fail" response indicates a failure to comply for each individual file reviewed. The results of each test applied to a sample are reported separately. The examiners used the NAIC standards of 7% error rate on claims test (93% compliance rate) and 10% error rate on all other tests (90% compliance rate) to determine whether or not an apparent pattern or practice of being compliant, predominately compliant, or non-compliant existed for any given test.

Sampling Methodology – Claims:

The PPACA, federal rule sections 45 CFR §§ 147.150, 147.126, 147.130 and 156.110, requires Issuers to provide benefit coverage for the ten (10) Essential Health Benefits without lifetime or annual limits, and without imposing cost sharing on preventive care services performed by in-network providers. The PPACA also seeks to ensure benefit coverage for individuals participating in approved clinical trials. Additional protections are provided through the mental health and substance abuse parity (MHPAEA), women's health and cancer rights (WHCRA), and newborns' and mothers' protections (NMHPA) laws. Included in these rights, are the non-discrimination requirements related to pre-existing health conditions, dependent coverage up to age 26, genetic testing, and limitations or exclusions due to health status.

Essential Health Benefits (EHBs):

- Ambulatory;
- Hospitalization;
- Prescription drugs (pharmacy);
- Mental health and substance use disorder;
- Preventive care services;
- Pregnancy/maternity;
- Emergency services;
- Laboratory;
- Rehabilitative/Habilitative services; and,
- Pediatric services (dental and vision).

Additional categories of claims sampled included:

- Clinical trials;
- Newborns' and Mothers' Health Protection Act (NMHPA);
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA); and,

- Women's Health and Cancer Rights Act (WHCRA)..

The claims sampling methodology that the examiners chose for this Affordable Care Act (ACA) examination varied from a normal random sampling of paid and denied claims, in order to determine compliance with the requirements of the PPACA related to the payment of claims within specific benefit categories. Therefore, using ACL, extracts from the primary claims data files provided by the Company were generated utilizing ICD-9 diagnostic codes and CPT codes identified for each of the following categories:

- Ambulatory/hospitalization;
- Prescription drugs (pharmacy);
- Mental health and substance abuse (MHPAEA);
- Preventive care services;
- Newborns (NMHPA) and pregnancy/maternity;
- Emergency services;
- Clinical trials;
- Laboratory;
- Pediatric services (dental and vision);
- Women's Health and Cancer Rights Act (WHCRA); and,
- Rehabilitative/Habilitative services.

Sample sizes for each of the categories were determined, based on the total population, utilizing the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*.

The following guidelines were used when reviewing the sample files:

- If, after the review of 25 paid claim files in a sample population, no issues were identified, the review of that sample was terminated.
- If, after the review of 50 denied claim files in a sample population, no issues were identified, the review of that sample was terminated.

Demographic analysis of the claims data was performed to provide an overview of the composition of the claims submitted for payment.

Sampling Methodology – Underwriting Samples:

The underwriting and rating review involved the review of samples for new business, renewals, and cancellations/terminations.

The Company was requested to provide separate data files for the following:

- Catastrophic Plans issued to Individuals;
- New Business issued to Individuals;
- Renewal policies for Individuals;

- New Business issued to Small Groups/Small Business Health Options Program (SHOP);
- Renewal policies for Small Groups/SHOP;
- Terminations/Cancellations of policies in force more than 90 days; and,
- Applications declined for all markets.

Sample sizes for each of the categories were determined, based on the total population, utilizing the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*.

A. COMPANY OPERATIONS/MANAGEMENT

The evaluation of standards in the Company operations/management business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to examiners. The review is designed to provide a view of the Company structure and how it operates, and is not based on sampling techniques. The review is not intended to duplicate the management review of a financial examination, but to assist the examiners in gaining a better understanding of the examinee. Many troubled companies have become so because management has not been structured to adequately recognize and address problems that can arise. Well-run companies generally have processes that are similar in structure. While these processes vary in detail and effectiveness from company to company, the absence of the processes or the ineffective application of them often result in failure of various standards tested during an examination. The processes usually include:

- A planning function where direction, policy, objectives, and goals are formulated;
- An execution or implementation of the planning function elements;
- A measurement function that considers the results of the planning and execution; and,
- A reaction function that utilizes the results of measurement activities to take corrective action or to modify the process to develop more efficient and effective management of company operations.

Standard A.1: The regulated entity has an up-to-date, valid internal or external audit program. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 1)

Test Methodology:

- Does the Company have an internal and external audit program to detect structural problems before they occur? [W.Va. Code §§33-33-1, 3 & 4]

Examiner Observations: The Company's *Internal Audit Manual* and the *WV Audit Plan*, as well as a sample of internal audit reports for audits performed during the scope of the examination, were reviewed. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.2: The regulated entity has appropriate controls, safeguards and procedures for protecting the integrity of computer information. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 2)

Test Methodology:

- Does the Company have central recovery and backup procedures? [W.Va. Code R §114-62-3]

Examiner Observations: Documentation reviewed included *Overview of the Business Continuity and IT Disaster Recovery Planning Process*, the *Information Security Policy*, the *Privacy Policies Handbook*, and the *Privacy and Security Training* manual. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.3: The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 3)

Test Methodology:

- Does the Company have an adequate, up-to-date fraud plan in compliance with statutes, rules and regulations? [no statutory requirement]
- Does the Company antifraud plan include procedures for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner or applicable state regulatory agency pursuant to applicable state statutes, rules and regulations? [W.Va. Code R §33-41-5]

Examiner Observations: The Company has procedures in place for the mandatory reporting of possible fraudulent insurance acts to the insurance commissioner. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.4: The regulated entity has a valid disaster recovery plan. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 4)

Test Methodology:

- Does the Company have a disaster recovery plan that will detail procedures for continuing operations in the event of any type of disaster? [no statutory requirement]

Examiner Observations: An overview of the Company's disaster recovery plan was reviewed. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.5: Contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and management agreements must comply with applicable licensing requirements, statutes, rules and regulations. (2015 NAIC Market Regulation Handbook, Chapter 16, §A, Standard 5)

Test Methodology:

- **FFM Compliance:** Do the contracts between the Company and entities assuming a business function or acting on behalf of the regulated entity, such as but not limited to managing general agents (MGAs), general agents (GAs), third party administrators (TPAs) and management agreements comply with applicable licensing requirements, statutes, rules and regulations? [W.Va. Code §33-37-2 and 45 CFR §156.340(a)]

Examiner Observations: All third party entity contracts were reviewed for appropriate licensure requirements; and were reviewed for language specifying the delegated activities and reporting responsibilities, providing for revocation of delegated activities and reporting standards if such parties have not performed satisfactorily, and providing access to records for audit purposes. All contracts were properly executed and included the necessary language or an executed addendum with said language. The company does not utilize MGAs. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.6: The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity. (2015 NAIC Market Regulation Handbook, Chapter 16, §A, Standard 6)

Test Methodology:

- Do the Company contracts with third-party entities specify the responsibilities of the MGA, GA and TPA concerning record keeping and responsibilities of the regulated entity for conducting audits? [W.Va. Code §33-37-2]
- **FFM Compliance:** Does the Company audit the activities of the contracted entities? [W.Va. Code §33-37-4 and 45 CFR §156.340(b)]

Examiner Observations: All third party contracts were determined to specify the recordkeeping responsibilities and the responsibilities of the Company to conduct regular audits. The Company provided an audit schedule, and the examiners reviewed audits of third party entities conducted during the scope of the examination. The company does not utilize MGAs. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.7: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 7)

Test Methodology:

- Does the Company maintain records in compliance with state record retention requirements? [W.Va. Code §33-2-9 and W.Va. Code R §114-15-4]
- **FFM Compliance:** Does the Company adhere to FFM records retention requirements of ten (10) years related to grievances/appeals? [W.Va. Code R §114-96-3 and 45 CFR §156.705]

Examiner Observations: The Company's records retention schedule was reviewed and it was determined to be in compliance with both state and federal retention requirements. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.8: The regulated entity is licensed for the lines of business that are being written. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 8)

Test Methodology:

- Does the Company have Certificates of Authority for the lines of business written? [W.Va. Code §33-3-1]

Examiner Observations: The Company is properly licensed for the lines of business written as required. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.9: The regulated entity cooperates on a timely basis with examiners performing the examinations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 9)

Test Methodology:

- Did the Company provide records in a timely basis? [W.Va. Code §33-2-9 and W.Va. Code R §114-15-4.9a]

Examiner Observations: The Company's representative cooperated in a timely manner with all examiner requests and within the timeframes required by statute. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.10: The regulated entity has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers that are not customers. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 12)

Test Methodology:

- Do the Company policies, practices and procedures regarding protection and disclosure of nonpublic personal information of customers, former customers and consumers who are not customers comply with applicable state laws regarding privacy? [W.Va. Code R §§114-57-11 and 114-62-5]

Examiner Observations: The examiners reviewed the *Information Security Policy*, the *Privacy Policies Handbook*, and the *Privacy and Security Training* manual, as they relate to the protection of nonpublic personal information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.11: The regulated entity provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 13)

Test Methodology:

- Do the Company privacy notices comply with applicable state laws? [W.Va. Code R §§114-57-2 and 114-57-5]
- Does the Company provide privacy notices timely as required by applicable state laws? [W.Va. Code R §§114-57-4 and 114-57-8]

Examiner Observations: The examiners confirmed that privacy notices provided to customers and/or non-customers comply with the law, and are sent timely. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.12: If the regulated entity discloses information subject to an opt-out right, the regulated entity has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the regulated entity provides opt-out notices to its customers and other affected consumers. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 14)

Test Methodology:

- Does the Company provide consumers the opportunity to opt out before nonpublic personal information is disclosed? [W.Va. Code R §114-57-6]
- Does the Company have the capability to keep nonpublic personal financial information from being unlawfully disclosed to nonaffiliated third parties when a consumer has opted out? [W.Va. Code R §114-57-9]

Examiner Observations: The Company's policy does not allow the disclosure of nonpublic personal financial information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.13: The regulated entity's collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 15)

Test Methodology:

- Does the Company comply with regulations regarding disclosing nonpublic personal financial information of its customers or consumers who are not customers to nonaffiliated third parties for joint marketing purposes? [W.Va. Code R §114-57-11]

Examiner Observations: The Company’s policy does not allow the disclosure of nonpublic personal financial information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.14: In states promulgating the health information provisions of the NAIC model regulation, or providing equivalent protection through other substantially similar laws under the jurisdiction of the insurance department, the regulated entity has policies and procedures in place so that nonpublic personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 16)

Test Methodology:

- Does the Company obtain valid authorizations from customers and consumers who are not customers before disclosing their nonpublic personal health information, except to the extent such disclosures are permitted? [W.Va. Code R §114-57-15]

Examiner Observations: The Company’s policy does not allow the disclosure of nonpublic personal health information to nonaffiliated third parties. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard A.15: Each Licensee shall implement a written information security program for the protection of nonpublic customer information. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §A, Standard 17)

Test Methodology:

- Does the Company have procedures for the security of information? [W.Va. Code R §114-62-1 et seq.]
- Does the Company have procedures in place to protect the entity’s database(s) from various hazards, including environmental? [W.Va. Code R §114-62-1]
- **FFM Compliance:** Does the Company adhere to specific privacy and security requirements when accepting enrollment information? [45 CFR §§155.260 and 156.265(c)]

Examiner Observations: The examiners reviewed the *Information Security Policy*, the *Privacy Policies Handbook*, and the *Privacy and Security Training* manual, as they relate to the protection of nonpublic personal information. The Company has a disaster recovery plan in place to protect its database from various hazards. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

B. MARKETING AND SALES

The review of standards related to the Company's business area of marketing and sales was incorporated within each of the following specific ACA/QHP review components:

- Clinical trials;
- Extension of dependent coverage to age 26;
- Guaranteed availability;
- Guaranteed renewability;
- Lifetime/annual benefit limits;
- Prohibitions on preexisting conditions exclusions for individuals under 19 years of age;
- Preventive services; and,
- Review of compliance with QHP minimum certification standards.

C. PRODUCER LICENSING

The evaluation of standards is based on the review of the Center for Medicare Services (CMS) database, the West Virginia Offices of the Insurance Commissioner (WVOIC) records, and the Company responses to information requests, questions, interviews, and presentations made to the examiners. The producer licensing review is designed to test the Company's compliance with federal and state producer licensing laws and rules. All training and registration status of all producers selling QHP plans was verified to determine compliance with federal statutes/rules related to the FFM. A random sample of terminated producers was reviewed to determine compliance with WVOIC statutes and rules. The Company's compliance with licensure and appointment was determined through a random sample of new business policies issued.

Standard C.1: The producers are properly licensed, appointed, and have appropriate continuing education (if required by state law) in the jurisdiction where the application was taken. (2015 NAIC Market Regulation Handbook, Chapter 16, §D, Standard 2)

Test Methodology:

- Are Company producer appointments effective within fifteen days of the producer writing business on behalf of the regulated entity? [W.Va. Code §33-12-18]
- Are the producers authorized for the types of business he/she is eligible to solicit? [45 CFR §156.340]
- **FFM Compliance:** Have the producers met the required continuing education and producer training requirements for selling QHP insurance? [45 CFR §156.340]

Examiner Observations: New business written underwriting samples were reviewed to determine compliance with appointment and licensing regulations. However, as a mandate for FFM Compliance, the list of all appointed producers with the Company was reviewed against the CMS database records to determine compliance with the continuing education and producer registration requirements. It was determined that 73 out of a total of 448 producers had failed to complete the registration process prior to selling QHP plans in the federally facilitated marketplace. According to federal requirements, no producer is permitted to write policies prior to registering.

Examiner Recommendations: The Company should implement a verification process to ensure all producers complete the education and registration requirements for selling QHP plans.

Results: Non-compliant

Table C.1 Results: Producer Appointed Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	195	195	0	90%	100%
Small Group – New Business	15,727	116	116	0	90%	100%
Totals	74,812	311	311	0	90%	100%

Table C.1.a Results: Producer QHP Compliance Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
CMS Training	448	448	448	0	100%	100%
CMS Registration	448	448	375	73	100%	84%

Standard C.2: Records of terminated producers adequately document reasons for terminations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §D, Standard 5)

Test Methodology:

- Does the Company properly document reasons for producer terminations? [W.Va. Code §33-12-25]
- Does the Company properly report to the insurance department producer terminations for cause? [W.Va. Code §33-12-25]

Examiner Observations: Producer file documentation was reviewed for cause of termination and proper reporting to the WVOIC if applicable. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table C.2 Results: Termination of Producer Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Terminated Producers	527	25	25	0	90%	100%

D. POLICYHOLDER SERVICE

The evaluation of standards related to the Company's business area of policyholder service is based on responses to information requests, questions, interviews, and presentations made to the examiner, and file sampling performed during the examination process. The policyholder service portion of the examination is designed to test the Company's compliance with statutes regarding billing notices, reinstatements, delays, premium refunds, and coverage questions.

Standard D.1: Reinstatement is applied consistently and in accordance with policy provisions. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §E, Standard 1)

Test Methodology:

- Does the Company consistently and in a nondiscriminatory manner comply with the reinstatement provisions of the policy? [W.Va. Code §33-15-4]

Examiner Observations: Examiners reviewed Health Insurance Casework System (HICS) cases for enrollment/disenrollment to determine compliance with nondiscrimination requirements. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.1 Results: HICS Cases Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
HICS Cases (Enrollment)	2,192	115	115	0	90%	100%

Standard D.2: Premium notices and billing notices are sent out with an adequate amount of advance notice. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 1)

Test Methodology:

- Does the Company properly handle renewals in accordance with state guidelines? [W.Va. Code R §114-54-6 and 45 CFR §§156.270 and 155.735]
- **FFM Compliance:** Does the Company provide a three (3) month grace period if at least one (1) full month's premium was paid during the benefit year for QHP subsidized policies? [45 CFR §§156.270(d)]
- **FFM Compliance:** Does the Company cancel policies for other than non-payment of premium? [45 CFR §§155.430]

Examiner Observations: The examiner reviewed renewed policies and cancelled/terminated policies to determine compliance with handling and notification requirements. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.2 Results: Policyholder Service Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual Renewal	65,762	116	116	0	90%	100%
Small Group Renewals	62,101	116	116	0	90%	100%
Policies Issued Prior to 1/1/2014	10,421	116	116	0	90%	100%
QHP/Non-QHP Plans	25,750	116	116	0	90%	100%
Totals	164,034	464	464	0	90%	100%

Standard D.3: Policy issuance and insured requested cancellations are timely. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 2)

Test Methodology:

- Does the Company handle insured requested cancellations in a timely manner without excessive paperwork requirements for the insured? [W.Va. Code §33-11-1 et seq.]

Examiner Observations: The examiner reviewed a sample of cancelled/terminated policies to determine whether insured requested cancellations were handled timely and without excessive paperwork. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.3 Results: Cancelled/Terminated Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Policies Issued Prior to 1/1/2014	10,421	116	116	0	90%	100%
QHP/Non-QHP Plans	25,750	116	116	0	90%	100%
Totals	36,171	232	232	0	90%	100%

Standard D.4: All correspondence directed to the regulated entity is answered in a timely and responsive manner by the appropriate department. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §E, Standard 3)

Test Methodology:

- Does the correspondence in the policy files show the Company response was appropriate and timely handled? [W.Va. Code §33-11-1 et seq. and W.Va. Code R §114-14-5]

Examiner Observations: Renewal policy files were reviewed to determine whether the Company response was appropriate and timely handled. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table D.4 Results: Policyholder Service Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual Renewal	65,762	116	116	0	90%	100%
Small Group Renewals	62,101	116	116	0	90%	100%
Totals	127,863	232	232	0	90%	100%

Standard D.5: A health carrier shall make a summary of benefits and coverage available in compliance with final regulations issued by the federal Department of Health and Human Services (HHS), Department of Labor (DOL) and the Treasury.

(2015 NAIC Market Regulation Handbook, Chapter 20A, §J, Standard 2)

Test Methodology:

- Does the Company make the Summary of Benefits and Coverage and Uniform Glossary available without cost to consumers, when “shopping,” upon application for insurance, or during a plan or policy year? [45 CFR §147.200]

Examiner Observations: The examiner verified that current Summary of Benefits and Coverage are provided upon application and renewal. The Company also makes the documents available on its website. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

E. UNDERWRITING AND RATING

The evaluation of standards for the business area related to the Company's underwriting and rating practices were based on responses to information requests, questions, interviews, presentations made to the examiner, and file sample reviews. The application process under Healthcare Reform no longer involves medical underwriting. However, the underwriting and rating practices portion of this examination is designed to verify how the Company treats the public, and whether that treatment is in compliance with applicable statutes, rules and regulations. It is typically determined by testing a random sampling of files and applying various tests to the sampled files. Samples were taken from the population of new business policies issued. In general, declinations and cancellations/terminations were reviewed under the Health Reform standards of guaranteed availability and guaranteed renewability. Policy form and rate filings were not reviewed, but accepted as in compliance based on prior WVOIC filing and approval.

Standard E.1: The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the regulated entity's rating plan. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 1)

Test Methodology:

- Do the premium rates charged match the premium rates that were filed and approved? [W.Va. Code §33-16B-1]
- **FFM Compliance:** Does the Company adhere to the premium payment rules established by the Exchange? [45 CFR §156.265(d) and 45 CFR §155.240]

Examiner Observations: Examiners reviewed the new business underwritten and verified the rates charged were the same as those filed and approved by the WVOIC. Review of the payment process indicated compliance with the rules established by the Exchange. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.1 Results: Underwriting Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	116	116	0	90%	100%
Small Group – New Business	15,727	116	116	0	90%	100%
Catastrophic Plans	153	79	79	0	90%	100%
Totals	74,965	311	311	0	90%	100%

Standard E.2: All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. (2015 NAIC Market Regulation Handbook, Chapter 16, §F, Standard 2)

Test Methodology:

- Does the Company provide an annual notification to individuals regarding the availability of WHCRA benefits? [42 U.S.C. §300gg-52]
- Does the Company provide internal and external appeals notices as required? [45 CFR §147.136]
- Does the Company prominently post rate change justification on their website? [45 CFR §156.210]
- Does the Company provide notification for group health plans of the election of mental health/substance use disorder coverage? [42 U.S.C. §300gg-26]

Examiner Observations: The examiner reviewed the Company’s practices regarding providing of all mandated notifications through review of a sample of renewal policies during the scope of the examination. The Company indicated that a record was not maintained in the individual policyholder files. In response to a request for proof of mailing, the Company provided a mail log, and specimen copies of the notification letters which indicate renewal premium, renewal packet, and other mandatory notices. The Company was determined to be predominantly in compliance.

Examiner Recommendations: It is recommended that the Company establish a process to document in each policyholder file the mailing dates of specific mandated notices, such as premium increases, Summary of Benefits and Coverage, WHCRA, and any other notices.

Results: Predominantly Compliant

Table E.2 Results: Mandated Notification Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual Renewal	65,762	116	116	0	90%	100%
Small Group Renewals	62,101	116	116	0	90%	100%
Totals	127,863	232	232	0	90%	100%

Standard E.3: Pertinent information on applications that form a part of the policy are complete and accurate and applications conform to applicable statutes, rules and regulations. (2015 NAIC Market Regulation Handbook, Chapter 20, §F, Standard 2)

Test Methodology:

- Does the Company have a verification process in place to determine the accuracy of the application information? [W.Va. Code §33-6-7]

Examiner Observations: QHP enrollment is done through the government website and the verification process is performed on the backend. Examiners also reviewed Non-QHP applications for compliance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.3 Results: Underwriting Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	116	116	0	90%	100%
Small Group – New Business	15,727	116	116	0	90%	100%
Catastrophic Plans	153	79	79	0	90%	100%
Totals	74,965	311	311	0	90%	100%

Standard E.4: The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations. (2015 NAIC Market Regulation Handbook, Chapter 20, §F, Standard 3)

Test Methodology:

- Do Company procedures regarding declinations/cancellations comply with COBRA, which allows individuals to continue their group coverage for specified periods in accordance with the provisions of HIPAA? [W. Va. R §114-93-3]

Examiner Observations: The procedures and plan documents were reviewed with regard to continuation of coverage in compliance with the HIPAA provisions. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.4 Results: Cancelled/Terminated Policy Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Policies Issued Prior to 1/1/2014	10,421	116	116	0	90%	100%

Standard E.5: The regulated entity complies with the Genetic Information Nondiscrimination Act of 2008. (2015 NAIC Market Regulation Handbook, Chapter 20, §F, Standard 4)

Test Methodology:

- Does the Company comply with the requirements of GINA, which prohibits group health plans and health insurance issuers from discriminating based on genetic information? [45 CFR §146.122(b) and 45 CFR §148.180(b)(1)]

Examiner Observations: The examiners reviewed an underwriting sample of new business to determine whether discrimination was applied in the issuing of policies based on genetic information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.5 Results: Underwriting Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	116	116	0	90%	100%
Small Group – New Business	15,727	116	116	0	90%	100%
Catastrophic Plans	153	79	79	0	90%	100%
Totals	74,965	311	311	0	90%	100%

Standard E.6: All forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the insurance department, if applicable. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §F, Standard 5)

Test Methodology:

- Did the Company use forms and endorsements that were filed and approved by the WVOIC? [W.Va. Code §33-6-8]

Examiner Observations: The review of Company filing documentation confirmed the Company was using forms, which were filed and approved by the WVOIC. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.7: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §A, Standard 1)

Test Methodology:

- Does the Company have established and implemented underwriting policies and procedures regarding the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials in accordance with statute and regulatory guidance established by HHS, DOL and the Treasury? (no statutory requirement)
- Does the Company deny participation by a qualified individual in an approved clinical trial? [W.Va. Code §33-25F-2(c)(1) and (2) and 42 U.S.C. §300gg-8]
- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about coverage for individuals participating in approved clinical trials? [45 CFR §156.225(b)]

Examiner Observations: The examiner reviewed all unique denied clinical trials and a sample of paid clinical trials. It was determined that no covered persons were discriminated against or denied coverage based on participation in clinical trials. The marketing and training materials used by the Company provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.8: A group health plan, or a health carrier offering group or individual health insurance coverage, that makes available dependent coverage of children shall make such coverage available for children until attainment of 26 years of age. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §B, Standard 1)

Test Methodology:

- Does the Company have established and implemented underwriting policies and procedures related to extension of dependent coverage for individuals to age 26 in compliance with final regulations established by HHS, DOL and the Treasury? (no statutory requirement)
- Do the plan benefits vary based upon age, except for dependent children who are 26 years of age or older? [45 CFR 147.120(b)]
- Does the health carrier provide a dependent child whose coverage ended with at least a 30-day written notice of the opportunity to enroll in a health benefit plan? [45 CFR 147.120(f)]
- Does the Company treat a dependent child enrolling in group health insurance coverage as a special enrollee, as provided under final regulations established by HHS, DOL and Treasury? [45 CFR 147.120(f) and 45 CFR 146.117(d)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to dependent child for whom coverage was inappropriately cancelled or denied? [W.Va. Code R §114-15-4.2]
- Were the policy forms filed and approved by the state for use in the QHP marketplace? [W.Va. Code §33-6-8]

- Do marketing materials provided to insureds and prospective purchasers by the Company provide complete and accurate information about extension of coverage for dependents to age 26? [45 CFR §156.225(b)]

Examiner Observations: A review of the underwriting procedures showed that no guidelines were in place to deny the extension of coverage to dependents to age 26, or vary plan benefits based on dependents age. Procedures are in place for the required 30-day notification. All policy forms were filed and approved by the WVOIC. Marketing materials were found to provide complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.8 Results: Dependent Coverage Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	116	116	0	90%	100%
Small Group – New Business	15,727	116	116	0	90%	100%
Total	74,812	232	232	0	90%	100%

Standard E.9: A health carrier offering individual market health insurance coverage shall issue any applicable health benefit plan to any eligible individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).
(2015 NAIC Market Regulation Handbook, Chapter 20A, §D, Standard 1)

Test Methodology:

- Do the Company underwriting practices related to guaranteed availability provide adequate and appropriate processes to ensure the health carrier makes individual market health insurance coverage available on a guaranteed availability basis to eligible plan applicants in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code §33-15-2b and 45 CFR §147.104(a)]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed availability of coverage? [W.Va. Code §33-15-2b and 45 CFR §147.104(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R §114-15-4.2]

- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of individual market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of coverage. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.9 Results: Guaranteed Availability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – New Business	59,085	116	116	0	90%	100%

Standard E.10 A health carrier offering small group market health insurance coverage shall issue any applicable health benefit plan to any eligible small group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §D, Standard 2)

Test Methodology:

- Do the Company underwriting practices related to guaranteed availability provide adequate and appropriate processes to ensure the health carrier makes small group market health insurance coverage available on a guaranteed availability basis to eligible small employers in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code §114-54-9 and 45 CFR §§146.150(a) and 147.104(a)]
- Do the Company procedures prohibit any waiting period that exceeds 90 days? [45 CFR §147.116]
- Does the Company require participation levels greater than: 100% of eligible employees working for groups of 3 or fewer employees; and, 75% of eligible employees working for groups with more than 3 employees? [W.Va. Code R §114-54-9.4]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed availability of coverage? [W.Va. Code R §114-54-9 and 45 CFR §§146.150(a) and 147.104(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible small employer who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R §114-15-4.2]

- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed availability of small group market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of coverage. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.10 Results: Guaranteed Availability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Small Group – New Business	15,727	116	116	0	90%	100%

Standard E.11: A health carrier offering individual market health insurance coverage shall renew or continue in force the coverage, at the option of the policyholder, subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).
(2015 NAIC Market Regulation Handbook, Chapter 20A, §E, Standard 1)

Test Methodology:

- Do the Company underwriting practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the policyholder, individual market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code R §114-54-6 and 45 CFR §147.106]
- Do the Company underwriting practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W.Va. Code R §114-54-6 and 45 CFR §147.106]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed renewability of coverage? [W.Va. Code R §114-54-6 and 45 CFR §147.106]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an eligible plan applicant who was not offered health insurance coverage on a guaranteed availability basis? [W.Va. Code R §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed renewability of individual market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of renewal coverage. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.11 Results: Guaranteed Renewability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Individual – Renewals	59,085	116	116	0	90%	100%

Standard E.12: A health carrier offering small group market health insurance coverage shall renew or continue in force the coverage, at the option of the small employer subject to final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §E, Standard 2)

Test Methodology:

- Do the Company underwriting practices related to guaranteed renewability provide adequate and appropriate processes to ensure the health carrier renews, or continues in force, at the option of the small employer, small group market health insurance coverage, in compliance with final regulations established by HHS, DOL and the Treasury? [W.Va. Code R §114-54-6 and 45 CFR §146.152(a)]
- Do the Company underwriting practices ensure that nonrenewal or discontinuance of coverage of a health benefit plan is performed only as defined by applicable statutes and rules? [W.Va. Code R §114-54-6 and 45 CFR §146.152(b)]
- Do the Company complaint register/logs and complaint files identify complaints pertaining to restriction of guaranteed renewability of coverage? [W.Va. Code R §114-54-6 and 45 CFR §147.106(a)]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to a policyholder whose health benefit plan providing small group market health insurance coverage was nonrenewed or discontinued? [W.Va. Code R §114-15-4.2]
- Do the Company marketing materials provided to insureds and prospective purchasers by the health carrier provide complete and accurate information about guaranteed renewability of small group market health insurance coverage? [45 CFR §156.225]

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of renewal coverage. All

files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table E.12 Results: Guaranteed Renewability Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Small Group – Renewals	15,727	116	116	0	90%	100%

Standard E.13: A health carrier may not deny coverage to applicants/proposed insureds under the age of 19 years pursuant to the provisions of any preexisting condition exclusion or preexisting condition limitation. (2015 NAIC Market Regulation Handbook, Chapter 20A, §G, Standard 1)

Test Methodology:

- Does the Company limit or exclude coverage under an individual or group health insurance benefit plan for an individual under the age of 19 via the health carrier’s issuance of a preexisting condition exclusion on that individual? [W.Va. Code §33-6-8 and 45 CFR §147.108]
- Do the Company grievance/complaint records identify inquiries regarding coverage denials for applicants/proposed insureds under 19 years of age on the basis of a preexisting condition? [W.Va. Code §33-6-8 and 45 CFR §147.108]
- Does the Company that only covers individuals under age 19, offer such coverage continuously throughout the year, or during one or more open enrollment periods as set forth in applicable state statutes, rules and regulations?

Examiner Observations: All underwriting guidelines were determined to be in compliance with regulations. A review of complaints identified none related to denial of coverage due to preexisting conditions. All files were properly documented. All marketing materials provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.14: Policy language, enrollment materials and marketing and sales materials may not directly or indirectly indicate that individuals under the age of 19 with a preexisting condition cannot enroll in coverage or receive benefits under a group health or individual health insurance policy. (2015 NAIC Market Regulation Handbook, Chapter 20A, §G, Standard 3)

Test Methodology:

- Do the Company's filed policy forms and endorsements contain limitations or exclusions for preexisting conditions applicable to individuals under the age of 19? [W.Va. Code §33-6-8]
- Do the Company's enrollment materials, marketing and sales materials and other information disseminated to applicants/proposed insureds, insureds and claimants provide complete and accurate information about the limitations and restrictions regarding the issuance of preexisting condition exclusions limitations on individuals under the age of 19? [45 CFR §155.225]

Examiner Observations: A review of marketing and training materials were determined to be accurate and not misleading regarding the issue of preexisting condition limitations or exclusions. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.15: A health carrier may not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 1)

Test Methodology:

- Does the Company rescind policies inappropriately? [45 CFR §147.128]
- Does the Company take appropriate corrective action/adjustments regarding the reinstatement of coverage in a timely and accurate manner on the insured's policy when coverage has been rescinded inappropriately? [45 CFR §147.128]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R §114-15-4.2]

Examiner Observations: The Company stated that it had not rescinded any policies during the scope of the examination. A memorandum of attestation was provided. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.16: A health carrier offering group or individual health insurance coverage shall provide at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage may be rescinded. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §I, Standard 2)

Test Methodology:

- Does the Company provide the required 30-day advance written notice to a plan enrollee, or, in the individual market, a primary subscriber? [45 CFR §147.128]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R §114-15-4.2]

Examiner Observations: The policy form contains language indicating that 30 days' notice will be provided in the event of rescission. As indicated above the Company stated that it had not rescinded any policies during the scope of the examination.

Examiner Recommendations: None

Results: Compliant

Additional FFM Standards:

Standard E.17: The QHP issuer must adhere to the enrollment periods and processes for qualified individuals. (2015 CCIIO Compliance Review Protocols, C.8 and C.9)

Test Methodology:

- Does the Company comply with enrollment eligibility and qualification requirements? [45 CFR §156.265(b)]
- Does the Company enroll qualified individuals only during the initial and annual open enrollment period; and make available special enrollment periods for eligible individuals? [45 CFR §155.410(b) and (e), 45 CFR §155.420(d)]

Examiner Observations: The Company's underwriting process and procedures were reviewed, and interviews were conducted with representatives of the Company regarding enrollment eligibility and qualification requirements, as well as open and special enrollment periods. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard E.18: The QHP issuer must adhere to the enrollment periods and processes specific to Federally Facilitated SHOP plans. (2015 CCIIO Compliance Review Protocols, C.8 and C.9)

Test Methodology:

- Does the Company comply with enrollment eligibility and qualification requirements?
[45 CFR §156.285]

Examiner Observations: The Company's underwriting process and procedures were reviewed, and interviews were conducted with representatives of the Company regarding enrollment eligibility and qualification requirements, as well as open and special enrollment periods. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

F. CLAIMS

The evaluation of standards related to the claims business area is based on Company responses to information requested by the examiner, discussions with company staff, electronic testing of claim databases, and file sampling during the examination process. The claims portion of the examination is designed to provide a view of how the Company treats claimants, and whether that treatment is in compliance with applicable statutes and rules. As stated under the Methodology section, the claims samples were specifically selected to verify compliance with the ACA/QHP mandated service requirements.

Therefore, using ACL, randomly selected extracts from the primary claims data files provided by the Company were generated utilizing ICD-9 diagnostic codes and CPT codes identified for each of the following categories:

- Ambulatory/hospitalization;
- Prescription drugs (pharmacy);
- Mental health and substance abuse (MHPAEA);
- Preventive care services;
- Newborns (NMHPA) and pregnancy/maternity;
- Emergency services;
- Clinical trials;
- Laboratory;
- Pediatric services (dental and vision);
- Women’s Health and Cancer Rights Act (WHCRA); and,
- Rehabilitative/Habilitative services.

The initial claims database was broken down as follows:

TOTAL POPULATION - CLAIMS

Claim Type	LARGE GROUP	INDIVIDUAL / SMALL GROUP	TOTAL	PERCENT OF TOTAL
Hospital/Facility	2,435,732	2,537,575	4,973,307	24.98%
Professional	2,842,266	3,539,772	6,382,038	32.05%
Pharmacy	4,195,637	4,361,090	8,556,727	42.97%
TOTALS	9,473,635	10,438,437	19,912,072	100.00%

The breakdown of claims based on In-Network versus Out-of-Network was as follows:

Claim Type	LARGE GROUP	INDIVIDUAL / SMALL GROUP	TOTAL	PERCENT OF TOTAL
In-Network	6,222,394	6,387,129	12,609,523	63.33%
Out-of-Network	3,251,241	4,051,308	7,302,549	36.67%
TOTALS	9,473,635	10,438,437	19,912,072	100.00%

Facility Claim Populations by Network Type

Network Type	Facilities PAID	%Paid	Facilities DENIED	% Denied	Facilities Total
Large Group In Network	1,372,610	84.59%	250,141	15.41%	1,622,751
Large Group Out of Network	10,803	74.17%	3,762	25.83%	14,565
Individual & Small Group In Network	1,499,678	82.23%	324,071	17.77%	1,823,749
Individual & Small Group Out of Network	23,703	82.17%	5,142	17.83%	28,845

Professional Claim Populations by Network Type

Network Type	Professional PAID	%Paid	Professional Denied	% Denied	Professional Total
Large Group In Network	2,326,137	96.81%	76,532	3.19%	2,402,669
Large Group Out of Network	64,756	89.06%	7,951	10.94%	72,707
Individual & Small Group In Network	2,358,118	97.70%	55,579	2.30%	2,413,697
Individual & Small Group Out of Network	65,872	95.23%	3,298	4.77%	69,170

Sample Anomalies: The initial sample size for the different claim categories was set as the AST table standard of 109, and the samples were selected. However, it became clear early in the review that many CPT codes used in extracting for each of the different categories were applicable to numerous diagnosis codes. Therefore, there were claims in some categories that were not relevant to those categories. For example, many laboratory services are used in multiple claims categories. After discussion, it was determined that re-doing the samples would not change the results. Therefore, the examiners reviewed those claims within each sample that were accurate representations of the claims category being tested. Since it was decided at the start of the examination that, if no issues were found, examiners would limit the reviews to only 25 paid claims and 50 denied claims in each category, the tables associated with each procedure below reflect the number of actual claims reviewed in the sample set.

Standard F.1: Claim files are handled in accordance with policy provisions, HIPAA and state law. (2015 NAIC Market Regulation Handbook, Chapter 20, §G, Standard 1)

Test Methodology:

- Does the Company have procedures, training manual, and claim bulletins in place for the proper handling of claims in a fair and nondiscriminatory manner? [W.Va. Code §33-11-4(9)(c)]
- Does the Company have procedures for the detection and reporting of fraudulent or potentially fraudulent insurance acts and proper referral of suspicious claims? [W.Va. Code §§33-41-3 and 5]

- Does the Company handle claims in accordance with policy provisions? [W.Va. Code §33-45-2 and 45 CFR §156.110]

Examiner Observations: The examiner reviewed the Company procedures for claims processing, the Company Anti-Fraud manual, and claims handling in accordance with plan benefits. The review identified two (2) issues:

1. In the case of one policyholder, the Coordination of Benefits had not been applied properly in relation to Medicaid benefits. Two (2) denied claims from this policyholder were in the sample; however, an additional six (6) claims for the policyholder were also incorrectly denied; and,
2. The Preventive Schedule table for developmental screening in children was determined to be in conflict with the footnote defining the number of treatments allowed.

Examiner Recommendations: In the first case, the Company was asked to recalculate the policyholder benefits and pay appropriately. For the second issue, it is recommended that the Company clarify the Preventive Schedule to ensure policyholders do not incur expenses due to a misunderstanding of the number of treatments that qualify as covered services.

Results: Predominantly Compliant

Table F.1.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	270,264	26	26	0	93%	100%
Emergency Services	110,576	25	25	0	93%	100%
Rehabilitative/Habilitative Services	15,969	26	26	0	93%	100%
Preventive/Wellness Services	344,120	50	50	0	93%	100%
Prescription Drugs/Pharmacy	2,237,344	25	25	0	93%	100%
Mental Health/Substance Abuse Services	130,935	26	26	0	93%	100%
Pediatric Services	2,299	25	25	0	93%	100%
Laboratory Services	111,193	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	40,099	25	25	0	93%	100%
Clinical Trials	293	25	25	0	93%	100%
WHCRA	28,908	66	66	0	93%	100%
Large Group	3,308,789	108	108	0	93%	100%
TOTALS	6,600,789	452	452	0	93%	100%

Table F.1.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	47,529	50	50	0	93%	100%
Emergency Services	491	50	50	0	93%	100%
Rehabilitative/Habilitative Services	691	50	48	2	93%	96%
Preventive/Wellness Services	13,744	50	50	0	93%	100%
Prescription Drugs/Pharmacy	1,352,128	47	47	0	93%	100%
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%
Pediatric Services	10	10	10	0	93%	100%
Laboratory Services	1,765	49	49	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%
Clinical Trials	12	10	10	0	93%	100%
WHCRA	81	20	20	0	93%	100%
Large Group	1,270,261	109	109	0	93%	100%
TOTALS	2,772,949	505	503	2	93%	99%

Standard F.2: The company complies with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996. (2015 NAIC Market Regulation Handbook, Chapter 20, §G, Standard 2)

Test Methodology:

- Does the Company comply with the standards of the NMHPA with regard to 48/96 hour minimums? [45 CFR §146.130]
- Does the Company engage in incentive arrangements to circumvent the requirements of the law? [45 CFR §146.130]

Examiner Observations: A sample of claims related to maternity and newborn benefits were reviewed. The Company complies with the 48/96 minimum standard, and did not engage in incentives to circumvent the requirements of the law. No issues were noted.

Examiner Recommendations: None

Results: Compliant

Table F.2.a Results: NMHPA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Pregnancy/Maternity/Newborn Care	40,099	25	25	0	93%	100%

Table F.2.b Results: NMHPA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%

Standard F.3: Claims are resolved in a timely manner. (2015 NAIC Market Regulation Handbook, Chapter 16, §G, Standard 3)

Test Methodology:

- Does the Company resolve claims in accordance with state requirements? [W.Va. Code R §114-14-6]

Examiner Observations: Time studies on the claim samples determined that all claims were paid in compliance with state requirements. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.3.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	270,264	26	26	0	93%	100%
Emergency Services	110,576	25	25	0	93%	100%
Rehabilitative/Habilitative Services	15,969	26	26	0	93%	100%
Preventive/Wellness Services	344,120	50	50	0	93%	100%
Prescription Drugs/Pharmacy	2,237,344	25	25	0	93%	100%
Mental Health/Substance Abuse Services	130,935	26	26	0	93%	100%
Pediatric Services	2,299	25	25	0	93%	100%
Laboratory Services	111,193	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	40,099	25	25	0	93%	100%
Clinical Trials	293	25	25	0	93%	100%
WHCRA	28,908	66	66	0	93%	100%
Large Group	3,308,789	108	108	0	93%	100%
TOTALS	6,600,789	452	452	0	93%	100%

Table F.3.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	47,529	50	50	0	93%	100%
Emergency Services	491	50	50	0	93%	100%
Rehabilitative/Habilitative Services	691	50	50	0	93%	100%
Preventive/Wellness Services	13,744	50	50	0	93%	100%
Prescription Drugs/Pharmacy	1,352,128	47	47	0	93%	100%
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%
Pediatric Services	10	10	10	0	93%	100%
Laboratory Services	1,765	49	49	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%
Clinical Trials	12	10	10	0	93%	100%
WHCRA	81	20	20	0	93%	100%
Large Group	1,270,261	109	109	0	93%	100%
TOTALS	2,772,949	505	505	0	93%	100%

Standard F.4: The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 3)

Test Methodology:

- Does the health plan comply with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008? [45 CFR §146.136]

Examiner Observations: The examiners reviewed the claim samples to determine if the claims for mental health and substance abuse were paid in accordance with the parity requirements provided under the law and without additional requirements relative to authorizations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.4.a Results: MHPAEA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Mental Health/Substance Abuse Services	130,935	26	26	0	93%	100%

Table F.4.b Results: MHPAEA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%

Standard F.5: The group health plan complies with the requirements of the federal Women's Health and Cancer Rights Act of 2008. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §G, Standard 4)

Test Methodology:

- Does the Company provide mastectomy-related reconstruction coverage as required by law? [42 U.S.C. §300gg-52 and 29 U.S.C. §1185b]

Examiner Observations: A sample of claims related to reconstructive surgery and prosthetic treatments or devices was reviewed to determine compliance under WHCRA. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.5.a Results: WHCRA Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
WHCRA	28,908	66	66	0	93%	100%

Table F.5.b Results: WHCRA Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
WHCRA	81	20	20	0	93%	100%

Standard F.6: Claim files are adequately documented. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §G, Standard 5)

Test Methodology:

- Does the Company adequately document all claim files? [W.Va. Code R §114-14-3]
- Does the Company maintain claim file documentation in accordance with state retention requirements? [W. Va. Code R §114-15-4]

Examiner Observations: Review of the claim files determined that all were adequately documented. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.6.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	270,264	26	26	0	93%	100%
Emergency Services	110,576	25	25	0	93%	100%
Rehabilitative/Habilitative Services	15,969	26	26	0	93%	100%
Preventive/Wellness Services	344,120	50	50	0	93%	100%
Prescription Drugs/Pharmacy	2,237,344	25	25	0	93%	100%
Mental Health/Substance Abuse Services	130,935	26	26	0	93%	100%
Pediatric Services	2,299	25	25	0	93%	100%
Laboratory Services	111,193	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	40,099	25	25	0	93%	100%
Clinical Trials	293	25	25	0	93%	100%
WHCRA	28,908	66	66	0	93%	100%
Large Group	3,308,789	108	108	0	93%	100%
TOTALS	6,600,789	452	452	0	93%	100%

Table F.6.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	47,529	50	50	0	93%	100%
Emergency Services	491	50	50	0	93%	100%
Rehabilitative/Habilitative Services	691	50	50	0	93%	100%
Preventive/Wellness Services	13,744	50	50	0	93%	100%
Prescription Drugs/Pharmacy	1,352,128	47	47	0	93%	100%
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%
Pediatric Services	10	10	10	0	93%	100%
Laboratory Services	1,765	49	49	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%
Clinical Trials	12	10	10	0	93%	100%
WHCRA	81	20	20	0	93%	100%
Large Group	1,270,261	109	109	0	93%	100%
TOTALS	2,772,949	505	505	0	93%	100%

Standard F.7: A health carrier may not deny coverage or restrict coverage for qualified individuals, as defined in applicable statutes, rules and regulations, who participate in approved clinical trials. (2015 NAIC Market Regulation Handbook, Chapter 20A, §A, Standard 1)

Test Methodology:

- Does the Company deny, limit or impose additional conditions on the coverage of routine patient costs for items or services furnished in connection with participation in a trial? [W.Va. Code §§33-25F-2(c)(1) and (2) and 42 U.S.C. §300gg-8]
- Does the Company maintain proper documentation for correspondence, including website notifications, supporting corrective action provided to an individual for whom coverage for participation in an approved clinical trial was inappropriately restricted or denied? [W.Va. Code R §114-15-4.2]

Examiner Observations: The examiner reviewed all unique denied clinical trials and a sample of paid clinical trials. It was determined that no covered persons were discriminated against or denied coverage based on participation in clinical trials. All claims were paid in accordance with the plans schedule of benefits. The marketing and training materials used by the Company provided complete and accurate information. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.7.a Results: Clinical Trials Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Clinical Trials	293	25	66	0	93%	100%

Table F.7.b Results: Clinical Trials Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Clinical Trials	12	10	10	0	93%	100%

Standard F.8: A health carrier shall not establish any lifetime or annual limit on the dollar amount of essential health benefits (EHB)s for any individual, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §F, Standard 1)

Test Methodology:

- Does the Company apply lifetime/annual limits on the dollar amount of essential health benefits for any individual, in violation of final regulations established by HHS, the DOL and the Treasury? [45 CFR §147.126]

Examiner Observations: Review of the policy plans determined that no lifetime or annual limits are applied to benefits. A review of claims samples found no lifetime/annual limits applied. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.8.a Results: Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	270,264	26	26	0	93%	100%
Emergency Services	110,576	25	25	0	93%	100%
Rehabilitative/Habilitative Services	15,969	26	26	0	93%	100%
Preventive/Wellness Services	344,120	50	50	0	93%	100%
Prescription Drugs/Pharmacy	2,237,344	25	25	0	93%	100%
Mental Health/Substance Abuse Services	130,935	26	26	0	93%	100%
Pediatric Services	2,299	25	25	0	93%	100%
Laboratory Services	111,193	25	25	0	93%	100%
Pregnancy/Maternity/Newborn Care	40,099	25	25	0	93%	100%
Clinical Trials	293	25	25	0	93%	100%
WHCRA	28,908	66	66	0	93%	100%
Large Group	3,308,789	108	108	0	93%	100%
TOTALS	6,600,789	452	452	0	93%	100%

Table F.8.b Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	47,529	50	50	0	93%	100%
Emergency Services	491	50	50	0	93%	100%
Rehabilitative/Habilitative Services	691	50	50	0	93%	100%
Preventive/Wellness Services	13,744	50	50	0	93%	100%
Prescription Drugs/Pharmacy	1,352,128	47	47	0	93%	100%
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%
Pediatric Services	10	10	10	0	93%	100%
Laboratory Services	1,765	49	49	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%
Clinical Trials	12	10	10	0	93%	100%
WHCRA	81	20	20	0	93%	100%
Large Group	1,270,261	109	109	0	93%	100%
TOTALS	2,772,949	505	505	0	93%	100%

Standard F.9: A health carrier may not deny benefits under a policy to any insured under the age of 19 pursuant to the provisions of any preexisting condition exclusion or other preexisting condition limitation. (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §G, Standard 2)

Test Methodology:

- Do the Company grievance/complaint records identify inquiries regarding denial of benefits to insureds under 19 years of age on the basis of a preexisting condition? [45 CFR §147.108]
- Does the Company take appropriate corrective action/adjustments regarding the removal of the limitations/exclusions in a timely and accurate manner when a health carrier has improperly applied limitations or exclusions of coverage through the issuance of a preexisting condition exclusion on any individual under the age of 19? [45 CFR §147.108]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R §114-15-4.2]

Examiner Observations: A review of claim samples identified no claims denied due to preexisting conditions which would have required corrective action. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.9 Results: Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Ambulatory/Hospitalization	47,529	50	50	0	93%	100%
Emergency Services	491	50	50	0	93%	100%
Rehabilitative/Habilitative Services	691	50	50	0	93%	100%
Preventive/Wellness Services	13,744	50	50	0	93%	100%
Prescription Drugs/Pharmacy	1,352,128	47	47	0	93%	100%
Mental Health/Substance Abuse Services	3,601	20	20	0	93%	100%
Pediatric Services	10	10	10	0	93%	100%
Laboratory Services	1,765	49	49	0	93%	100%
Pregnancy/Maternity/Newborn Care	82,636	40	40	0	93%	100%
Clinical Trials	12	10	10	0	93%	100%
WHCRA	81	20	20	0	93%	100%
Large Group	1,270,261	109	109	0	93%	100%
TOTALS	2,772,949	505	505	0	93%	100%

Standard F.10: A health carrier shall not impose cost sharing requirements upon preventive services, as defined in, and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §H, Standard 1)

Test Methodology:

- Does the Company take appropriate corrective action/adjustments on the insured’s policy deductibles, copayments, coinsurance and other cost-sharing mechanisms in a timely and accurate manner when improper assessment of cost-sharing upon insureds occurs? [45 CFR §147.130]
- Does the Company maintain proper documentation for all correspondence supporting corrective action provided to the insured, including website notifications? [W.Va. Code R §114-15-4.2]
- Do the Company’s enrollment materials, marketing and sales materials, and other information disseminated to applicants/proposed insureds, insureds and claimants provide complete and accurate information about the restriction of cost-sharing methods the health carrier may impose on the insured for preventive items and services described in the final regulations established by HHS, the DOL and the Treasury? [W.Va. Code §33-11-4 and 45 CFR §155.225]

- Does the Company properly apply deductibles, co-payments, coinsurance and other methods of cost-sharing on preventive items and services, in accordance with final regulations established by HHS, the DOL and the Treasury? [45 CFR §147.130]

Examiner Observations: Claim samples were reviewed to verify that cost sharing was not imposed on preventive services performed in-network. Enrollment materials and marketing materials were reviewed and found to provide complete and accurate information regarding the restrictions on the application of cost sharing on preventive services. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table F.10.a Results: Preventive Services Paid Claims Sample

Type	Total Population	Paid Sample	Pass	Fail	Standard	Compliance
Preventive Services	344,120	25	25	0	93%	100%

Table F.10.b Results: Clinical Trials Denied Claims Sample

Type	Total Population	Denied Sample	Pass	Fail	Standard	Compliance
Preventive Services	13,744	50	50	0	93%	100%

Additional FFM Standards:

Standard F.11: Prescription Drug Distribution and Cost Reporting

Test Methodology:

- Does the Company provide a URL to the formularies and information regarding formularies to consumers? [45 CFR §147.200(a)(2)(i)(K)]
- Do the Company's diabetic and HIV/anti-retroviral drugs listed on the formularies match the Prescription Drug (RX) Template submitted to CMS for the 2015 benefit year?
- Does the Company have prescription drug benefit plans that discourage consumers with high cost prescription drug needs from enrolling? [45 CFR §156.122(c)]

Examiner Observations: The examiner reviewed the drug formularies for compliance with CMS requirements for the 2015 benefit year. All formularies were found to be compliant, and did not include plans to discourage consumers from enrolling. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

G. COMPLAINTS/GRIEVANCES/APPEALS

Complaint Handling

Evaluations of the standards in the Company's complaint handling business area are based on Company responses to various information requests and the review of compliant files at the Company. Complaints reviewed included "direct" consumer complaints and complaints received from the Office of the Insurance Commissioner. W.Va. Code §33-11-4(10) requires the Company to "...maintain a complete record of all complaints which it has received since the date of its last examination." The statute also requires that the Company maintain records to indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. The definition of a complaint is, "...any written communication primarily expressing a grievance." Also in the review were case submissions through the handling of Health Insurance Casework System (HICS), including issues with enrollment/disenrollment and non-adverse determination complaints. ACL was used to generate a sample based on the Acceptance Samples Table (AST) found in the NAIC *Market Regulation Handbook*.

Standard G.1: All complaints are recorded in the required format on the regulated entity's complaint register. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 1)

Test Methodology:

- Does the Company record and maintain a complaint register with all required information? [W.Va. Code §33-11-4 and W.Va. Code R §114-15-4.6]

Examiner Observations: The Company records and maintains a complaint register and a log of all HICS cases. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table G.1 Results: HICS/OIC Complaints Recorded Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
HICS Cases (Enrollment)	2,192	115	115	0	90%	100%
HICS Cases (All others)	1,128	114	114	0	90%	100%
Complaints	201	83	83	0	90%	100%
Totals	3,521	312	312	0	90%	100%

Standard G.2: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 2)

Test Methodology:

- Does the Company have complaint procedures in place to satisfactorily handle complaints received? [W.Va. Code R §114-14-5]
- Does the Company provide a telephone number and address for consumer inquiries? [no statutory requirement]

Examiner Observations: The examiners reviewed the *HICS Resolution Guide*, the *Customer Service Grievance Policy and Procedures*, and the *Legal Department Complaint Procedures*. The Company has adequate procedures in place for the handling of complaints and grievances. The enrollment packet and policy forms were found to include a Company telephone number and address for consumer inquiries. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.3: The regulated entity takes adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 3)

Test Methodology:

- Does the Company respond fully to the issues raised in all complaints? [W.Va. Code R §114-14-5]
- Does the Company adequately document all complaint files? [W.Va. Code R §114-15-4]
- **FFM Compliance:** Does the Company resolve all HICS complaints as appropriate? [45 CFR §156.1010(b)]

Examiner Observations: A review of the WVOIC complaints and the HICS cases determined that all were satisfactorily resolved. However, it was determined the Company failed to adequately document HICS cases. No exceptions were noted.

Examiner Recommendations: The Company should ensure that all HICS case documentation is complete.

Results: Compliant

Table G.3 Results: HICS/OIC Complaints Finalized Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
HICS Cases (Enrollment)	2,192	115	115	0	90%	100%
HICS Cases (All others)	1,128	114	114	13	90%	90%
Complaints	201	83	83	0	90%	100%
Totals	3,521	312	312	0	90%	100%

Standard G.4: The time frame within which the regulated entity responds to complaints is in accordance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 16, §B, Standard 4)

Test Methodology:

- Does the Company respond timely, within 15 working days, to the issues raised in all complaints? [W.Va. Code R §114-14-5]
- **FFM Compliance:** Does the Company resolve HICS standard cases within 15 calendar days and urgent complaints within 72 hours? [**45 CFR §156.1010(d)**]

Examiner Observations: The review of WVOIC complaints and HICS cases determined the Company was out of compliance with federal regulation **45 CFR §156.1010(d)** for timely resolution, as it failed to adequately resolve HICS cases within 15 calendar days. It was noted that the majority of the delays occurred during the open enrollment periods.

Examiner Recommendations: It is recommended that the Company review and amend its procedures for handling HICS cases, especially during peak periods.

Results: Non-compliant

Table G.4 Results: HICS/OIC Complaint Timely Response Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
HICS Cases (Enrollment)	2,192	115	82	33	90%	72%
HICS Cases (All others)	1,128	114	59	55	90%	52%
Complaints	201	83	83	0	90%	100%
Totals	3,521	312	224	88	90%	72%

Grievances/Appeals

The evaluation of the standards related to the processing of grievances and appeals is based on the Company’s responses to information requests from the examiner, discussions with company staff, and file sample reviews during the examination process. Included in the review were first-level, expedited, and non-adverse determination appeals. Also included were any HICS cases reviewed which resulted in adverse determinations. Compliance issues were determined based on both federal and state statutes and rules related to internal and external appeals as applied to FFM/QHP products, specifically 45 CFR §§147.136 and 156.1010(b) and W.Va. Code §§114-96-4 and 5. ACL was utilized to select samples from HICS cases and appeals filed with the Company.

Standard G.5: A health carrier offering individual health insurance coverage shall maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by the U.S.

Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 1)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding grievance records handling in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R §114-96-4.2]
- Does the Company maintain and make available grievance records for at least six years for first level grievances involving an adverse determination and for expedited reviews of grievances involving an adverse determination? [W.Va. Code R §114-96-3.1.b and 45 CFR §147.136(b)(3)(H)]
- **FFM Compliance:** Does the Company maintain QHP grievance records for at least ten years for first level grievances involving an adverse determination and for expedited reviews of grievances involving an adverse determination? [**45 CFR 156.705(c)**]

Examiner Observations: The examiners reviewed the Company's appeals and grievance policies and procedures to determine whether the Company was in compliance with all state and federal statutes and regulations. The Company retention schedules were reviewed to ensure that the Company maintains grievance records for at least six (6) years and QHP appeals and grievances for at least ten (10) years. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.6: The health carrier shall comply with grievance procedures requirements, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §C, Standard 2)

Test Methodology:

- Does the Company have procedures for and conduct first level reviews of grievances involving an adverse determination to include a statement of a covered person's right to contact the insurance commissioner's office or ombudsman's office for assistance at any time, and include the telephone number and address of the insurance commissioner or ombudsman's office in compliance with applicable statutes, rules and regulations? [42 U.S.C. §300gg-19 and 45 CFR §147.136]
- Does the Company provide notice within 10 days after the independent reviewer rejects the grievance for the opportunity to resubmit under applicable state statutes, rules and regulations equivalent to the Health Carrier Grievance Procedure Model Act (#72)? [W.Va. Code R §114-96-4.1]

Examiner Observations: The procedures were reviewed for the applicable language regarding the covered person’s rights and contact information for the insurance commissioner’s office or ombudsman’s office for assistance. Grievance samples were reviewed to determine compliance with the 10-day notification requirement. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table G.6 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Appeals	586	113	113	0	90%	100%

Standard G.7: The health carrier shall conduct first-level reviews of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

(2015 NAIC Market Regulation Handbook, Chapter 20A, §C, Standard 3)

Test Methodology:

- Does the Company ensure that the first level review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the review decision? [W.Va. Code R §§114-9-5.2.b and c and 5.3, and 45 CFR §147.136(b)(2)(ii)(D)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? [W.Va. Code R §114-96-5.9 and 45 CFR §147.136(b)(2)(ii)(E)]
- Does the Company provide the notice as required in case of disenrollment or rescission, as included in the definition of adverse determination? [45 CFR §147.136(b)(3)(ii)(A)]

Examiner Observations: A sample of appeals and HICS cases was reviewed. It was determined that, in one (1) HICS case of disenrollment, a notification of adverse determination was not sent in compliance with 45 CFR §147.136(b)(3)(ii)(A).

Examiner Recommendations: It is recommended that the Company revise its procedures to include the requirement that notices regarding adverse determinations related to disenrollment are to be sent to the consumer in writing.

Results: Predominantly Compliant

Table G.7 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
HICS Cases (Enrollment)	2,192	115	114	1	90%	99%
Appeals	586	113	113	0	90%	100%
Totals	2,778	228	227	1	90%	100%

Standard G.8: The health carrier shall conduct expedited reviews of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of labor (DOL) and the U.S. Department of the Treasury (Treasury).

(2015 NAIC Market Regulation Handbook, Chapter 20A, §C, Standard 4)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding receiving and resolving expedited review of urgent care requests of grievances involving an adverse determination in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R §114-96-7 and 45 CFR §147.136(b)(2)(ii)(A)]
- Does the Company provide the notice in a culturally and linguistically appropriate manner in accordance with federal regulations? [W.Va. Code R §114-96-7.8.b and 45 CFR §147.136(b)(2)(ii)(E)]

Examiner Observations: The Company policies and procedures were reviewed for compliance. Sample appeal files were reviewed to determine compliance with the adverse determination notification requirement. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table G.8 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Appeals	586	113	113	0	90%	100%

Standard G.9: The health carrier treats as a grievance any written complaint, and any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the health carrier.

(2015 NAIC Market Regulation Handbook, Chapter 20, §H, Standard 1)

Test Methodology:

- Does the Company define “Grievance” as a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint? [W.Va. Code R §114-96-2.17]

Examiner Observations: The Company grievance procedures were reviewed to verify that the definition is in compliance with state law. No exception was noted.

Examiner Recommendations: None

Results: Compliant

Standard G.10: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 2)

Test Methodology:

- Does the Company maintain a grievance register consisting of written records to document all first level and expedited grievances received during a calendar year (the register) in the format prescribed by law? [W.Va. Code §33-11-4(10) and W.Va. Code R §114-96-3]
- Does the Company retain the grievance register compiled for a calendar year for the longer of three years or until the insurance commissioner has adopted a final report of an examination that contains a review of the grievance register for that calendar year, or for Exchange plans 10 years? [W.Va. Code R §114-96-3 and 45 CFR 156.705]
- Does the Company submit to the insurance commissioner, at least annually, a report in the format specified by the insurance commissioner? [W.Va. Code R §114-96-3.2]

Examiner Observations: The Company’s complaint, grievance, and appeals registers were reviewed for the required content. The Company’s records retention schedule was reviewed to verify compliance with the retention requirements. Examiner’s verified the Company had submitted the required annual report. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.11: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 3)

Test Methodology:

- Has the Company filed with the insurance commissioner a copy of its grievance procedures required by applicable state statutes, rules and regulations regarding first level review of grievances involving an adverse determination, standard review of grievances not involving an adverse determination, and voluntary review of grievances from covered persons, or, if applicable, the covered person's authorized representative, including all forms used to process grievance requests? [W.Va. Code R §114-96-4.2]
- Does the Company file annually with the insurance commissioner, as part of its annual grievance report required by applicable state statutes, rules and regulations, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with applicable state statutes, rules and regulations? [W.Va. Code R §114-96-4.3]
- Does the Company include a description of its grievance procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons? [W.Va. Code R §114-96-4.4]
- Do the Company grievance procedure documents include a statement of a covered person's right to contact the insurance commissioner's office for assistance at any time, and include the telephone number and address of the insurance commissioner's office? [W.Va. Code R §114-96-4.5]

Examiner Observations: The examiners verified that the Company provides the insurance commissioner a copy of the grievance procedures and a certificate of compliance annually, as well as verifying that the grievance procedures are included in the membership booklet provided to the covered persons. The grievance procedure documents include a statement of the covered person's right to contact the insurance commissioner's office for assistance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard G.12: The health carrier has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §H, Standard 5)

Test Methodology:

- Does the Company have established written procedures for standard review of grievances that do not involve an adverse determination, which permit the covered person to file a grievance with the health carrier, and which comply with applicable statutes and rules? [W.Va. Code Rule §114-96-6.1 et seq.]
- Does the Company, within three working days from the date the grievance is received, inform the covered person of his or her right to submit written material for the person or

persons designated by the health carrier to consider when conducting the review? [W.Va. Code R §114-96-6.2.b]

- Does the Company notify in writing the covered person of the decision within 20 working days after the date of receipt of the request, for a standard review of a grievance? [W.Va. Code R §114-96-6.4]
- Does the Company's written decision issued pursuant to a standard review of a grievance not involving an adverse determination contain all the required information pursuant to applicable statutes and rules? [W.Va. Code R §114-96-6.5]

Examiner Observations: The grievance procedures were reviewed for the applicable language regarding the handling of grievances not involving adverse determination. A time study was performed on a sample of appeals to determine compliance with regulations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table G.11 Results: Grievance/Appeal Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Appeals	586	113	113	0	90%	100%

H. NETWORK ADEQUACY

The evaluation of the business area related to the Company's network adequacy is based on Company responses to information requested by the examiner, discussions with company staff, and review of the Company geographic mapping by ZIP code of all providers including Essential Community Providers (ECPs). This portion of the examination is designed to test whether the Company has sufficient providers to cover all the medical and mental health needs of each of the members.

Standard H.1: The company demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to ensure that all services to enrollees will be accessible without unreasonable delay. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 1)

Test Methodology:

- Has the Company established and maintained adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residences of enrollees? [W.Va. Informational Letter 100A and **45 CFR §156.230**]
- **FFM Compliance:** Does the Company monitor, on an ongoing basis, its providers, provider groups, and intermediaries with which it contracts, to ensure the ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to enrollees? [**45 CFR §156.340**]

Examiner Observations: The Company's process for ensuring an adequate network was reviewed. It was determined that the Company has established and maintained adequate arrangements, and has a monitoring process in place to ensure all providers and provider groups have the ability, clinical capacity, financial capability and legal authority to furnish all contracted benefits to enrollees. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.2: The company has a plan of operation for each plan offered in the state, and files updates whenever it makes a material change to an existing plan. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 2)

Test Methodology:

- Does the Company have a plan of operation for each plan offered in the state? [45 CFR §155.1050]

Examiner Observations: The examiner reviewed the Company's plan of operations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.3: The company ensures that enrollees have access to emergency services twenty-four (24) hours per day, seven (7) days per week within its network and provides coverage for urgently needed services and emergency services outside of the service area. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 4)

Test Methodology:

- Does the Company operate or contract with facilities within the network to provide enrollees with access to emergency and urgently needed services on a twenty-four (24) hours per day, seven (7) day per week basis? [45 CFR §147.138 and 45 CFR §156.230]
- Does the Company cover emergency services or services that are immediately required for an unforeseen illness, injury or condition, when it is not reasonable to obtain services through network providers with the cost sharing applied not greater than that applied to in-network providers? [45 CFR §147.138 and 45 CFR §156.230]

Examiner Observations: The examiner reviewed all contracts with providers to ensure access to services was available to emergency and urgently needed services on a twenty-four (24) hours per day, seven (7) day per week basis, and that all emergency services are covered in full. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.4: The health carrier's contracts with intermediaries are in compliance with statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 6)

Test Methodology:

- **FFM Compliance:** Does the Company have contracts with downstream entities, which are in compliance with statutes and regulations including specifying the delegated activities and reporting responsibilities, and providing for revocation of the delegated activities and reporting standards or specify other remedies if determined to have not performed satisfactorily? [45 CFR §156.340]

Examiner Observations: All downstream entity contracts were reviewed and determined to be in compliance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard H.5: The company provides at enrollment a directory of providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory and files the directory with the insurance commissioner. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §I, Standard 7)

Test Methodology:

- **FFM Compliance:** Does the Company provide directory updates to enrollees and to the insurance commissioner at the frequency required by federal law? [45 CFR §156.230]

Examiner Observations: The Company's provider directory was reviewed and the website checked to ensure updated directories were available as required by law. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Additional FFM Standards:

Standard H.6: The QHP Issuer must provide access to Essential Community Providers, including Indian health providers and Federally Qualified Health Centers (FQHC).

Test Methodology:

- Does the Company maintain a network that is sufficient in number to assure that all services will be accessible without unreasonable delay? [45 CFR §§156.230(a) and 156.235]

Examiner Observations: The Company has contracted with all Essential Community Providers in the state. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

I. QUALITY ASSESSMENT AND IMPROVEMENT

The evaluation of the business area related to the Company's quality assessment program is required in the QHP marketplace, and is based on Company responses to information requested by the examiner, discussions with company staff, and review of the Company's ongoing program to evaluate and assess the quality of health care provided to covered persons, and to provide oversight to its contracted entities. This portion of the examination is designed to test whether the Company has sufficient procedures and assessment tools in place to collect, analyze and respond to the needs of its members.

Standard I.1: The health carrier develops and maintains a quality assessment program in compliance with statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §K, Standard 1)

Test Methodology:

- Does the Company have an established system designed to assess the quality of health care provided to covered persons, which includes a system for systematic collection, analysis and reporting of relevant data in accordance with statutory and regulatory requirements? [45 CFR §156.1105]

Examiner Observations: The Company Quality Assessment Program was reviewed. It was determined to include a system for the collection, analysis and reporting of relevant data in compliance with state and federal laws. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard I.2: The company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements of state law are met. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §K, Standard 4)

Test Methodology:

- Does the Company have a policy to address effective methods of accomplishing oversight of each delegated activity? [45 CFR §156.1105]

Examiner Observations: The Company has a schedule for internal audits to monitor all entities with which it contracts to perform quality assessment or quality improvement function. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

J. UTILIZATION MANAGEMENT

The evaluation of the standards related to the Company's utilization management program is based on the Company's responses to information requests from the examiner, discussions with company staff, and file sample reviews during the examination process. Included in the review were all requests for benefits or services, which required approval as part of the Company's utilization management program designed to control costs and provide for effective customer services. Compliance issues were determined based on both federal and state statutes and rules related to internal and external appeals as applied to FFM/QHP products, specifically 45 CFR §147.136 and W.Va. Code §114-95-1 et seq. The West Virginia code had an effective date of January 1, 2015. ACL was utilized to select samples from the utilization management requests filed with the Company.

Standard J.1: The health carrier shall operate its utilization review program in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC *Market Regulation Handbook*, Chapter 20A, §K, Standard 1)

Test Methodology:

- Does the Company have established and implemented written policies and procedures regarding the operation of its utilization review program, in accordance with final regulations established by HHS, the DOL and the Treasury? [W.Va. Code R §114-95-5]
- Does the Company ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination? [45 CFR §147.136(b)(3)(ii)(D)]
- Does the Company have procedures to ensure effective corporate oversight of its utilization review program? [W.Va. Code R §114-95-3]
- Does the Company annually certify in writing to the insurance commissioner that the utilization review program of the health carrier complies with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R §114-95-10]
- Does the Company use documented clinical review criteria and ensure that qualified health care professionals administer the utilization review program and oversee review decisions, and that it appoints clinical peers to evaluate the clinical appropriateness of adverse determinations? [W.Va. Code R §114-95-5]
- Does the Company issue utilization review decisions and benefit determinations in a timely and efficient manner pursuant to the requirements set forth in applicable state statutes, rules and regulations? [W.Va. Code R §114-95-7.1]

Examiner Observations: The examiner reviewed the Company's Utilization Management Program. Its procedures are in compliance with regulations and the reviews are conducted to ensure independence and impartiality of the individuals making the review. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard J.2: The health carrier shall provide written notice of an adverse determination of standard utilization review and benefit determinations, in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §K, Standard 2)

Test Methodology:

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W.Va. Code R §114-95-7.3.b and 45 CFR §147.136(b)(3)(ii)(E)]
- Does the Company, if the adverse determination is a rescission, provide the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission? [45 CFR §147.128]
- Does the Company issue notification in writing or electronically of an adverse determination in a manner calculated to be understood by the covered person? [W.Va. Code R §114-95-7.]

Examiner Observations: A sample of utilization requests were reviewed to determine if notification is provided in compliance with regulations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.2 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Utilization requests	23,786	116	116	0	90%	100%

Standard J.3: The health carrier shall conduct expedited utilization review and benefit determinations, in a timely manner and in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury). (2015 NAIC Market Regulation Handbook, Chapter 20A, §K, Standard 3)

Test Methodology:

- Does the Company provide the notice in a culturally and linguistically appropriate manner? [W.Va. Code R §114-95-7.3.b and 45 CFR §147.136(b)(3)(ii)(E)]

- Does the Company, if the adverse determination is a rescission, provide the advance notice of the rescission determination required to be provided under applicable state statutes, rules and regulations related to the advance notice requirement of a proposed rescission? [45 CFR §147.128 and 45 CFR §147.136(b)(3)(ii)(A)]
- Does the Company have established written procedures pursuant to applicable state statutes, rules and regulations for receiving benefit requests from covered persons of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests? [W.Va. Code R §114-95-8 and 45 CFR §147.136]
- Does the Company, for an urgent care request, provide notice of the adverse determination, no later than 72 hours after the receipt of the request by the health carrier, in accordance with applicable state statutes, rules and regulations regarding procedures for expedited utilization review and benefit determination? [W.Va. Code R §114-95-8 and 45 CFR §147.136]
- Does the Company make a determination for concurrent review urgent care requests involving a request by the covered person to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments no more than 24 hours after the health carrier's receipt of the request? [45 CFR §147.136]
- Is the Company notification of an adverse determination pursuant to an expedited utilization review and benefit determination set forth in a manner calculated to be understood by the covered person, or, if applicable, the covered person's authorized representative? [45 CFR §147.136(b)(2)(ii)(E)]

Examiner Observations: A sample of utilization requests were reviewed to determine if notification is provided in compliance with regulations. No rescissions were found in the sample. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.3 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Utilization requests	23,786	116	116	0	90%	100%

Standard J.4: The health carrier shall conduct utilization reviews or makes benefit determinations for emergency services in accordance with final regulations established by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the Treasury (Treasury).

(2015 NAIC Market Regulation Handbook, Chapter 20A, §K, Standard 4)

Test Methodology:

- Does the Company provide benefits for services in an emergency department of a hospital that follows provisions set forth in applicable statutes, rules and regulations? [W.Va. Code R §114-95-9]
- Does the Company provide in-network emergency services subject to applicable copayments, coinsurance, and deductibles? [W.Va. Code R §114-95-9.3]
- Does the Company provide out-of-network emergency services with cost-sharing requirements that do not exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network? [W.Va. Code R §114-95-9]

Examiner Observations: A sample of utilization requests were reviewed for compliance with emergency service benefits. All cost sharing requirements were imposed the same for out-of-network providers as for in-network providers. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Table J.4 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Utilization requests	23,786	116	116	0	90%	100%

Standard J.5: The health carrier discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations. (2015 NAIC Market Regulation Handbook, Chapter 20, §L, Standard 3)

Test Methodology:

- Does the Company provide a clear and accurate summary of its utilization review and benefit determination procedures to covered persons, or, if applicable, to the covered person's authorized representative? [W.Va. Code R §114-95-11]
- Does the Company provide a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining adverse review determinations, and a statement of rights and responsibilities of covered persons, or, if applicable, the covered person's authorized representative, with respect to those procedures, in the certificate of coverage or member handbook provided to covered persons? [W.Va. Code R §114-95-11]
- Does the Company print on its membership cards a toll-free telephone number to call for utilization review and benefit determination decisions? [W.Va. Code R §114-95-11]

Examiner Observations: A review of the utilization program determined that the Company provides to covered persons a clear and accurate summary of its utilization review and benefit determination procedures, including procedures for obtaining adverse review determinations, and

a statement of rights and responsibilities. The Company prints a toll-free telephone number on its membership cards. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard J.6: The health carrier makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA. (2015 NAIC Market Regulation Handbook, Chapter 20, §L, Standard 4)

Test Methodology:

- Does the Company, for prospective review determination, make the determination and notify the covered person no later than 15 days after the date the health carrier receives the request? [W.Va. Code R §114-95-7]
- Does the Company make the notification of the adverse determination in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination? [W.Va. Code R §114-95-7]
- Does the Company continue the health care service or treatment that is the subject of the adverse determination without liability to the covered person with respect to the internal review request made pursuant to state statutes, rules and regulations equivalent to the Health Carrier Grievance Procedure Model Act (#72)? [W.Va. Code R §114-95-7]
- Does the Company, for retrospective review determinations, make the determination no later than 30 working days after the date of receiving the benefit request? [W.Va. Code R §114-95-7]
- Does the Company make the notification of the adverse determination for retrospective review determinations in accordance with state statutes, rules and regulations regarding procedures for standard utilization review and benefit determination? [W.Va. Code R §114-95-7]

Examiner Observations: A review and time study of utilization requests was performed to determine compliance with the notification requirements, as well as to determine compliance with laws and regulations regarding adverse determination continued treatment requirements.

Examiner Recommendations: None

Results: Compliant

Table J.6 Results: Utilization Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
Utilization requests	23,786	116	116	0	90%	100%

Standard J.7: The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with a applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations. (2015 NAIC Market Regulation Handbook, Chapter 20, §L, Standard 7)

Test Methodology:

- Does the Company maintain adequate oversight of any delegated entities? [W.Va. Code R §114-95-3]
- Does the Company have policies and procedures in place that ensure the utilization review programs of designees comply with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R §114-95-5]
- Does the Company annually certify in writing to the insurance commissioner that the utilization review program of its designee complies with all applicable state and federal laws establishing confidentiality and reporting requirements? [W.Va. Code R §114-95-10]

Examiner Observations: The examiner reviewed the Company's Utilization Management Program. The program has all components required by statute. The examiner verified the Company annually certifies in writing to the insurance commissioner that the program is in compliance. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

K. EXTERNAL REVIEW

The evaluation of the standards related to the Company's external review process is based on the Company's responses to information requests from the examiner, discussions with company staff, and file sample reviews during the examination process. Included in the review were all appeal requests for external review, for which all internal appeals were exhausted. Compliance issues were determined based on both federal and state statutes and rules related to internal and external appeals as applied to QHP products, specifically 45 CFR §147.136 and W.Va. Code §114-97-4 et seq. All external appeals were reviewed.

Standard K.1: Companies covered under the NAIC Health Carrier External Review Model Act will be in compliance with the following procedures and criteria as well as with other applicable statutes, rules and regulations. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §M, Standard 1)

Test Methodology:

- Does the Company notify covered persons in writing of the right to request an external review and include notice of the Company's responsibilities? [45 CFR §147.136]
- Does the Company provide the review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage? [W.Va. Code R §114-97-14]
- Does the Company maintain written records in the aggregate and for each type of health benefit plan offered by the health carrier on all requests for external review? [W.Va. Code R §114-96-3]

Examiner Observations: The examiner reviewed all (19) external reviews conducted during the scope of the examination for compliance with regulations. No exceptions were noted.

Examiner Recommendations: None

Results: Compliant

Standard K.2: In jurisdictions that choose the Option 1 or Option 2 under the NAIC Health Carrier External Review Model Act for providing an external review process, companies will be in compliance with the following requirements, whether the request for the review is for a standard, expedited, or experimental/investigational review. (2015 NAIC *Market Regulation Handbook*, Chapter 20, §M, Standard 2)

Test Methodology:

- Does the Company comply with the external review process requirements for a standard, expedited, or experimental/investigational review? [W.Va. Code R §§114-97-6, 7 and 8 and 45 CFR §147.136]

Examiner Observations: The examiner reviewed all (19) external reviews conducted during the scope of the examination for compliance with regulations. One (1) case did not follow the process of W.Va. Code R §114-97-6.5, which was effective on policies issued subsequent to 1/1/2015, and was not reported to the Office of the Commissioner as required. The examiner notes that the remaining external reviews were not subject to the West Virginia Rule due to the effective dates of the member’s policies; as a result those reviews were evaluated only for consistency with 45 CFR §147.136.

Examiner Recommendations: The Company should ensure all external reviews requested by members of policies issued or renewed after January 1, 2015 are referred to the Office of the Insurance Commissioner for evaluation and assignment to an approved External Review Organization. The Company should also ensure that all final adverse determination notices contain language consistent with W.Va. Code R §114-97-3.

Results: Compliant

Table K.2 Results: External Review Sample

Type	Population	Sample	Pass	Fail	Standard	Compliance
External review	19	19	18	1	90%	95%

SUMMARY OF RECOMMENDATIONS

1. Recommendation Standard C.1 (page 19) - The Company should implement a verification process to ensure all producers complete the education and registration requirements for selling QHP plans.
2. Recommendation Standard E.2 (page 25) - The Company should establish a process for indicating in each policyholder file the mailing dates of specific mandated notices, such as premium increases, Summary of Benefits and Coverage, WHCRA, and any other notices.
3. Recommendation Standard F.1 (page 38) - Based on Coordination of Benefit requirements, the Company should recalculate the policyholder benefits and pay appropriately.
4. Recommendation Standard F.1 (page 38) - The Company should clarify the Preventive Schedule to ensure policyholders do not incur expenses due to a misunderstanding of the number of treatments that qualify as covered services.
5. Recommendation Standard G.3 (page 51) - The Company should ensure that all HICS case documentation is complete.
6. Recommendation Standard G.4 (page 52) - The Company should review and amend its procedures for handling HICS complaints, especially during peak periods.
7. Recommendation Standard G.7 (page 54) - The Company should revise its grievance procedures to include the requirement that notices regarding adverse determinations related to enrollment are to be sent to the consumer in writing.
8. Recommendation Standard K.2 (page 69) - The Company should ensure all external reviews requested by members of policies issued or renewed after January 1, 2015 are referred to the Office of the Insurance Commissioner for evaluation and assignment to an approved External Review Organization. The Company should also ensure that all final adverse determination notices contain language consistent with W.Va. Code R §114-97-3.

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiner would like to acknowledge the cooperation and assistance extended by the Company during the course of the examination, in particular Keisha Haynes, Senior External Audit Analyst.

In addition to the undersigned, Cynthia Fitzgerald, AIE, AIRC, ACS, AIAA, MCM, CFE, Craig L. Leonard, CIE, MBA, CPCU, CCP, ARC, FLMI, ARM, AIAF, Michael Morrissey, AES, CISA, CISSP, AMCM, Parker Stevens, FLMI, AIRC, CCP, AMCM, CIE, MPM, Holly Blanchard, MCM, FLMI, AIE, ACP, CCP, AINS, AIRC, Colleen Burns, JD, MCM, Uma Dua, PharmD, MCM, Victor M. Negrón, CIE, FLMI, IR, MCM, and LaChelle R. Simmons, JD, MCM all with Examination Resources, LLC, and Mark Hooker, CIE, CPCU, CLMI, PIR, AMCM, CWCP, CCP, AIRC, PAHM, John Stike, CIE, CPCU, MCM, CWCP, CIPA, AU, APA, AFI, Desiree Mauller, CWCP, MCM, Barbara Hudson, MCM, CWCP, PAHM, and Letha Greene, MCM all with the West Virginia Offices of the Insurance Commissioner also participated in this examination.



Ann M. McClain, CIE, AMCM, CICS, FLMI,
FLHC, AIRC, AIC, CCP, AIAA, ARA, ACS, AIS
Examiner-in-Charge

EXAMINER'S AFFIDAVIT

State of Idaho

County of Bonner

**EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES
USED IN AN EXAMINATION**

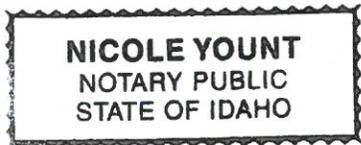
I, Ann M. McClain, being duly sworn, states as follows:

1. I have the authority to represent West Virginia in the examination of Highmark, Inc.
2. I have reviewed the examination work papers and examination report, and the examination of Highmark, Inc. was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.

Ann M. McClain *2/11/2016*

Ann M. McClain, CIE, AMCM, CICSR, FLMI,
FLHC, AIRC, AIC, CCP, AIAA, ARA, ACS, AIS
Examiner-in-Charge



Nicole Yount 02/11/2016
Bonner County, Idaho
Ex. 11/01/2018