

**PROCEEDING BEFORE THE HONORABLE JANE L. CLINE
INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA**

**IN RE:
CARELINK HEALTH PLANS, INC.
NAIC #95408**

**ADMINISTRATIVE PROCEEDING #
08-MAP-10001**

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

NOW COMES The Honorable Jane L. Cline, Insurance Commissioner of the State of West Virginia, and issues this Agreed Order which adopts the Report of Market Conduct Examination, directs corrective action and assesses a penalty as a result of findings in the Report of Market Conduct Examination for the examination of **CARELINK HEALTH PLANS, INC.** (hereinafter "CARELINK") for the examination period ending December 31, 2007 based upon the following findings, to wit:

PARTIES

1. The Honorable Jane L. Cline 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. CARELINK is a for-profit corporation operating as a Health Maintenance Organization ("HMO") in the State of West Virginia authorized by

the Insurance Commissioner to transact its business as permitted under Chapter 33, Article 25A of the West Virginia Code.

3. This statutory market conduct examination was conducted and instituted as result and per the authority of West Virginia Code § 33-2-9.

FINDINGS OF FACT

1. A Market Conduct Examination concerning the operational affairs of CARELINK for the one year period ending December 31, 2007, was conducted in accordance with West Virginia Code § 33-2-9(c) by examiners duly appointed by the Insurance Commissioner.

2. On November 9, 2009, the examiner filed with the Insurance Commissioner, pursuant to West Virginia Code § 33-2-9(j)(2), a Report of Market Conduct Examination.

3. On November 10, 2009, a true copy of the Report of Market Conduct Examination was sent to CARELINK by certified and electronic mail and was received by CARELINK on November 12, 2009. A certified mail, return receipt requested, and was also delivered and acknowledged by the Company. .

4. On November 10, 2009, CARELINK was notified pursuant to West Virginia Code § 33-2-9(j) (2) that it had thirty (30) days after receipt of the Report of Market Conduct Examination to file a submission or objection with the Insurance Commissioner.

5. The Report of Market Conduct Examination included findings including, but not limited to, the following: the need for regular audits of its producer licensing and appointment vendor(s); compliance with W.Va. Code

St. R. § 114-15-4; antifraud reporting per W.Va. Code § 33-41-1, et seq.; timely Level I appeal responses; maintenance of claims handling per W.Va. Code § 33-45-2(a)(3); failure to respond to grievances/appeals within contractual confines; inaccurate advertising materials; failure to provide timely and/or mandatory information in all of its Certificates of Creditable Coverage; employing some underwriting restrictions on guaranteed issue to some small eligible employers; limiting guaranteed renewability in small and large group markets; record retention issues; failure to pay proper commissions and bonuses to producers for its max-rated small groups; failure to offer open enrollment in the individual market; failure to underwrite some employer groups with proper industry codes; misrepresentations concerning rescinded coverage; large group underwriting issues; uniformly applying underwriting guidelines issues; definition and implementation of emergency care services not in compliance with W.Va. Code § 33-25A-8d; limitations on claims handling concerning mandated benefits for reconstructive breast surgery; improper characterization of "right of recovery/subrogation" rights for the company; incorrect processing of claims per W.Va. Code § 33-45-2(3); and handling of emergency service claims; and failure to file description of its utilization management program.

6. On November 24, 2009, CARELINK responded to the Report of Market Conduct Examination ("CARELINK's Response") and essentially did not dispute certain facts pertaining to findings, comments, results, observations, or recommendations contained in the Report of Market Conduct Examination with the following exceptions:

(a) CARELINK respectfully disputes that it needs to provide an annual open enrollment period for individuals to enroll for coverage as set out in W.Va. Code §33-25A-11(1);

(b) CARELINK respectfully disputes that it is not allowed to re-rate a group with a change of at least 10% in its group's census and has found nothing in HIPAA nor Department of Labor guidance nor West Virginia law that prohibits the same;

(c) CARELINK respectfully disputes that it does not thoroughly review the referenced appeal during the first level appeal process; and

(d) CARELINK respectfully disputes and states that its current claims handling practice for emergency claims is compliant with West Virginia law.

7. Thereon November 24, 2009, the Market Conduct Examination was reopened and field work continued to ensue through negotiations, discussions and review of data concerning the issues of dispute. Said disputes were resolved such that this Agreed Order has now been accepted by both Parties to the agreement and therefore the field work and the Market Conduct Examination was closed on or about February 12, 2010.

8. CARELINK, despite the above stated objections, herein wishes to accept and not contest the authority of the Offices of the Insurance Commissioner in moving forward with directive action and assessment of penalty concerning the same where applicable.

9. CARELINK hereby waives additional time for examination report

review, notice of administrative hearing, any and all rights to an administrative hearing, and to judicial appellate review of any matters contained herein this Agreed Order.

10. 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 of and the parties to this proceeding.

2. This proceeding is pursuant to and in accordance with West Virginia Code § 33-2-9.

3. That CARELINK has incurred violations of West Virginia Code, including but not limited to, §§ 33-41-1, et seq., 33-45-2(a)(3); 33-16-3m(a); 33-25A-4(b); 33-16D-4; 33-16D-7; 33-25A-11; 33-25A-8d; 33-25A-8f; 33-45-2(3); AND West Virginia Code of State Rules including §§ 114-15-4; 114-54-5.4(b); 114-54-6; 114-15-4.2 & 4.3b; and 114-51-4.2.

4. The Commissioner herein recognizes, however, that there is a legitimate dispute concerning the provisions of W.Va. Code § 33-25A-11(1) and that Carelink relied on representations from the OIC that it was not required to provide open enrollment for individuals for its group business, and thereby states herein as a conclusion of law that any violations of the open enrollment provisions contained therein that referenced section concerning the individual market are specifically exempted herein from penalty, restitution and/or corrective action in the interests of fairness and due process of law, and that Carelink is not required to provide open enrollment concerning individuals until it

is formally directed to do so in writing by the Offices of the Insurance Commissioner.

5. The Commissioner herein recognizes that the prohibition regarding rerating of a group with a change of at least 10% in its group census only applies to small groups (2-50 members) and further only applies if the original group and the resulting group after a change of at least 10% qualify as small groups and herein states as a conclusion of law this prohibition is limited to small groups only.

6. The Commissioner herein recognizes that the failure by Carelink to thoroughly review a referenced appeal is an isolated instance and thereby states herein as a conclusion of law that this is not a violation for which any corrective action is required.

7. The Commissioner herein recognizes that Carelink's current claims handling practices for emergency claims is compliant with West Virginia law and is not a systemic violation for which corrective action is required.

8. The Commissioner is charged with the responsibility of verifying continued compliance with West Virginia Code and the West Virginia Code of State Rules by CARELINK as well as all other provisions of regulation that CARELINK is subjected to by virtue of their Certificate of Authority to operate in the State of West Virginia.

9. Any Conclusion of Law that is more properly a Finding of Fact is hereby incorporated as such.

ORDER

Pursuant to West Virginia Code § 33-2-9(j)(3)(A), following the review of the Report of Market Conduct Examination, the examination work papers, and CARELINK's Response thereto, the Insurance Commissioner and CARELINK have agreed to enter into this Agreed Order adopting the Report of Market Conduct Examination. The Parties have further agreed to the imposition of corrective action and an administrative penalty against CARELINK as set forth below.

It is accordingly **ORDERED** as follows:

(A) The Report of Market Conduct Examination of CARELINK for the period ending December 31, 2007, is hereby **ADOPTED** and **APPROVED** by the Insurance Commissioner.

(B) It is **ORDERED** that CARELINK will **CEASE AND DESIST** from failing to comply with the statutes, rules and regulations of the State of West Virginia concerning any business so handled in this State and more specifically the provisions enumerated herein this Order where applicable.

(C) It is further **ORDERED** that CARELINK shall continue to monitor its compliance with the West Virginia Code, West Virginia Code of State Rules, and all Federal laws it is subject thereto.

(D) It is further **ORDERED** that within thirty (30) days of the next regularly scheduled meeting of its Board of Directors, CARELINK shall file with the West Virginia Insurance Commissioner, in accordance with West Virginia Code § 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, DIRECTING CORRECTIVE ACTION AND ASSESSING PENALTY.

(E) It is further **ORDERED** that CARELINK shall ensure compliance with the West Virginia Code and the Code of State Rules. CARELINK shall specifically cure those violations and deficiencies identified in the Report of Market Conduct including providing appropriate restitution or other handling of the issue so as to bring the violation into compliance and conformity with the Commissioner's recommendations and Federal and State law.

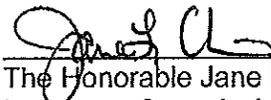
(F) It is further **ORDERED** that CARELINK shall file a Corrective Action Plan which will be subject to the approval of the Insurance Commissioner. The Corrective Action Plan shall detail CARELINK'S changes to its procedures and/or internal policies to ensure compliance with the West Virginia Code and 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. CARELINK 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 CARELINK 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.

(G) The Insurance Commissioner has determined and it has been

ORDERED that CARELINK shall pay an administrative penalty to the State of West Virginia in the amount of Ten Thousand Dollars (\$10,000.00) for non-compliance with the West Virginia Code as described herein. The payment of this administrative penalty is in lieu of any other regulatory penalty, and is due within **THIRTY (30) calendar days** upon execution of this Order.

(H) It is finally **ORDERED** that all such review periods, 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 any future action taken, if any, on such Order by the Commissioner against CARELINK.

Entered this 9th day of March, 2010.



The Honorable Jane L. Cline
Insurance Commissioner

REVIEWED AND AGREED TO BY:

On Behalf of the INSURANCE COMMISSIONER:



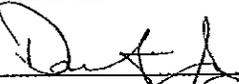
Andrew R. Pauley, Associate Counsel
Attorney Supervisor, APIR

Dated: 3/8/10

On Behalf of CARELINK:

By: Drew A. Joyce
[Print Name]

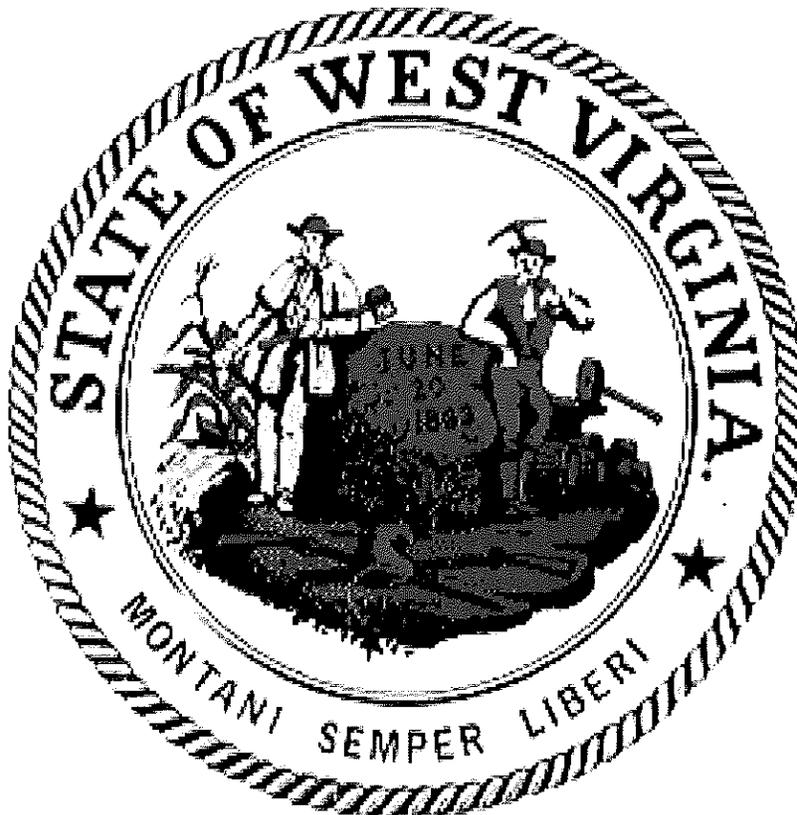
Its: CEO

Signature: 

Date: Feb. 24, 2010

Report of Market Conduct Examination

As of December 31, 2007



Carelink Health Plans, Inc.

500 Virginia Street Suite 400
Charleston, West Virginia 25301

NAIC COMPANY CODE 95408
Examination Number WV014-M15

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November 9, 2009

The Honorable Jane L. Cline
West Virginia Insurance Commissioner
1124 Smith Street
Charleston, West Virginia 25301

Dear Commissioner Cline:

Pursuant to your instructions and in accordance with W. Va. Code § 33-2-9, an examination has been made as of December 31, 2007 of the business affairs of

CARELINK HEALTH PLANS, INC.
500 Virginia Street Suite 400
Charleston, West Virginia 25301

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

SCOPE OF EXAMINATION

The basic business areas that were examined during this examination were:

- A. Company Operations/Management
- B. Complaint Handling
- C. Marketing and Sales
- D. Producer Licensing
- E. Policyholder Services
- F. Underwriting and Rating
- G. Claims Handling
- H. Grievance Procedure
- I. Network Adequacy
- J. Provider Credentialing
- L. Utilization Review

Each business area has standards that the examination measured. Some standards have specific statutory guidance, others have specific Company guidelines, and yet others have contractual guidelines.

The examination focused on the methods used by the Company to manage its operations for each of the business areas subject to this examination. This includes an analysis of how the Company communicates its instructions and intentions to its staff, how it measures and monitors the results of those communications, and how it reacts to and modifies its communications based on the resulting findings of the measurement and monitoring activities. The examiners also determine whether this process is dynamic and results in enhanced compliance activities. Because of the predictive value of this form of analysis, focus is then directed to those areas in which the process used by management does not appear to be achieving appropriate levels of statutory and regulatory compliance. Most areas are nevertheless tested to see that the Company complies with West Virginia statutes and rules.

This examination report is a report by test rather than a report by exception. This means that all standards tested are described and the results indicated.

EXECUTIVE SUMMARY

The market conduct examination of the Company began on June 30, 2008 and concluded on October 31, 2008. The examination covered seventy-nine (79) standards from the 2007 NAIC Market Regulation Handbook. The Company passed sixty-nine (69) of these standards with eleven (11) of the passed standards being accompanied by recommendations for actions the Company could adopt to improve its operations. The remaining ten (10) standards examined fell short of the error tolerance standard established for this exam and therefore, failed those standards. Of the 10 (ten) failed standards, two (2) were associated with Marketing and Sales,

one (1) was associated with Producer Licensing, one (1) was associated with Policyholder Services, four (4) were associated with Underwriting and Rating, and two (2) were associated with Utilization Review. Significant failures were noted under Marketing and Sales, Policyholder Services and Underwriting and Rating. The area of Quality Assurance was not tested because Carelink was NCQA accredited and therefore, presumed to be operating in compliance with W. Va. Code St. R. 114-53-1, et seq.

The following list summarizes issues raised in this report:

- Some of the Company's advertising materials, its website, and some of the producer materials provided information that was inaccurate.
- The Company failed to provide mandatory information in all of its certificates of creditable coverage (CCCs) issued during the period under examination, in violation of W. Va. Code St. R. § 114-54-5.4(b) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, the Company failed to issue some CCCs timely, in violation of W. Va. Code § 33-16-3m(a), HIPAA and W. Va. Code St. R. § 114-54-5.3.
- The Company's underwriting guidelines permitted restriction of guaranteed issue to some eligible small employers. Restriction of guaranteed issue would violate W. Va. Code § 33-16D-4 and HIPAA.
- The Company's group health plan provisions and guidelines limited guaranteed renewability in the small and large group markets. Any limitation of guaranteed renewability would violate W. Va. Code § 33-16D-7, W. Va. Code St. R. § 114-54-6 and HIPAA.
- The Company did not retain records of the declination of small employer applications or of any failure to provide small employers with an application, in violation of W. Va. Code § 33-2-9(g) and W. Va. Code St. R §§ 114-15-4.2 and 4.3b.
- The Company's evidence of coverage (EOC) and its utilization review (UR) guidelines included limitations on mandated benefits for reconstructive breast surgery, in violation of W. Va. Code § 33-25A-8f.
- The Company failed to pay proper producer commissions and bonuses for its max-rated small groups, which restricted the mandated requirements of W. Va. Code §§ 33-16D-4 & 7, and HIPAA.
- The Company failed to offer open enrollment in the individual market in compliance with W. Va. Code § 33-25A-11.

There were sporadic errors with respect to claims handling. However, the error ratios for all claims standards were within tolerance levels and therefore warranted a "pass."

Various non-compliant practices were identified during the examination. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to West Virginia insurance statutes and rules.

During the examination process the Company remediated a claim error for a member, and also agreed to correct language associated with its EOC and UR guidelines, and to correct commission payments for its max-rated small groups.

COMPLIANCE WITH PREVIOUS EXAMINATION FINDINGS

The prior examination of the Company by the West Virginia Offices of Insurance Commissioner (“WVOIC”) was conducted as of December 31, 2002. The report of that examination disclosed nine (9) recommendations for corrective actions to be completed by the Company. The determination of the Company’s actions subsequent to the recommendations were noted by this current examination and are as follows:

Recommendation A-5

Carelink should perform regular audits, not less than annually, of its claim-receiving vendors to assure that the contracted level of performance is met and the process can be expected to remain in compliance with West Virginia law.

This examination determined the Company adequately addressed this recommendation. The Company monitors its claims receiving contracted entities by performing bi-weekly audits of claim processing accuracy, which included auditing of the front-end keying for one vendor, and daily file validation for the other.

Recommendation B-2

It is recommended that the Company monitor all complaints and file written plans when it receives ten or more complaints on the same or similar subject matter during any six-month period in compliance with W.Va. Code St. R. § 114-53-5.10.

This examination determined the Company adequately addressed this recommendation. The Company did not have ten or more complaints on the same or similar subject matter during any six month period during the examination period. However, it had enacted a written plan if it would have occurred.

Recommendation C-3

It is recommended that Carelink resubmit annual grievance reports for the years 2000, 2001, 2002 in accordance with W.Va. Code § 33-25A-10 conforming the definition of a formal grievance to that outlined in W.Va. Code § 33-25A-12(a). It is further recommended that future reports are also in compliance W.Va. Code § 33-25A-12(a).

This examination determined the Company adequately addressed this recommendation by defining and maintaining grievances in compliance with W. Va. Code § 33-25A-12(a).

Recommendation C-5

It is recommended that Carelink process its Second Level appeal within the time requirements outlined in W.Va. Code § 33-25A-12(f). It is further recommended that the Company provide the Insurance Commissioner with a copy of all final decision letters for denials of grievance as outlined in W.Va. Code § 33-25A-12(g). Additionally, Carelink should take steps to insure that it complies with all time requirements specified in the Company’s internal procedures.

This examination determined the Company adequately addressed second level appeals, because all of the second level appeals tested were addressed timely. However, two (2) level one appeals were not responded to within its contractual fifteen (15) days timeframe.

Recommendation F-1

It is recommended that Carelink establish an internal control mechanism to ensure that its group plans are only serviced by agents who are properly appointed by the Company. It is further recommended that the Company immediately appoint the forty-four (44) agents remitting the appropriate fees to the Insurance Commissioner.

This examination determined the Company had addressed this recommendation, but failed to establish internal controls ensuring its listing of appointed agents was accurate and complete. However, for all the group plans tested during the current examination the producers were licensed and appointed. Testing of this standard is located at D 1, because the NAIC completed a change in the alphabetic listing for examination standards.

Recommendation F-2

It is recommended that Carelink establish an internal control mechanism to ensure that its group plans are only serviced by agents who are properly appointed by the Company.

This examination determined the Company adequately addressed this recommendation. The Company established internal controls for ensuring producers were licensed and appointed prior to issuance of group plans. For all the group plans tested during the current examination, the producers were licensed and appointed.

Recommendation J-1

It is recommended that Carelink utilize only those rates factors for small groups which are filed and approved by the Insurance Commissioner. It is further recommended that the company identify each time it overcharged a group to make appropriate restitution.

This examination determined the Company adequately addressed this recommendation. The Company had filed its rating plan and rates with the WVOIC, and followed the approved rates for all group plans tested.

Recommendation K-11

It is recommended that Carelink annually review UM activity of delegate organizations regardless of accreditation status.

This examination determined the Company adequately addressed this recommendation. The Company conducted annual reviews of UM activity with its delegate organization.

Recommendation K-12

It is recommended that the Company adhere to its external review procedures.

The Company had written external review procedures, however, the Company stated there were no external reviews conducted during the examination period. Therefore, compliance with those procedures could not be determined.

HISTORY AND PROFILE

Carelink Health Plans, Inc. ("Carelink") was originally incorporated on August 16, 1991, as Charleston Area Health Plan, Inc., a for-profit corporation authorized to do business as a Preferred Provider Organization ("PPO"). At the time of incorporation, the PPO was owned by Camcare, Inc., a West Virginia Hospital and Health Care Provider Holding Company. On January 1, 1995, Charleston Area Health Plan, Inc. was licensed as a Health Maintenance Organization ("HMO") in the State of West Virginia. On September 5, 1997, Charleston Area Health Plan, Inc. changed its name to Carelink Health Plans, Inc. Coventry Health Care, Inc. ("Coventry") acquired Carelink on October 1, 1999, by merging one of Coventry's wholly owned subsidiaries, Coventry Health Plan of West Virginia, a licensed HMO in West Virginia doing business as HealthAssurance HMO, with and into Carelink with Carelink as the surviving corporation. On February 1, 2000, Coventry HealthCare Development Corporation (a wholly owned Coventry subsidiary) acquired PrimeONE, Inc., a West Virginia corporation (formerly Anthem Health Plan of West Virginia, Inc.) from The Anthem Companies, Inc. On February 10, 2000, PrimeONE, Inc. was merged with and into Carelink with Carelink as the surviving corporation. On May 20, 2003, Coventry HealthCare Development Corporation was merged into Coventry with Coventry as the surviving corporation. Carelink is a wholly owned subsidiary of Coventry.

On April 1, 2006, Carelink entered into a management agreement with Southern Health Services, Inc. ("Southern Health"), a sister corporation licensed in Virginia as an HMO, for certain specified management services. Southern Health is contracted to perform general management services for Carelink to include but not be limited to senior management services, financial and accounting services, regulatory compliance and governmental affairs, medical management services, and human resources consulting.

Carelink is a for-profit corporation operating as an HMO in the State of West Virginia and has as its commercial service area all 55 counties in West Virginia. The company serves commercial group members as well as Medicaid recipients. Under its commercial business, Carelink offers health care coverage under annual contracts to employer groups that seek health care coverage for their employees and may also include coverage to the employees' eligible dependents. Carelink provides Administrative Services Only ("ASO") contracts, which are services to employer benefit plans to provide a full range of health care options without assuming insurance risk. As of December 31, 2007, Carelink had 49,032 members in West Virginia.

METHODOLOGY

This examination was based on the standards and tests for market conduct examinations of health insurers found in Chapter XVI and XX of the NAIC Market Regulation Handbook and in accordance with West Virginia statutes and rules.

Some of the standards were measured using a single type of review, while others used a combination or all types of review. The types of review used in this examination fall into three general categories: Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using automated sampling software. For statistical purposes, an error tolerance level of 7% was used for claims and a 10% tolerance was used for other types of review. The sampling techniques used are based on a 95% confidence level.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records provided by the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were measured using tests designed to adequately measure how the Company met certain benchmarks. The various tests utilized are set forth in the NAIC Market Regulation Handbook for a health insurer. Each standard applied is described and the result of testing is provided under the appropriate standard. The standard, its statutory authority under West Virginia law, and its source in the NAIC Market Regulation Handbook are stated and contained within a bold border. In some cases, a standard is applicable to more than one phase of the examination. When that occurs, the reader is directed to the first occurrence of that standard for the results of testing, in order to avoid redundancy.

Each standard is accompanied by a "Comment" describing the purpose or reason for the Standard. "Results" are indicated, examiner's "Observations" are noted, and in some cases, a "Recommendation" is made. Comments, Results, Observations and Recommendations are kept with the appropriate standard, except as noted above.

A. COMPANY OPERATIONS/MANAGEMENT

Comments: The evaluation of standards in this business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to provide a view of how the Company is structured and how it operates and is not based on sampling techniques. 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 them or the ineffective application of them is often reflected in failure of the various standards tested throughout the 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 to take corrective action or to modify the process to develop more efficient and effective management of its operations.

Standard A 1

NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 1.

The company has an up-to-date, valid internal or external audit program.

W.Va. Code St. R. § 114-53 & W.Va. Code § 33-3-14

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement as it pertains to annual audited financial statements. A company that has no audit function lacks the ready means to detect structural problems until problems have occurred. A valid internal or external audit function, and its use, is a key indicator of competency of management, which the Commissioner may consider in the review of an insurer.

Results: Pass

Observations: Carelink had both internal and external audit processes. Carelink had a Policies and Procedures Committee that met regularly throughout the year to create, review, and revise all internal policies. Each policy is considered at least annually. In order to maintain its Excellent NCQA accreditation, Carelink continuously monitored utilization, quality, and credentialing functions. Carelink had an annual UM and QI program and a workplan that were both monitored throughout the year by the Company's NCQA Task Force, and reviewed and evaluated annually by Carelink's Executive Quality Management Committee. Periodically, audits were performed on Carelink's complaints and appeals to determine compliance with the appropriate statutes and internal policies. Carelink had an internal auditor that performed audits of other internal functions as needed. As part of Coventry's HIPAA privacy and security initiatives, the Compliance Department performed an annual audit of the Carelink offices to ensure compliance with its privacy and security policies. The Company's financial statements were audited in accordance with W. Va. Code § 33-3-14.

Recommendations: None

Standard A 3

NAIC Market Regulation Handbook - Chapter XVI, § A, Standard 3.

The regulated entity has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

W. Va. Code § 33-41-1et seq.

Comments: The review methodology for this standard is both generic and sample. The standard has a direct statutory requirement. Written procedural manuals or guides and antifraud plans should provide sufficient detail to enable employees to perform their functions in accordance with the goals and direction of management. Appropriate antifraud activity is important for asset protection, as well as policyholder protection, and is an indicator of the competency of

management, which the Commissioner may consider in the review of an insurer. Further, the insurer has an affirmative responsibility to report fraudulent activities of which it becomes aware.

Results: Pass with Recommendations

Observations: The Company had developed and implemented guidelines for identifying, reporting, and addressing suspected fraudulent, wasteful and/or abusive practices by providers and/or its members. The Company had also developed procedures for notifying the WVOIC when required, which stated in part, “. . . legal counsel will review state law to determine whether reporting to state agencies is mandatory or voluntary. In either instance, the standard for reporting should be reviewed to determine if the conduct satisfies the state reporting requirement. The decision to report needs to be approved by either the Health Plan CEO, the Medical Director, and/or VP for Provider Relations. Counsel should be consulted before a report is made. Mandatory state reporting: If reporting is mandatory, Coventry should determine if the conduct meets the legal standard set forth by state law . . .” Carelink did not report any potential fraudulent activities to the WVOIC during the period under examination. It appears unlikely there were not potential fraudulent activities during the period under examination. However, testing of all files did not reveal instances where the Company should have reported to the WVOIC. Therefore, this standard was not failed.

Recommendations: The Company should ensure that its antifraud procedures provide for investigations and reporting to the WVOIC in compliance with W. Va. Code § 33-41-1.

Standard A 4 The regulated entity has a valid disaster recovery plan.	<i>NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 4.</i> <i>W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17</i>
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The review methodology for this standard is generic. The standard does not have a direct statutory requirement. It is essential the Company have a formalized disaster recovery plan that details procedures for continuing operations in the event of any type of disaster. Appropriate disaster recovery planning is an indicator of the competency of management, which the Commissioner may consider in the review of an insurer.

Results: Pass

Observations: The Company had a disaster recovery plan, which was deemed to be sufficient.

Recommendations: None

Standard A 6 The HMO is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.	<i>NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 6.</i> <i>W.Va. Code St. R. § 114-53-4.</i>
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Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that a Company using subcontractors

engages in a realistic level of oversight. Contracts should be reviewed to assure compliance with the MGA statutes governing contract content and oversight features. The focus is on the oversight of records and actions considered in a market conduct examination such as, but not limited to, trade practices, claims practices, policy selection and issuance, rating, complaint handling, etc. Particular emphasis is suggested concerning a subcontractor's dealings with policyholders and claimants.

Results: Pass with recommendations

Observations: Carelink did not contract with MGAs, GAs, or TPAs during the period under examination. The Company's producer contracts provided essentially no authority other than to produce and offer business. Coverage could not be bound by a producer and payments had to be made payable to Carelink. In addition, Carelink had a contract with its parent, Coventry Health Care, wherein the parent provided senior management services, advertising, marketing and public relations, purchasing services, information systems, service center services, pharmacy services, corporate and legal services, regulatory compliance and governmental affairs, accounting services, tax compliance and consulting, facilities management, risk management, human resource consulting, and payroll services.

Carelink outsourced its claim receiving functions to two vendors, Emdeon and ACS. The Company stated that ACS was used to image and key paper claims and Emdeon was the clearinghouse used for electronic claims. Carelink was essentially dependent upon the appropriate and continuous performance of these two vendors to assure that it remained compliant with West Virginia law relating to claims handling. The Company stated that it monitored both Emdeon and ACS. For ACS it performed bi-weekly audits of claim processing accuracy, which included auditing of the front-end keying vendor. For Emdeon, the Company indicated it performed a daily file validation.

The Company contracted with Cumberland Licensing Corporation for the licensing and appointment of some of its producers during the period under examination. The Company failed to perform audits of this agency as noted at D 1.

The Company also contracted with three provider credentialing entities, Preferred Integrated Provider Access Corporation, Health Partners Network, Inc. and Preferred Care of Virginias, Inc. The Company completed annual audits for each of the provider credentialing and re-credentialing entities.

Recommendations: Carelink should perform regular audits, not less than annually, of its producer licensing and appointment vendor to assure the contracted level of performance is met, and ensure the process remains in compliance with West Virginia law.

Standard A 7 Records are adequate, accessible, consistent, and orderly and comply with state record retention requirements.	<i>NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 7.</i> <i>W.Va. Code § 33-2-9</i>
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Comments: The review methodology for this standard is generic. The standard does have a direct statutory requirement. This standard is intended to assure that an adequate and accessible

record exists of the Company's transactions. The focus is on the records and actions considered in a market conduct examination such as, but not limited to, trade practices, claim practices, policy selection and issuance, rating, and complaint handling, etc. Inadequate, disorderly, inconsistent, and inaccessible records can lead to inappropriate rates and other issues, which can provide harm to the public.

Results: Pass with Recommendations

Observations: Carelink's records were adequately documented, and provided in an orderly manner. However, the Company initially provided a listing that included some ASO (Administrative Services Only) and Coventry PPO plans with the requested Carelink file populations. This resulted in the need for further sampling and replacement of files. Carelink is a licensed HMO, and therefore cannot offer PPO plans in the State of West Virginia. The Company indicated that it had provided some PPO plans in its file populations in error, but also indicated that it notified the examination team immediately, when it discovered ASO or PPO plans had been included in the sample. Additionally, the Company at first denied access to its litigated files, which delayed testing of those files (see the NAIC Standard located at G 11 of this report). After reconsideration the Company provided access to those files.

Recommendations: The Company should devise an adequate means of distinguishing its HMO plans from ASO plans and Coventry's PPO plans.

Standard A 8

The regulated entity is licensed for the lines of business that are being written.

NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 8.

W.Va. Code § 33-25A-3

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company's operations are in conformance with its certificate of authority.

Results: Pass

Observations: Carelink was a licensed Health Maintenance Organization in the State of West Virginia during the period under examination.

Recommendations: None

Standard A 9

The regulated entity cooperates on a timely basis with examiners performing the examination.

NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 9.

W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is aimed at assuring that the Company is cooperating with the State in the completion of an open and cogent review of the Company's operations in West Virginia. Cooperation with examiners in the conduct of an examination is not only required by statute, it is conducive to completing the examination in a timely fashion and minimizing cost.

Results: Pass with Recommendations

Observations: The Company was generally cooperative throughout the examination. It provided adequate workspace and responses to requests in a timely manner. The Company at first denied access to its litigated files, which initially restricted testing of those files (see the NAIC Standard located at G 11 of this report). After reconsideration the Company provided access to those files.

Recommendations: The Company should cooperate with the examination and provide files when requested to avoid delay in the examination process, in compliance with W. Va. Code § 33-2-9, W. Va. Code St. R. § 114-15-4, and NAIC standardized testing.

Standard A 12 *NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 12.*
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.
W. Va. Code § 33-2-9 & W. Va. Code § 33-25A-26

Comments: The review methodology for this standard is generic. The standard has a direct insurance statutory requirement. This standard is intended to assure that the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company had formal written procedures for the management, collection, use and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants, claimants and policyholders.

Recommendations: None

Standard A 13 *NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 13*
The company provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding the treatment of nonpublic financial information.
W. Va. Code St. R. § 114-57-1, et seq.

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company provided privacy notices to its applicants and policyholders.

Recommendations: None

Standard A 14*NAIC Market Regulation Handbook— Chapter XVI, § A, Standard 14*

If the company 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 affected consumers.

W. Va. Code St. R. § 114-57-1, et seq.

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company had a standard cover letter that was available for any consumer that was not a customer, and who requested to opt out of disclosure of non-public personal information. During the period under examination, no such request was made. The Company's letter would have provided a consumer with an adequate avenue for opting out.

Recommendations: None

Standard A 15*NAIC Market Regulation Handbook— Chapter XVI, § A, Standard 15*

The company's use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules, and regulations.

W. Va. Code St. R. 114-57-1, et seq.

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company has formal written procedures for the management, collection, use and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants, policyholders, and claimants.

Recommendations: None

Standard A 16*NAIC Market Regulation Handbook— Chapter XVI, § A, Standard 16*

The company 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.

W. Va. Code St. R. § 114-57-1, et seq.

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company provides adequate

protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company has formal written procedures for the management, collection, use and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants and policyholders.

Recommendations: None

Standard A 17

NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 17

Each Licensee shall implement a written information security program for the protection of nonpublic customer information.

W. Va. Code St. R. § 114-62-1, et seq.

Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is intended to assure that the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants, policyholders, and claimants.

Results: Pass

Observations: The Company has formal written procedures for the management, collection, use and disclosure of information gathered in connection with insurance transactions to minimize any improper intrusion into the privacy of applicants, policyholders, and claimants

Recommendations: None

B. COMPLAINT HANDLING

Comments: Evaluation of the standards in this business area is based on Company responses to various information requests and complaint files at the Company. HMO's are not subject to W. Va. Code § 33-11-4 (Unfair Trade Practices Act) and therefore there are no specific time frames required for responses to complaints received at the Offices of the Insurance Commissioner. W. Va. Code § 33-25A-12 outlines specific procedures for resolution of complaints which meet the definition of a grievance. Those complaints that meet the definition of a grievance are evaluated in Section H, "Grievance Procedures."

Standard B 2

NAIC Market Regulation Handbook – Chapter XVI, § B, Standard 2

The company has adequate complaint handling procedures in place and communicates such procedures to policyholders.

W. Va. Code St. R. § 114-53-5.10

Comments: The review methodology for this standard is generic and sample. The standard has a direct regulatory requirement. W. Va. Code St. R. § 114-53-5.10 states in part, ". . . develop a

specific written plan of actions to the resolution of complaints and file a report with the Commissioner on how the complaints were successfully resolved” if the Company receives ten or more complaints from members during a six month period that “relate to the same or similar subject matter.” Neither the W. Va. Code nor an informational letter has further defined “same or similar subject matter.”

Results: Pass

Observations: Carelink had developed a written plan for disposition of complaints. In addition, the WVOIC did not receive ten or more complaints during any six-month period during the period under examination. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

<p>Standard B 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.</p>	<p><i>NAIC Market Regulation Handbook - Chapter XVI, § B, Standard 3</i> <i>W.Va. Code St. R. § 114-53-5.10</i></p>
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Comments: The review methodology for this standard is generic. The standard has a direct statutory requirement. This standard is concerned with whether the Company has an adequate complaint handling procedure and whether the Company takes adequate steps to resolve and finalize complaints.

Results: Pass

For internal complaints for 2007: the entire population of thirty-three (33) complaints was tested. For internal complaints for 2006, a sample of twenty-seven (27) files from a population of one hundred forty-five (145) such files, was obtained by use of ACL. Therefore, a total of sixty (60) files were tested.

For WVOIC complaints, the WVOIC provided a population of ninety-three (93) complaints. However, forty-seven (47) files related to Coventry or ASO plans and therefore those files were not included for testing (N/A). The results of testing of the forty-six (46) WVOIC complaint files determined that two (2) files failed as indicated below.

Type	Population	Sample	N/A	Pass	Fail	% Pass
OIC complaints	93	93	47	44	2	96%
Internal complaints	178	60	0	60	0	100%
Total	271	153	47	104	2	98%

Observations: No exceptions were noted during testing of internal complaints.

- One WVOIC complaint file indicated that the Company did not promptly address an incorrect precertification, resulting in late payment of a claim without the required interest payment in violation of W. Va. Code §§ 33-45-2(a)(1) and (a)(4). The Company's response stated in part, "The original claim did pay timely since the date of service was 2/10/05 and the claim was paid on 2/15/05. However, because the number of units preauthorized did not match to the number of units billed, some of the original claim denied. Adjustments to the original claim should have included payment of interest but did not."

- One WVOIC complaint file indicated that the Company denied a claim for inpatient services following an emergency room admission on the basis firstly that preauthorization had not been obtained and subsequently on the basis that the member had not provided her ID card at the time of the emergency room admission. To deny coverage for these reasons is a violation of W. Va. Code § 33-25A-8d. The Company's response stated in part, ". . . the Provider Manual . . . all inpatient services require preauthorization. Since the inpatient stay was not preauthorized, the claim was initially denied to the provider with no member responsibility. However, during the provider's reconsideration review, information was provided that the member did not present her ID card to the hospital until 15 days from the date she was admitted and 13 days after she was discharged. . . . in the judgment of Carelink's First Level Appeals Committee, presenting her Carelink ID card 15 days after admission to the hospital was not within a reasonable period of time. . . . However, in the judgment of Carelink's Second Level Appeal Committee, the 15 day delay in presenting the member's Carelink ID card to the hospital was considered to be reasonable, resulting in the Committee's decision to overturn the denial and pay the claim. . . . Based on the information in the appeal file, the two committees interpreted the same documentation differently, which is the reason for having more than one level of appeal. . . . WV Code § 33-25A-8d(a) does allow the HMO to 'apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services.' . . ."

Recommendations: None

C. MARKETING AND SALES

Comments: The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to evaluate the representations made by the HMO about its product(s). It is not typically based on sampling techniques but can be. The areas to be considered in this kind of review include all media (radio, television, videotape, etc.), written and verbal advertising and sales materials.

Standard C-1	<i>NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 1.</i>
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.	<i>W. Va. Code § 33-25A-14 & § 33-25A-10.</i>

Comments: Review methodology for this standard is generic and sample. The standard has a direct statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with all forms of media (print, radio, television, etc.).

Results: Fail

Testing for this standard was performed on the entire population of fifty one (51) media advertising and marketing materials, and the Company's website. The results of testing are as follows:

Table C 1: Advertising and Sales Results					
Type	Population	N/A	Pass	Fail	% Pass
Marketing and Sales Materials	51	3	37	11	73%
Total	51	3	37	11	73%

Observations: Three (3) of the advertising materials provided were not used during the period under examination. The remaining materials were tested to determine if there were misrepresentations or inaccuracies in those materials.

- The Company provided ten (10) marketing materials stating that referrals were “a thing of the past,” and that access to “specialists did not need a referral.” These statements are inaccurate in violation of W. Va. Code § 33-25A-14(a). The Company's response stated in part, “The quotation . . . is meant to reflect the physician’s perspective. The meaning being that physicians can send their patients to other providers within Carelink’s network easily because the members have direct access to these providers, thus, there is no formal “referral process” and the process for sending patients to non-network providers is not much more difficult since this process is handled by a medical review by Carelink to determine if these services can be preauthorized. A formal referral process would require that the member must get a referral number or a paper referral to go to see any in-network provider. . . . The flyer reflects the member’s perspective that s/he can go directly to a Carelink participating provider without having to get either a referral number or a paper referral, which used to be generally accepted industry requirements. The quotation in the network brochure means that the physician can send his/her patients to another Carelink participating provider easily since there is no formal referral process required by Carelink.

- The Company's website stated in part, “. . . In addition to HMO products, Carelink offers PPO health insurance and consumer-driven health products through Coventry Health and Life Insurance Company. *Carelink also offers CoventryOne, a trust product for individuals and families.*”

The Company's website indicated that Carelink “offers” a PPO product for individuals and families. Carelink is an HMO plan and under its Certificate of Authority may only “offer” HMO managed care plans. Carelink does not offer products in the individual market. The information provided on the website was misleading and inaccurate in violation of W. Va. Code § 33-25A-14(a). The Company's response stated in part, “Offer means to make available or to propose. In that regard, Carelink, as administrator for the CoventryOne product, does make the product available to individuals and families. However, individuals who purchase this coverage, purchase it from Coventry Health and Life Insurance Company under its WV COA . . . Carelink is only the administrator of products sold and underwritten by Coventry Health and Life Insurance Company. As a result, Carelink does not believe that the information on its website implies that Carelink, as a WV HMO, writes PPO coverage or that it is the carrier underwriting

the CoventryOne product. Therefore, Carelink’s website is in compliance with W. Va. Code § 33-25A-14 . . .” In addition, the Company stated, “It should be noted that the website has been revised to change the term “offer” to “makes available” and to clarify that CoventryOne is underwritten by Coventry Health and Life Insurance Company.”

As a result of the market conduct examination, the Company agreed to modify its website.

Recommendations: The Company should ensure that its advertising materials and its website provide information that is not misleading, deceptive or inaccurate.

Standard C 2 *NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 2*
HMO internal producer training materials are in compliance with applicable statutes, rules and regulations. *W.Va. Code § 33-25A-14*

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with training or instructional representations made by the HMO to its producers.

Results: Fail

Testing for this standard was performed on the entire population of nine (9) producer materials utilized during the period under examination. The results of testing are as follows:

Table C 2: Advertising and Sales Results					
Type	Population	N/A	Pass	Fail	% Pass
Internal Producer Materials	9	0	5	4	56%
Total	9	0	5	4	56%

Observations: Producer training and marketing materials, and an enrollment kit were tested to determine if there were misrepresentations or inaccuracies provided in those materials.

- Three of the Company’s producer solicitation materials did not comply with the requirements of HIPAA or W. Va. Code § 33-16D-8, which requires that information concerning renewability be included in small employer solicitation and sales materials. The Company’s response stated in part, “Carelink agrees that information about renewability for small group coverage is not in the solicitations for new business; however, it should be noted that Carelink does automatically generate a renewal quote for each small group at least sixty (60) days prior to the group’s renewal date. . . .”

- The Company provided its producers with a Member Enrollment Kit, “Carelink Small Group Underwriting Process made Simple,” which stated in part, “The following information is required to finalize and enroll the group: Quarterly Wage and Tax Statement . . . Current Carrier Invoice . . .” For compliance with guaranteed availability in the small group market an issuer is not permitted to “require” an employer to provide either document. A listing of employees by the employer must be accepted and provision of a previous invoice cannot be a mandated

requirement for guaranteed issuance. Therefore, the materials did not comply with the requirements of W. Va. Code 33-25A-14(a) and were in violation of that code. If the Company or its producers declined to offer coverage based solely upon the stated requirements, it was in violation of W. Va. Code § 33-16D-4. Testing could not be completed to determine compliance, because the Company failed to retain documentation of declined small groups as noted at F 7.

The Company's response stated in part, “. . . In most cases, the documentation the group provides includes its most recent Quarterly Wage and Tax Statement and its previous carrier invoice. If the group does not have a Wage and Tax Statement or previous carrier invoice, Carelink accepts other documentation that proves the group meets the definition of a small employer. The Carelink Small Group Underwriting Process Made Simple flyer is meant to be a quick reference guide for producers. It should also be noted that flyer is being updated at this time to clarify what information is requested to finalize the quote. Carelink does not mandate either the tax form or a previous carrier invoice prior to issuing coverage to a qualified small employer. These documents are simply the most commonly-provided materials submitted by groups to prove they are small employers.”

The Company's producer materials indicated that the two documents are “required.” It was also found that the Company's nonrenewal letters (see testing performed at Standard F 8), stated in part, “Carelink *must* receive notification of the additional eligible employees by submission of the most recent valid wage and tax statement or W-2 forms for those employees . . .” The Company's materials were misleading and in violation of W. Va. Code § 33-25A-14(a). It appears that as a result of the examination the flyer is being updated.

Recommendations: The Company's small group solicitation materials should indicate that all small employer groups are guaranteed renewable. The Company should not provide statements concerning a mandatory tax form for an otherwise eligible employer to gain coverage under a small group health plan.

Standard C 3

NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 3.

HMO communications to producers are in compliance with applicable statutes, rules and regulations.

W. Va. Code § 33-25A-14

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. This standard is intended to assure compliance with the prohibitions on misrepresentation. It is concerned with representations made by the HMO to its producers in other than a training mode.

Results: Pass

Observations: The Company's written and electronic communications, other than those tested under Standard C 2, did not reveal misrepresentations. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard C 4*NAIC Market Regulation Handbook - Chapter XX, § C, Standard 2***Outline of coverage is in compliance with applicable statutes, rules and regulations.***W.Va. Code § 33-25A-8 & § 33-25A-10*

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. This standard is aimed at assuring compliance with the prohibitions on misrepresentation. It is concerned with representations made by the HMO to its members through outlines of coverage.

Results: Pass

Observations: The Company did not provide outlines of coverage for its West Virginia members. West Virginia does not mandate outlines of coverage for group products.

Recommendations: None

D. PRODUCER LICENSING

Comments: The evaluation of these standards is based on review of the Insurance Commissioner's files and Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to test the Company's compliance with West Virginia producer licensing laws and rules.

Standard D 1*NAIC Market Regulation Handbook - Chapter XVI, § D, Standard 1.***Company records of licensed and appointed producers agree with department of insurance records.***W.Va. Code § 33-25A-24(d); W.Va. Code § 33-12-18 & W.Va. Code St. R. § 114-02-1 et seq.*

Comments: This standard has a direct statutory requirement. It is not file specific. This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed. Such producers are presumed to have met the test to be qualified for such license. W. Va. Code § 33-12-3 states, "No person shall in West Virginia act as or hold himself out to be an agent, broker or solicitor nor shall any person in any manner solicit, negotiate, make or procure insurance covering subjects of insurance resident, located or to be performed in West Virginia, unless then licensed therefore pursuant to this article." W. Va. Code § 33-12-3(d) states, "No insurer shall accept any business from or pay any commission to any individual insurance producer who does not then hold an appointment as an individual insurance producer for such insurer pursuant to this article."

Results: Fail

The Company's listing of six hundred fifty-two (652) producers, which was the entire population, was tested for this standard. Additionally, included in the Table below were twenty-one (21) currently appointed producers not included on the Company listing. The results of testing are as follows:

Table D 1: Producer Licensing Sample Results					
Type	Population	N/A	Pass	Fail	% Pass
Producers	673	0	601	72	89.0%
Total	673	0	601	72	89.0%

Observations: The Company had fifty-one (51) producers that were no longer appointed on its listing of current appointed producers. One of the producers was terminated during 2004, and several others had been terminated for more than twelve (12) months. On its listing of current licensed and appointed producers, the Company failed to include twenty-one (21) producers that appeared on the WVOIC list. The Company agreed that its producer listing was not complete.

Recommendations: It is recommended that Carelink establish internal controls to ensure that its producer listings are current in order to validate that all underwritten applications are received from West Virginia licensed and appointed producers.

Standard D 2 *NAIC Market Regulation Handbook – Chapter XVI, § D, Standard 2.*
The producers are properly licensed and appointed (if required by state law) in the jurisdiction where the application was taken.
W. Va. Code § 33-12-1

Comments: This standard has a direct statutory requirement. As applied in this section, it is not file specific. This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed for business solicited in West Virginia.

Results: Pass

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of sixty (60) newly issued small groups, the forty-five (45) renewed small groups, and the ten (10) renewed association groups. The results of testing are as follows:

Table D 2 Producer Licensing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Groups	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	2	58	0	100%
Renewal Small Groups	45	45	0	45	0	100%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	120	0	100%

Observations: Testing determined that all of the producers associated with the newly issued and renewed employer applications were appointed and licensed in West Virginia. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard D 3**Termination of producers complies with statutes regarding notification to the producer and notification to the state if applicable.***NAIC Market Regulation Handbook – Chapter XVI, § D, Standard 3.**W.Va. Code § 33-12-25a & W.Va. Code St. R. § 114-02-1 et seq.*

Comments: This standard has a direct statutory requirement. It is generally not file specific. This standard is aimed at avoiding unlicensed placements of insurance.

Results: Pass

Observations: The Company’s listing of terminated producers revealed the WVOIC was notified of producers that were terminated by Carelink. The Company stated that none of its producers were terminated for cause. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard D 5**Records of terminated producers adequately document reasons for terminations.***NAIC Market Regulation Handbook – Chapter XVI, § D, Standard 5.**W.Va. Code § 33-12-25a & W.Va. Code St. R. § 114-02-1 et seq.*

Comments: This standard has a direct statutory requirement. It is generally file specific. This standard is intended to aid in the identification of producers involved in unprofessional behavior which is harmful to the public. W. Va. Code § 33-12-25 provides, “(a) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the Insurance Commissioner within thirty days following the effective date of the termination, using a format prescribed by the Insurance Commissioner . . . Upon written request of the Insurance Commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer. . . (d)(1) At the time of making the notification . . . the insurer shall simultaneously mail a copy of the notification to the producer at his or her last known address. . . .”

Results: Pass

There were sixty-one (61) producers terminated during 2006 and 2007. All sixty-one (61) terminations were tested. The results of testing are as follows:

Table D 5 Producer Licensing Sample Results					
Type	Population	N/A	Pass	Fail	% Pass
Producers Terminated	61	0	61	0	100.0%
Total	61	0	61	0	100.0%

Observations: The Company maintained adequate documentation, including the notice of termination for its terminated producers. The Company stated that none of its producers were terminated for cause. There were no exceptions noted during testing of this standard.

Recommendations: None

E. POLICYHOLDER SERVICES

Comments: The evaluation of standards in this business area is based on review of Company responses to information requests, questions and interviews, presentations made to the examiner, files and file samples during the examination process. The policyholder service portion of the examination is designed to test a company's compliance with statutes regarding notice/billing, delays/no response, premium refund, and coverage questions.

Standard E-1 *NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 1.*
Premium notices and billing notices are sent out with an adequate amount of advance notice.

Comments: Review methodology for this standard is generic, sample, and electronic. There is no direct statutory requirement. This standard is intended to provide insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, the forty-five (45) renewed small groups, and the ten (10) renewed association groups. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Groups	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	2	58	0	100%
Renewal Small Groups	45	45	0	45	0	100%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	120	0	100%

Observations: Typically, the coverage's issued by Carelink were effective on the first of the month and were paid on a monthly basis. Carelink strived to have enrollment guides (member handbooks) and ID cards available for employer groups or members, on or before the effective date of coverage. In addition, premium was due prior to coverage issuance, and in all instances premium notices appeared to provide employers with an adequate amount of advance notice. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard E.2*NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 2.***Insured-requested cancellations are timely.***W. Va. Code §33-25A-1 et seq.*

Comments: Review methodology for this standard is generic, sample, and electronic. There is no direct statutory requirement. This standard is intended to provide insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Testing for this standard was performed based on: a sample of sixty (60) terminated small groups, the four (4) large groups terminated, and the two (2) association groups terminated. Small and large group coverage is guaranteed renewable. The results of testing are as follows:

Table E 2 Policyholder Service Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Group Cancellations	107	60	1	59	0	100%
Large Group Cancellations	4	4	0	4	0	100%
Association Group Cancellations	2	2	0	2	0	100%
Total	113	66	1	65	0	100%

Observations: Occasionally a group would notify Carelink in advance that it intended to terminate its contract. In such cases, Carelink's goal was to enter the requested date of cancellation in advance of the cancellation. More often, Carelink learns of the group's election to terminate after the fact, because rather than providing advanced notice the group merely stops paying premiums. For the files tested where the employer requested cancellation there were no exceptions noted.

Recommendations: None**Standard E.3***NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 3.***All correspondence directed to the HMO is answered in a timely and responsive manner by the appropriate department.**

Comments: Review methodology for this standard is generic, sample, and electronic. There is no direct statutory requirement. This standard is intended to provide insureds with information in a timely fashion so they can make informed decisions.

Results: Pass

Observations: All general mail was screened and then sent to the Company's most appropriate unit for response, based on the nature of the correspondence. The Company logged and tracked all correspondence. Carelink's goal was to respond to all written inquiries within thirty (30) days. However, the executive inquiries area and the correspondence unit's procedures called for a response or acknowledgement within three (3) business days. If the issue could not be resolved within fifteen (15) business days, a "delay letter" (explaining that there is a delay) was to be sent.

Recommendations: None

Standard E 5 *NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 5.*
Contract transactions are processed accurately and completely.

Comments: Review methodology for this standard is generic and sample. There is no direct statutory requirement. The focus of this standard is to assure that contract transactions are handled appropriately.

Results: Pass

Testing for this standard was performed based on: one (1) newly issued association group; six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, forty-five (45) renewed small groups, and ten (10) renewed association groups. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Groups	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	2	58	0	100%
Renewal Small Groups	45	45	0	45	0	100%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	120	0	100%

Observations: Testing indicated the Company was completing transactions accurately and completely. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard E 7 *NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 7.*
Unearned premiums are correctly calculated and returned to the appropriate party in a timely manner and in accordance with applicable statutes, rules, and regulations.

W.Va. Code St. R. §114-54-5.1

Comments: Review methodology for this standard is generic and sample. There is no direct statutory requirement. This standard is intended to provide insureds with the proper amount of premium refund upon cancellation, in a timely manner.

Results: Pass

Testing for this standard was performed based on: a sample of sixty (60) terminated small groups, the four (4) large groups terminated, and the two (2) association groups terminated. The results of testing are as follows:

Table E 7 Policyholder Service Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Group Cancellations	107	60	0	60	0	100%
Large Group Cancellations	4	4	0	4	0	100%
Association Group Cancellations	2	2	0	2	0	100%
Total	113	66	0	66	0	100%

Observations: There were no instances during testing where it was determined that the Company had not returned unearned premiums timely and in accordance with West Virginia law. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard E 8 *NAIC Market Regulation Handbook – Chapter XX, § E, Standard 1.*
Reinstatement is applied consistently and in accordance with policy provisions.
W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17

Comments: Review methodology for this standard is generic and sample. There is no direct statutory requirement. The focus of this standard is to assure that reinstatement guidelines are applied fairly among all employers that request reinstatement.

Results: Pass

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of sixty (60) newly issued small groups, the ten (10) renewed association groups, and the forty-five (45) renewed small groups. The results of testing are as follows.

Table E 8 Policyholder Service Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Groups	1	1	1	0	0	N/A
Newly Issued Large Groups	6	6	6	0	0	N/A
Newly Issued Small Groups	147	60	60	0	0	N/A
Renewal Small Groups	45	45	44	1	0	100%
Renewal Association Groups	10	10	10	0	0	N/A
Total	209	122	121	1	0	100%

Observations: There was one instance during testing of the newly issued and renewal files where the Company reinstated coverage. Testing determined the Company followed its guidelines and sent the reinstatement notice in a timely manner. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard E 9

NAIC Market Regulation Handbook – Chapter XX, § E, Standard 2.

Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules and regulations.

W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17

Comments: Review methodology for this standard is generic and sample. There is no direct statutory requirement. The focus of this standard is to assure that certificates of creditable coverage are issued in compliance with W. Va. Code St. R. § 114-54-5.3 and 5.4, and HIPAA. The certificates of creditable coverage should provide accurate and complete information, and be provided in a timely manner.

Results: Fail

Testing for this standard was performed based on: a sample of sixty (60) terminated small groups, the four (4) large groups terminated, and the two (2) terminated association groups. The results of testing are as follows:

Table E 9 Policyholder Service Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Group Cancellations	107	60	0	0	60	0%
Large Group Cancellations	4	4	0	0	4	0%
Association Group Cancellations	2	2	0	0	2	0%
Total	113	66	0	0	66	0%

Observations:

- The Company failed in every case to provide the name of the group health plan under which the health maintenance organization provided its certificates of creditable coverage (CCCs) during the period under examination, in violation of W. Va. Code St. R. § 114-54-5.4(b) and HIPAA. Therefore, all the CCCs issued during the period under examination failed. In addition, the Company failed to provide the dates associated with applicable waiting or affiliation periods on CCCs in violation of W. Va. Code St. R. § 114-54-5.4(e) and HIPAA. The Company's response stated, "Carelink agrees that the Certificates of Creditable Coverage did not include the name of the group health plan as required by WV Reg. § 114-54-5.4(b). In addition, Carelink agrees that it failed to include waiting periods or affiliation periods on line 9 of the form. Coventry (Carelink's Parent) has been made aware of the issues with the CCCs and is working toward a resolution."

- Furthermore, testing of the sample of sixty (60) small group terminated files revealed that seven (7) employer files failed (12%) because the CCCs should have included a waiting period for employee(s) or dependent(s). Testing also revealed that six (6) small employer files were failed (10%), because the Company did not issue CCCs timely to either employee(s) or dependent(s). Testing of four (4) large group terminated files revealed that all four (4) files (100%) were failed, because three groups were issued CCCs that should have included a waiting period for employee(s) or dependent(s) and one (1) was failed because the Company did not issue the CCCs timely to either an employee(s) or dependent(s). Testing of the two (2) association group plans terminated, revealed that one (50%) failed because the CCC issued

should have included a waiting period. For each of the files failed, the Company failed to act in compliance with W. Va. Code St. R. § 114-54-5.3(a) and 5.4(e)(1) and (2), and HIPAA.

Recommendations: The Company should provide verification that it has corrected its CCC form to include the name of the group health plan, and waiting/affiliation periods when applicable. In addition, the Company should provide all CCCs timely.

F. UNDERWRITING AND RATING

Comments: The evaluation of standards in this business area is based on a review of Company responses to information requests, questions, interviews, presentations made to the examiner, files and file samples. The underwriting and rating practices portion of the examination is designed to provide a view of how the Company treats the public and whether that treatment complies with applicable statutes and rules. It is typically determined by testing a random sample of files and applying various tests to those files. These standards are concerned with compliance issues.

<p>Standard F 1 The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company-rating plan.</p>	<p><i>NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 1</i> <i>W.Va. Code § 33-25A-8, W.Va. Code § 33-25A-24-5 & W.Va. Code § 33-16D-5</i></p>
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Comments: This standard has a direct statutory requirement. It is file-specific. It is necessary to determine if the Company complies with the rating systems that have been filed and approved by the West Virginia Insurance Commissioner. Wide scale application of incorrect rates by a company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a company is engaged in unfair competitive practices.

Results: Pass with recommendation

Testing for this standard was performed based on: the one (1) newly issued association group, six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, ten (10) renewal association groups, and forty-five (45) renewed small groups. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Group	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	2	58	0	100%
Renewal Small Groups	45	45	0	41	4	91%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	116	4	97%

Observations: No exceptions were noted during testing of the files for the newly issued association group, large groups or small groups.

- For four (4) renewal files tested, the Company assigned incorrect industry codes (SIC) when rating employers. The invalid industry codes led to a benefit in rating for each of the employers. However, to avoid unfair discrimination among employers, a Company is responsible for assigning proper SICs in compliance with W. Va. Code § 33-16D-5(b), which states, “Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.” The Company's responses stated in part, “Prior to 2008, the underwriter reviewed the information supplied for reasonableness, but did not verify the data through an independent source. . . . Carelink’s current process is to verify the SIC supplied by the broker/group with information available . . . for all new business quotations. . . . Carelink agrees . . . provided a benefit to the employer.” The Company's responses for all four files agreed the industry codes were incorrect and that rating was a benefit to the employers.

Recommendations: It is recommended that Carelink underwrite each employer group to ensure that industry codes are assigned properly, in order to ensure rating fairness for all groups.

Standard F 2	<i>NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 2.</i>
All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations.	
<i>W.Va. Code § 33-2-9, W.Va. Code § 33-25A-8 & W.Va. Code § 33-25A-17</i>	

Comments: This standard has a direct statutory requirement. It is necessary to provide insureds with appropriate disclosures, both mandated and reasonable. Without appropriate disclosures, insureds find it difficult to make informed decisions.

Results: Fail

Observations: The Company’s underwriting guidelines, evidence of coverage (EOC), enrollment guide, group contracts and the application were reviewed to determine if benefits and provisions were in compliance with West Virginia laws and HIPAA.

- The Company was asked to provide the month it had established for “open enrollment” in the West Virginia individual market for compliance with W. Va. Code § 33-25A-11(1). The West Virginia statute states in part, “Once a health maintenance organization has been in operation at least five years, or has enrollment of not less than fifty thousand persons, the health maintenance organization shall, in any year following a year in which the health maintenance organization has achieved an operating surplus, maintain an open enrollment period of at least thirty days during which time the health maintenance organization shall, within the limits of its capacity, accept individuals in the order in which they apply without regard to preexisting illness, medical conditions or degree of disability except for individuals who are confined to an institution because of chronic illness or permanent injury . . .” The Company's response stated in part, “WV Code § 33-25A-11 is an old code provision which has not been updated since 1996. This law was in place prior to-HIPAA and before WV Code § 33-15-2b was enacted. The intent behind this open enrollment requirement appears to be that it allows individuals an opportunity to obtain and enroll in individual HMO coverage. . . . Since Carelink does not participate in the

individual market, it does not offer individual policies through the provisions in either WV Code § 33-25A-11 or § 33-15.”

There is no evidence in West Virginia statutes or rules to support that open enrollment is no longer applicable due to the enactment of W. Va. Code § 33-15-2b. W. Va. Code § 33-15-2b addresses the requirement for individual carriers to enroll federally eligible individuals. For such individuals, the annual open enrollment period requirement of W. Va. Code § 33-25A-11(1) is unnecessary. Nothing in W. Va. Code § 33-25A-11(1), restricts its application to individual carriers.

- The Company’s underwriting guidelines denied small employer eligibility if more than ten percent (10%) of the total enrollees were COBRA continuees. To deny small group eligibility for this reason is a violation of W. Va. Code § 33-16D-4 and HIPAA. The Company’s response stated in part, “. . . As stated in Carelink’s Underwriting Guidelines, the restriction to disallow coverage for employers who have more 10% of their total enrolled employees under COBRA is one such rule that Carelink has which is applied uniformly to all small employers. . . . carriers may implement participation rules and *the COBRA restriction is such a participation rule*. Therefore, Carelink’s small group restriction on the number of COBRA enrollees is not a violation of WV Code § 33-16D-4 and is consistent with public law 104-191. It is also important to note that this restriction impacts only those groups with 20 or more employees and many of the groups that Carelink writes are smaller than that.” The Company’s group participation guidelines did not include a restriction on the number of COBRA enrollees and this restriction was not included in the group contract participation rules filed with the WVOIC.

- The Company's small group underwriting guidelines restricted small group eligibility to those employers in business for at least six months. Such a *restriction is a violation of W. Va. Code § 33-16D-4* and HIPAA and would deny guaranteed issue to otherwise eligible small groups. The Company did not retain copies of its declinations of small groups. Therefore, the Company’s application *of this guideline could not be tested*. The Company’s response stated in part, “The SG Risk Selection/Underwriting Guidelines . . . is a best practices guide for determining what risk factors should be applied when underwriting small groups. The provision . . . is in place to alert underwriters to be especially diligent in confirming business legitimacy on these groups . . . Carelink’s experience has been that many start ups go out of business within the first few months, leaving premiums unpaid, and claims outstanding or that individuals try to obtain group health care coverage when they are not a legitimate group business. This is particularly the case in the smaller segment (<10 employees). Again, the guideline is in place for diligent risk analysis, and to be put into practice as applicable laws allow. Carelink will still write these groups; the provision is listed in the guidelines in order to alert the underwriter about a possible risk factor.”

The company’s guidelines stated, “For groups with less than 10 eligible employees, 6 months in business is *required*.” Carelink’s underwriting guidelines permitted declination of eligible small groups. If any declination of a small group occurred solely for this reason, it would be non-compliant with West Virginia law and HIPAA.

- The Company’s small group underwriting guidelines restricted small group eligibility to those employers that provide workers' compensation coverage. These guidelines would permit the Company to act in violation of W. Va. Code § 33-16D-4 and HIPAA. West Virginia law

does not make workers' compensation mandatory for all eligible small employers. The Company did not retain copies of its declinations of small groups as noted at F 7. Therefore, this guideline could not be tested. The Company's response for the restriction of worker's compensation stated in part, ". . . it is understood that only employers *who are required* to provide Workers' Comp insurance will do so; however, Carelink does not track this coverage nor does it decline a group that does not have Workers Comp coverage. Again, this is intended to provide the underwriter with criteria that they need to appropriately evaluate the risk, not as a criterion to exclude coverage. . . ."

The Company's small group underwriting guidelines stated, "All employers *must* provide Workers Compensation coverage." The guidelines permitted the declination of eligible small groups, which was not in compliance with West Virginia law and HIPAA.

- The Company's "Carelink - Proposal Contingencies" (underwriting guidelines) permitted the Company to use misstatements or omissions to deny claims and/or rescind a group policy. Any denial of claims or rescission of a group policy for a misstatement or omission would not be in compliance with W. Va. Code § 33-16D-7(a)(2) and HIPAA. The Company's response stated in part, "The statement on the contingency page of the small group proposals . . . Carelink *may* rescind coverage for misstatements or omissions from the group during the application process. However, as indicated in the Group Agreement, terminations may result from fraud or material misrepresentation. The misstatements or omissions by the group during the quoting and application process would have to rise to the level of either fraud or material misrepresentation as determined by Carelink's Fraud Committee in order for Carelink to consider termination or rescission of the group's coverage."

Denial of claims or rescission of a group policy for misstatements or omissions would not be compliant with W. Va. Code § 33-16D-7(a)(2) or HIPAA, both of which require a higher standard prior to such actions.

- The Company's EOC limited the provision of prosthetic breasts and mastectomy bras by number and time period, in violation of W. Va. Code § 33-25A-8f and WHCRA, both of which require any limit to be set only by the physician in consultation with the member. The Company's response stated in part, "According to WV Code § 33-25A-8f(a)(3), an HMO may apply to prostheses needed as a result of a mastectomy annual deductible and coinsurance provisions that may be deemed appropriate and are consistent with those established for other benefits . . . Carelink interpreted this to include benefit limits which could be considered a coinsurance provision. . . . In addition, the restriction on the number of mastectomy bras and breast prostheses is also similar to a coinsurance provision and is consistently applied to other similar items under the same coverage category. It should be noted that Carelink can find no record of any mastectomy bra or breast prosthesis being denied for exceeding any benefit limits." The Company also stated, ". . . was revised based on the concerns expressed by the examiners . . . to no longer limit the number of mastectomy bras or breast prostheses. In addition, Carelink's EOC is being amended for 2009 to reflect the changes as well."

As a result of the market conduct examination the Company is revising its 2009 EOC.

- The Company's Group agreement/contract provided for amendment of the contract at any time upon thirty (30) days notice to the employer and for termination of the agreement if the employer did not agree to the amendment, thereby negating guaranteed renewability of a group health benefit plan. The provision permitted the Company to act in violation of W. Va. Code § 33-16D-7, W. Va. Code St. R. § 114-54-6 and HIPAA. The Company's response stated in part, "Carelink does not agree that its HMO Group Agreement/Group Contract failed to comply with West Virginia Code provisions cited . . . The intent of the amendment section of the agreement is only for amendments to the agreement itself, not the attachments and documents which are included as part of the agreement. Thus, no amendments would be made to the group's benefit plan except upon renewal. (It should also be noted that this amendment provision has not been exercised.) . . ."

The contract language allowed actions which were not permitted under West Virginia law or HIPAA.

- The Company's Small Group "Risk Selection/Underwriting Guidelines" permitted unfair discrimination between small employer groups by allowing changes to, and/or a reduction of, benefits under some small employers' health benefit plans other than at renewal. Any employer-initiated modification of a plan that is permitted for one small employer but not another would result in a violation of W. Va. Code § 33-16D-7(e). The Company's response stated, "The SG Risk Selection/Underwriting Guidelines found in the Coventry Underwriting Manual is a best practice guide for determining what risk factors should be applied when writing small groups, subject to regulatory approval. The provision concerning "Off cycle benefit changes" is not applicable in West Virginia since it is not allowed to make benefit plan changes except at renewal."

The Company's response addressed the underwriting of new small groups. The guidelines addressed post-issue benefit changes initiated by the Company, not conditions pertaining to the Company's underwriting of new groups. Neither West Virginia law, nor HIPAA permit a carrier to initiate benefit changes to an employer's plan off-renewal. The Company's underwriting guidelines permitted unfair discrimination based on a small group's size.

- The EOC stated that a member's coverage may be terminated for failure to make a copayment, in violation of W. Va. Code § 33-25A-4(b), which prohibits termination unless three or more copayments are not made in any twelve month period. The Company's response stated, "Carelink agrees that it may not terminate the coverage of a subscriber and/or his dependents for non-payment of one or two copayments in any 12-month period pursuant to WV Code § 33-25A-4-2(b). Carelink agrees that the language in its 2007 Evidence of Coverage permits termination for failure to pay copayments without clarifying the number of times the member must fail to pay the copayments within a specified period." Therefore, as a result of the market conduct examination it appears the Company will correct its 2009 EOC to comply with W. Va. Code § 33-25A-4(b).

- The group agreement/contract stated that any non-complying provision would be severable from the contract in violation of W. Va. Code § 33-6-17, which requires that a non-complying provision be construed in accordance with the laws of the State of West Virginia. The Company's response stated in part, "Carelink does not agree that its Group

Agreement/Group Contract fails to comply with WV Code § 33-6-17. . . . The code provision does contemplate that a document may contain a condition or provision that is not in compliance with the requirements of this chapter. The intent of this code provision is to require that if a document contains such a noncompliant condition or provision, any requirements set forth in the West Virginia Code will prevail. Carelink acknowledges and adheres to this requirement in its business practice. Therefore, the severability provision included in the Group Agreement/Group Contract has no effect since West Virginia law prevails in this matter. . . . If the Commissioner deems it necessary, Carelink will agree to file an amendment to the current agreement or file a new Group Agreement/Group Contract with the Department of Insurance to communicate its acknowledgment, understanding and current practice that in the event of a conflict between a contract provision and any requirement set forth in the Code of West Virginia, West Virginia law shall prevail.”

- The Company's “Health Care Underwriting Manual” for large Groups permitted it to violate W. Va. Code St. R. § 114-54-6 and HIPAA, by denying guaranteed renewability based on (1) comparability with other plan offerings; (2) a requirement for a twenty-five percent (25%) membership penetration; or (3) the perceived risk to the financial integrity of the current plan. The Company stated that it could decline, substitute a low option, or provide a self-funded alternative at renewal. None of these qualified as valid reasons for nonrenewal of a group health plan under either West Virginia law or HIPAA. The Company’s response stated in part, “. . . Both the state statutes and Public Law 104-191, Section 2712 allow for nonrenewal for violation of a participation or contribution rule. The guidelines stated relate to coverage in "slice" situations (more than one carrier) and the requirements are specific to both the employer’s contribution requirement and the group’s participation requirement. The underwriting guideline referenced does not mandate the replacement of the group's current offering, but suggests that an alternative plan should be explored as a means to bring the group into compliance with contribution and participation guidelines. The 25% penetration guideline is a prudent and valid participation requirement for slice business offerings.”

The Company’s participation guidelines in the group contract, and the three reasons listed above, including penetration of the group, were not included in its participation rules in the WVOIC filed group contract. The Carelink underwriting guidelines permitted nonrenewal of large groups and were therefore not in compliance with West Virginia law and HIPAA.

- The Company's large group underwriting guidelines provided for nonrenewal and re-writing of group plans due to a change in the number of eligible employees of plus or minus twenty percent (20%). Non-renewal or rewriting of an employer group for these reasons would violate W. Va. Code St. R. § 114-54-6 and HIPAA. The Company’s response stated in part, “Carelink does not feel that its Large Group Underwriting Guidelines permit nonrenewal of coverage for reasons other than those permitted under HIPAA and W. VA. Code St. R. § 114-54-6. The Large Group Underwriting Guidelines are corporate guidelines which are to be considered in combination with specific contract language. . . . Carelink’s Large Group Underwriting Guidelines allow Carelink to reconsider rates if there is a material change of 20% or more in the number of eligible employees. . . . The ability for Carelink to change rates is specifically addressed in the group contract. Furthermore, termination provisions are also addressed in the group contract and any language set forth in the contract provisions would prevail over corporate underwriting guidelines. In practice, if a large group experienced a material change in enrollment mid-contract year, the group would be allowed to continue with its

current products at the increased rates (if applicable) and any such rate increase would be implemented as set forth in the group contract. If the group wanted to make benefit changes, they would be offered the option of entering a new 12-month contract. The large group would not be terminated or non-renewed for a reason other than as permitted in accordance with HIPAA and West Virginia laws and regulations.”

The guidelines stated, “Existing accounts with a change in eligible employees of 20% or more (increase or decrease) may need to be *underwritten as a new group* if the change represents a *material change in risk*.” New large groups may be declined. Renewing large groups may not be declined, because large group coverage is guaranteed renewable. Therefore, the guidelines permit the violation of W. Va. Code St. R. § 114-54-6 and HIPAA.

- The Company's “Right of Recovery/Subrogation” provision in the EOC, improperly stated, “You must agree to reimburse Carelink in full for any benefits paid from any settlement, judgment or other payment You or Your attorney may receive as a result of Your personal injury. It does not matter how these payments are characterized, why they are paid, or whether they are labeled as being compensation for your medical bills or lost wages.” West Virginia Supreme Court, Kittle and Karl, *supra*, defined equity as, per se, denying insurers any recovery when insureds were not fully compensated by a settlement or judgment. The Company’s response stated, “While Carelink’s Evidence of Coverage states that the member must agree to reimburse Carelink in full, in practice, the amount received by Carelink in any subrogation matter is negotiable. Factors such as sharing in attorneys’ fees and costs, limited proceeds, and the application of the made whole doctrine are taken into consideration when negotiating a subrogation settlement.”

In general, subrogation rights allow a health carrier to recover only reimbursed medical payments.

Recommendations: The Company’s underwriting guidelines and practices, evidence of coverage (EOC), enrollment guide, group contracts and application should be provided in compliance with West Virginia statutes, rules and HIPAA.

Standard F 3

NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 3.

The Company does not permit illegal rebating, commission cutting or inducements.

W.Va. Code § 33-12-23

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. It is generally file specific. Illegal rebating, commission cutting or other illegal inducements are a form of unfair discrimination.

Results: Pass with recommendation

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, the forty-five (45) renewed small groups, and the ten (10) renewal association groups. The results of testing are as follows:

current products at the increased rates (if applicable) and any such rate increase would be implemented as set forth in the group contract. If the group wanted to make benefit changes, they would be offered the option of entering a new 12-month contract. The large group would not be terminated or non-renewed for a reason other than as permitted in accordance with HIPAA and West Virginia laws and regulations.”

The guidelines stated, “Existing accounts with a change in eligible employees of 20% or more (increase or decrease) may need to be *underwritten as a new group* if the change represents a *material change in risk*.” New large groups may be declined. Renewing large groups may not be declined, because large group coverage is guaranteed renewable. Therefore, the guidelines permit the violation of W. Va. Code St. R. § 114-54-6 and HIPAA.

- The Company's “Right of Recovery/Subrogation” provision in the EOC, improperly stated, “You must agree to reimburse Carelink in full for any benefits paid from any settlement, judgment or other payment You or Your attorney may receive as a result of Your personal injury. It does not matter how these payments are characterized, why they are paid, or whether they are labeled as being compensation for your medical bills or lost wages.” West Virginia Supreme Court, Kittle and Karl, *supra*, defined equity as, *per se*, denying insurers any recovery when insured’s were not fully compensated by a settlement or judgment. The Company’s response stated, “While Carelink’s Evidence of Coverage states that the member must agree to reimburse Carelink in full, in practice, the amount received by Carelink in any subrogation matter is negotiable. Factors such as sharing in attorneys’ fees and costs, limited proceeds, and the application of the made whole doctrine are taken into consideration when negotiating a subrogation settlement.”

In general, subrogation rights allow a health carrier to recover only reimbursed medical payments.

Recommendations: The Company’s underwriting guidelines and practices, evidence of coverage (EOC), enrollment guide, group contracts and application should be provided in compliance with West Virginia statutes, rules and HIPAA.

Standard F 3	<i>NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 3.</i>
The Company does not permit illegal rebating, commission cutting or inducements.	W.Va. Code § 33-12-23

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. It is generally file specific. Illegal rebating, commission cutting or other illegal inducements are a form of unfair discrimination.

Results: Pass with recommendation

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, the forty-five (45) renewed small groups, and the ten (10) renewal association groups. The results of testing are as follows:

Table F 3 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Group	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	0	58	2	97%
Renewal Small Groups	45	45	0	42	3	93%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	0	117	5	95%

Observations: Testing of the newly issued and renewed small group files determined the Company cut commissions and bonuses for some small group sales, which may have restricted guaranteed issue and renewability in the small group market.

- During 2005, 2006 and 2007, the Company failed to pay commissions accurately to its producers for six (6) max-rated small groups, which could have restricted the mandates in W. Va. Code §§ 33-16D-4 and 7, and HIPAA. The Company cut its commissions and bonus program for max-rated groups. The Company's practices and procedures were not valid and a recognized method of avoiding the guaranteed availability mandate applicable to all eligible small groups. The Company's response stated, "A recent review by the Coventry Health Care Legal Department, independent of Carelink's Market Conduct examination review and preparation, determined that Carelink needed to revise its commission program. An update to the bonus program is not necessary, as this program has been discontinued. Revisions to the Agent Agreement and Application, including the implementation of the same commission structure for sales and renewals of max-rated groups as for all other small group business are being sent to all appointed Carelink producers on August 1, 2008."

Recommendations: The Company should pay its producers the commissions it failed to pay for max-rated groups and any applicable bonus payments, which should have been paid during the period under examination.

<p>Standard F 4 The regulated entity's underwriting practices are not unfairly discriminatory. The regulated entity adheres to applicable statutes, rules and regulations and regulated entity guidelines in the selection of risks.</p>	<p><i>NAIC Market Regulation Handbook - Chapter XVI, § F, Standard 4.</i> <i>W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17</i></p>
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Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. Insurers must treat all employers and members the same within the same class to ensure no unfairly discriminatory practices occur.

Results: Fail

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of sixty (60) newly issued small groups, the forty-five (45) renewed small groups, and the ten (10) renewal association groups. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Group	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	5	1	83%
Newly Issued Small Groups	147	60	2	48	10	83%
Renewal Small Groups	45	45	0	37	8	82%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	101	19	85%

Observations:

- For one small group renewal file tested, the Company's underwriter allowed coverage to continue when participation did not meet its underwriting guidelines and group contract participation rules. The Company's response stated in part, "The file documentation does not indicate that participation was verified at the 2/1/07 renewal. . . . When it appears that the group may no longer meet the 50% rule, it is our policy to request documentation from the employer group . . . We have no evidence that this documentation was requested, so we cannot determine if the group failed to meet the guidelines or if the group was compliant due to a change in the number of eligible employees. It appears that for this case, the underwriter failed to perform the verification that is part of our standard process."

The Company failed to underwrite in compliance with its guidelines. Its actions were a violation of W. Va. Code §§ 33-16D-7(a)(3) and (4) and 33-25A-14a(d), which mandate that an HMO uniformly apply its rules to all employer groups.

- For three (3) small group renewal files tested, the Company did not comply with its underwriting guidelines and its group contract/agreement when it renewed three employer groups that did not meet its eligibility requirements. A Company response concerning this issue stated in part, "The underwriting guidelines indicate that 100% enrollment in a viable medical plan is required when the employer contributes 100% of the cost of the coverage. Carelink allows qualified group coverage (for example: spousal waivers, governmental coverage) to count toward the 100% rule. . . ."

The Company's guidelines and its group contract indicated that waivers are utilized when determining if the employer had 75% participation in groups with less than one-hundred percent (100%) employer contributions. However, waivers are not associated with an employer that is providing one-hundred percent (100%) of the premium, because there is no justification for an employee not to take coverage when the employer is offering to pay one-hundred percent (100%) of the premium associated with the group health plan.

The Company did not comply with its group contracts and its underwriting guidelines in violation of W. Va. Code §§ 33-16D-7(a)(3) and 33-25A-14a(d), which do not permit discrimination in enrollment. If the Company declined coverage based on these guidelines for other small employers, then it failed to uniformly apply its rules applicable to all employers in compliance with the above statutes. For four (4) small group renewal files tested, the Company

did not act in compliance with its underwriting guidelines, application or its group contract when it allowed renewal of small groups that did not meet its contribution requirements. The Company's application, contracts and its underwriting guidelines mandate that an employer pay fifty percent (50%) of total group premium. The Company's response stated, "The 50% employer contribution to the single rate is a hard guideline, and Carelink will decline a group that does not agree to pay 50% of this coverage level. The 50% of the total cost of the plan (which includes dependent coverage) is a recommended corporate guideline; however, we do not apply this guideline in West Virginia. The true test is participation. When participation guidelines are met, Carelink assumes that the employer has met his obligation by paying an appropriate share of the cost of coverage. . . . the employer agreed to contribute a minimum of 50% of the Employee Only rate, which satisfies the guideline as it is administered in West Virginia."

The Company's filed and approved application and group contract mandated that an employer meet a fifty percent (50%) contribution to the total group premium. Therefore, the Company's actions were a violation of W. Va. Code § 33-25A-14a(d), which does not permit discrimination in enrollment. If the company declined coverage for other small employers based on these eligibility guidelines, it failed to uniformly apply its rules, and therefore would not have been in compliance with W. Va. Code §§ 33-16D-7(a)(3) and 33-16D-4(b). The Company failed to retain small group declined documentation as noted at F 7.

- For five (5) small group newly issued files, the Company failed to uniformly enforce its group agreement/contract and underwriting guidelines, which required a fifty percent (50%) employer contribution towards the total cost of the plan, in violation of W. Va. Code §§ 33-25A-14a(d), 33-16D-4(b) and W. Va. Code St. R. § 114-73-3.1c. Please see the Company's response to the bulleted item above.

- For five (5) small group newly issued files the Company did not uniformly enforce its group agreement/contract and underwriting guidelines, which required one-hundred percent (100%) participation in a one-hundred percent (100%) non-contributory group, in violation of W. Va. Code § 33-16D-4(b) and § 33-25A-14a. Please see the Company's response to the bulleted item above concerning renewal group contributions.

- For one large group newly issued file, the Company allowed for a student dependent age limit that was not in compliance with W. Va. Code § 33-16-1a(d). The Company's response stated in part, "Carelink agrees that it did not comply with the student dependent age limit set forth in WV Code § 33-1a(d) . . . was the only Carelink group that was not compliant with . . . WV Code § 33-16-1a(d) during the exam period. As of July 1, 2007, there are no groups with a dependent age limit less than 25 years."

- During 2005, 2006 and 2007, the Company failed to pay commissions fairly to its producers for max-rated small groups, which restricted the mandates in W. Va. Code §§ 33-16D-4 and 7, 33-16D-4(b) and HIPAA. For details, please see the Company's response in section F.3 above.

Recommendations: Once the Company has established its underwriting guidelines it should enforce those guidelines fairly for all employers and members, and should pay producer commissions and bonuses fairly for all small groups issued.

Standard F 5 *NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 5.*
All forms, including contracts, riders, endorsement forms and certificates, are filed with the department of insurance, if applicable. *W. Va. Code § 33-25A-8*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. An HMO contract issued with forms that have not been filed and approved are technically not a part of the contract.

Results: Pass

Observations: Testing was completed to determine if the Company’s forms and endorsements had been filed with the WVOIC, and where required, determine that either prior approval had been obtained or that the applicable waiting periods following the filing had been met. The Company provided a listing of the contracts, endorsements and applications used during the period under examination and the date of approval by the WVOIC. There were no forms found during testing, which had not received the WVOIC’s approval. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard F 7 *NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 7.*
Rejections and declinations are not unfairly discriminatory. *W. Va. Code § 33-2-9, W. Va. Code § 33-25A-17 & W. Va. Code St. R. § 114-15-4.3(b)*

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. W. Va. Code St. R. § 114-15-4.3(b) states an insurer shall maintain all declined application files. Insurers must maintain copies of all communications associated with an application for coverage.

Results: Fail

Testing for this standard was performed based on the population of large groups declined during the period under examination. However, in the case of small groups, the Company failed to retain documentation to validate any denial of applications or coverage to small employer groups by its agents or customer service representatives. The results of testing are as follows:

Table F 7 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Group declined apps.	None Available	0	0	0	0	
Large Group declined apps.	51	51	2	49	0	100%
Total	51	51	2	49	0	100%

Observations: There were fifty-one (51) large groups that were declined coverage during the period under examination. Forty-nine (49) files were applicable for testing, and there were no exceptions noted during that testing. The Company stated there was no record of small employers being declined coverage.

- The Company restricted the definition of “eligible” small employer based on participation and employer contribution guidelines. However, the Company failed to track when an agent or its internal departments declined coverage due to failure to meet these underwriting restrictions. Therefore, records could not be tested to determine if the Company was declining small employers fairly and in compliance with West Virginia law, HIPAA and its guidelines. The Company should track this information for examination purposes. The Company failed to maintain those records in violation of W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4. The Company's response stated, “During the examination period, 2005 – 2007, Carelink did not maintain records on small groups when they did not meet participation or contribution guidelines.”

Recommendations: The Company should provide all small employers that indicate an interest in coverage with an application. W. Va. Code St. R. § 114-15-4.3b requires a declined file to both be maintained and contain an application. It should not have customer service or its agents making eligibility determinations that result in the declination of an employer group. If applications are received and maintained and small employers are declined coverage based on eligibility reasons, then the Company will have records available to support that decisions made are in compliance with West Virginia law.

Standard F 8

Cancellation/nonrenewal, discontinuance and declination notices comply with policy provisions, state laws and the regulated entity's guidelines.

NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 8.

W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. W. Va. Code § 33-16D-8, W. Va. Code St. R. § 114-54-6 and HIPAA provide that small and large group health plans are guaranteed renewable. The employer may terminate coverage at any time, but an insurer may only terminate coverage if the employer fails to pay the premium, fails to maintain contributions or participation in compliance with the insurer's guidelines, commits fraud or an intentional misrepresentation of a material fact or in the case of a network plan, the health carrier no longer has any enrollees in the service area. The insurer is also allowed to terminate coverage when it discontinues group health plans of a particular type, if it does so for all employers covered under that group health plan type, or it ceases to offer products in certain markets, as long as the insurer complies with the mandatory requirements for doing such.

Results: Pass with recommendation

Testing for this standard was performed based on: the two (2) association groups terminated, a sample of sixty (60) renewed small groups, and the four (4) large groups terminated. The results of testing are as follows:

Table F 8 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Terminated Association Groups	2	2	0	2	0	100%
Terminated Small Groups	107	60	1	59	0	100%
Terminated Large Groups	4	4	0	4	0	100%
Total	113	66	1	65	0	100%

Observations:

- The Company provided nonrenewal letters for twelve (12) of the sample of sixty (60) terminated small employers. The letter stated, "Carelink must receive notification of the additional eligible employees by submission of the most recent valid wage and tax statement or W-2 forms for those employees, along with a completed Enrollment/Change Form for each employee no later than April 30, 2007. If we do not receive the requested documents by April 30, 2007, this letter serves as your 31-day notice of termination of coverage."

The Company was not permitted to require receipt of tax forms. A listing of two or more employees indicates the employer is eligible for small group coverage, and therefore the employer's plan is guaranteed renewable. The Company's response indicated it did not mandate receipt of the form.

The statement in the Company's letter to small employers did not support the Company's response. Files were not failed for issuance of the nonrenewal letters. However, the Company should discontinue both use of the term, "must" in those letters and the threat of termination of coverage.

- The Company's Group agreement/contract provided for amendment of the agreement at any time upon thirty (30) days notice to the employer and for termination of the agreement if the employer did not agree to the amendment, thereby negating guaranteed renewability of a group health benefit plan. Please see the relevant bulleted item in Standard F2 for details.

- The Company's "Health Care Underwriting Manual" for large groups permitted it to violate W. Va. Code St. R. § 114-54-6 and HIPAA, by denying guaranteed renewability based on (1) comparability with other plan offerings; (2) a requirement for a 25% membership penetration; or (3) the perceived risk to the financial integrity of the current plan. Please see the relevant bulleted item in Standard F2 for details.

Recommendations: The Company's underwriting guidelines should not restrict guaranteed renewability of large or small group health plans in a manner that is not in compliance with West Virginia law and HIPAA.

Standard F 9*NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 9.***Rescissions are not made for non-material misrepresentation.***W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17*

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. The intent is to ensure rescission of coverage occurs only when it is determined that material information required for an underwriter to make an adequate assessment of risk, was not provided to the insurer.

Results: Pass with recommendation

Observations: The Company stated that it did not rescind coverage for any of its small or large groups during the period under examination.

- The Company's "Carelink - Proposal Contingencies" (guidelines) permitted the Company to use misstatements or omissions to deny claims and/or rescind a group policy. Please see the relevant bulleted item in Standard F 2 for details.

Recommendations: The Company's proposals should not permit coverage to be rescinded for reasons which would not be allowed under its filed and approved group contracts and applications, and West Virginia law and HIPAA.

Standard F 10*NAIC Market Regulation Handbook – Chapter XX, § F, Standard 5.***The regulated entity complies with the provisions of HIPAA and state laws regarding limits on the use of preexisting condition exclusions.***W.Va. Code § 33-25A-24, W.Va. Code § 33-16D-5 & W.Va. Code § 33-25A-14*

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct statutory requirement. If an insurer provides time constraints during which there is no coverage for a preexisting condition(s), then the insurer must act in accordance with W. Va. Code § St. R. 114-54-3 and HIPAA. An insurer must limit any preexisting condition exclusionary period by applying creditable coverage to limit such, and it must not allow a period of greater than twelve (12) months for exclusion of the preexisting condition(s).

Results: Pass

Observations: The Company is a health maintenance organization, which does not apply preexisting conditions exclusions for any of its members covered under any of its health plans. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard F 11*NAIC Market Regulation Handbook – Chapter XX, § F, Standard 6.***The regulated entity does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA.***W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement under W. Va. Code § 33-16-3n(a) and HIPAA. An insurer is not allowed to deny coverage or discriminate based on health status for any member of any large or small group. In addition, a federally eligible individual must be offered coverage in the market without preexisting conditions.

Results: Pass

Observations: The Company does not offer coverage in the individual market in West Virginia. However, it does make a conversion plan available to its group members that lose coverage, in compliance with W. Va. Code § 33-16A-1 et seq. There were no indications during testing of any files or records that the Company discriminated based on health status against any member or potential member in the group market. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard F 12*NAIC Market Regulation Handbook – Chapter XX, § F, Standard 7.***The regulated entity issues coverage that complies with the guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.***W.Va. Code § 33-16D-4 & W. Va. Code St. R. § 114-15-4.3b*

Comments: Review methodology for this standard is sample. This standard has a direct statutory requirement. W. Va. Code § 33-16D-4, W. Va. Code St. R. § 114-15-4.3b and HIPAA mandate that all eligible small employers be guaranteed issue of a small group health plan.

Results: Fail

The Company failed to retain documents to support the validity of declining small employers that were not provided an application (declinations by its agents or customer service). The results of testing are as follows:

Table F 12 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Declined Small Groups	None Avail.	0	0	0	0	N/A
Total		0	0	0	0	N/A

Observations: The Company stated there was no record of small employers being declined coverage. See testing completed at Standard F 7. Additionally, it was determined the Company

had practices and procedures in place during the period under examination which restricted guaranteed availability for some small employers. Those non-compliant procedures are indicated below:

- During 2005, 2006 and 2007, the Company failed to pay commissions fairly to its producers for max-rated small groups, thereby restricting the mandates of W. Va. Code §§ 33-16D-4 & 7, and HIPAA. For details, please see the relevant bulleted item in Standard F 3 above.
- The Company's underwriting guidelines denied small groups eligibility on the basis that more than ten percent (10%) of total enrollees were COBRA continuees. For details, please see the relevant bulleted item in Standard F 2 above.
- The Company's small group underwriting guidelines restricted small group eligibility to those employers in business for at least six months. For details, please see the relevant bulleted item in Standard F 2 above.
- The Company's small group underwriting guidelines restricted small group eligibility to those employers that provide workers' compensation coverage (West Virginia law does not make workers' compensation mandatory for all eligible small employers). For details, please see the relevant bulleted item in Standard F 2 above.

Recommendations: The Company should provide all small employers that solicit the Company through its producers or customer service with an application, thereby preventing producers and customer service representatives from deterring small employers from requesting coverage. Only in this manner are records available to support that the denial of coverage to small employers was based on allowable provisions of West Virginia law and HIPAA.

Standard F 13 Pertinent information on applications that form a part of the policy is complete and accurate.	<i>NAIC Market Regulation Handbook – Chapter XX, § F, Standard 2.</i> <i>W.Va. Code § 33-25A-14, W.Va. Code § 33-25A-24 & W.Va. Code § 33-16D-5</i>
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Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement. W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4.3, mandate that policy records include an application for each contract. The application is to be clearly legible, such that an examiner can clearly identify the producer involved in the transaction.

Results: Pass

Testing for this standard was performed based on: the one (1) newly issued association group, the six (6) newly issued large groups, a sample of fifty-eight (58) newly issued small groups, the forty-five (45) renewed small groups, and ten (10) renewal association groups. The results of testing are as follows:

Table F 13 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Association Group	1	1	0	1	0	100%
Newly Issued Large Groups	6	6	0	6	0	100%
Newly Issued Small Groups	147	60	2	58	0	100%
Renewal Small Groups	45	45	0	44	1	98%
Renewal Association Groups	10	10	0	10	0	100%
Total	209	122	2	119	1	99%

Observations:

- For one small group renewal file, it appeared the producer listed on the application was not a licensed or appointed producer. If that was the case, it would be a violation of W. Va. Code § 33-25A-15. However, the Company's response stated in part, "The information in the Underwriting file about the producer is incorrect. . . . has been the producer for this group since it was new with Carelink and he is licensed and appointed with Carelink." The file was failed for lack of proper documentation on the application, a violation of W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4.3(a)(1), which states, "The application shall bear a clearly legible means by which an examiner can identify a producer involved in the transaction. The examiners shall be provided with information clearly identifying the producer involved in the transaction."

Recommendations: None

Standard F 14 *NAIC Market Regulation Handbook – Chapter XX, § F, Standard 3.*
The regulated entity complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

W. Va. Code 33-16-3

Comments: Review methodology for this standard is sample and generic. This standard has a direct statutory requirement under federal law. An insurer is to allow continuation of coverage under a group health plan for all COBRA eligible individuals.

Results: Pass.

Observations: Neither the files tested, nor the Company's underwriting guidelines, indicated that the Company had restricted COBRA or state continuation coverage for any of its eligible members. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard F 15*NAIC Market Regulation Handbook – Chapter XX, § F, Standard 8.***The regulated entity issues individual coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with applicable statutes, rules and regulations.***W.Va. Code § 33-25A-24, W.Va. Code § 33-15-2b & W.Va. Code St. R. 114-55-1 et. seq.*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement under W. Va. Code § 33-15-2b and HIPAA. An insurer is not allowed to deny coverage in the individual market for a federally eligible individual.

Results: Pass

Observations: The Company does not offer coverage in the individual market in West Virginia other than its conversion plan. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

G. CLAIMS PRACTICES

Comments: The evaluation of standards in this business area is based on Carelink's responses to informational items requested by the examiner, discussions with Carelink staff, electronic testing of claim databases, and file sampling during the examination process. This 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, rules and regulations.

Claims to the HMO usually arise from a provider who delivers services to a member of the HMO. These providers are usually under contract with the HMO to provide certain services that are reimbursed at contracted levels. Under the contract, the provider may receive a capitation payment which covers the provider's cost to deliver certain levels and types of health care to HMO members that have designated that provider as their Primary Care Physician (PCP). Services contained within the capitation agreement are referred to as encounters. If the care provided to a member is not provided by or through a contracted PCP there is generally no coverage except in emergency and some urgent care situations.

Testing was completed to determine whether the Company's out-of-network provider reimbursements complied with West Virginia statutes and regulations. A Company response indicated that if a member does not know ahead of time that s/he will be getting services from a non-participating facility-based provider or does not call Carelink prior to the services being rendered, the covered services rendered by these providers will still be treated as in-network and the member will only be responsible for the applicable in-network deductibles, copayments, and/or coinsurance. The Company also stated its allowable charge policy states that "if a non-participating provider receives preauthorization to perform a covered service at the in-network level of benefits, the provider's billed charges will be used as the basis for payment to the provider . . . the claim will pay at the in-network level of benefits, paying billed charges less any applicable . . . deductibles, copayments and/or coinsurance as set out in the member's schedule of benefits." Testing of out-of-network reimbursements appeared to comply with West Virginia

statutes and rules. Therefore, no exceptions were noted during testing of out-of-network provider reimbursements.

Standard G 3 Claims are resolved in a timely manner.	<i>NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 3.</i> <i>W.Va. Code § 33-45-2</i>
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Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct statutory requirement. In an HMO setting, failure to resolve claims timely can result in a migration of providers from the network with resultant disruption of service to members. W. Va. Code § 33-45-2 requires claim resolution or written explanation within thirty (30) days of receipt of claim if submitted electronically and forty (40) days of receipt of claim if submitted by other means.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) paid claims from a population of 1,388,596 incurred during 2007, and a random sample of sixty (60) denied claims from a population of 142,828 incurred during 2007. The results of testing are as follows:

Table G 3 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Paid claims	1,388,596	60	0	60	0	100%
Denied claims	142,828	60	0	59	1	99%
Total	1,531,424	120	0	119	1	99%

Observations:

- For one denied claim file the Company failed to process the claim within the allowable time frame provided under W. Va. Code § 33-45-2(a)(1). The Company agreed it had not processed the claim timely.

Recommendations: None.

Standard G 4 The HMO responds to claim correspondence in a timely manner.	<i>NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 4.</i> <i>W.Va. Code § 33-45-2</i>
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Comments: Review methodology for this standard is generic, sample, and electronic. This standard does not have a direct statutory requirement.

Results: Pass

Observations: Carelink's claims contacts are generally by phone or with provider service representatives. Testing of the Company's claims procedural manuals, and denied and paid claims files indicated the Company was generally expedient in responding to correspondence

from its members and providers, and that its methods appeared to be in compliance with West Virginia law. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None.

Standard G 5
Claim files are adequately documented.

NAIC Market Regulation Handbook – Chapter XVI, § G, Standard 5.

W.Va. Code § 33-25A-1 et seq

Comments: Review methodology for this standard is generic and sample. This standard does not have a direct statutory requirement.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) paid claims from a population of 1,388,596 incurred during 2007, and a random sample of sixty (60) denied claims from a population of 142,828 incurred during 2007. The results of testing are as follows:

Table G 5 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Paid claims	1,388,596	60	0	60	0	100%
Denied claims	142,828	60	0	59	0	100%
Total	1,531,424	120	0	119	0	100%

Observations: There were no instances during testing of paid and denied claims files where the Company could not produce information associated with the claims sample. Most claim files were processed from provider submissions via CMS computer based forms. These forms constituted adequate documentation for the majority of claims tested. There were no exceptions noted during testing of this standard. However, as noted at B 3, the Company was responsible for the actions of its agents when claims responsibilities were contracted.

Recommendations: None

Standard G 6

Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.

NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 6.

W.Va. Code § 33-25A-7a

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. An HMO must provide claim handling in compliance with its provider contracts as governed under W. Va. Code § 33-25A-7a, and in compliance with W. Va. Code § 33-45-2.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) paid claims from a population of 1,388,596 such claims incurred during 2007. The results of testing are as follows:

Table G 6 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Paid claims	1,388,596	60	0	59	1	98%
Total	1,388,596	60	0	59	1	98%

Observations: In one case, the provider correctly charged the member two co-pays for services received on two dates. The Company incorrectly processed the claim as one claim, which should have resulted in one co-pay. The incorrect processing of the claim was a violation of W. Va. Code § 33-45-2(3). The Company agreed, and as a result of the market conduct examination it refunded one co-pay amount to the provider.

Recommendations: None

Standard G 7	<i>NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 7.</i>
Company claim forms are appropriate for the type of product.	<i>W.Va. Code § 33-25A-1 et seq.</i>

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) paid claims from a population of 1,388,596 incurred during 2007, and a random sample of sixty (60) denied claims from a population of 142,828 such claims incurred during 2007. The results of testing are as follows:

Table G 7 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Paid claims	1,388,596	60	0	60	0	100%
Denied claims	142,828	60	0	60	0	100%
Total	1,531,424	120	0	120	0	100%

Observations: Generally, providers submit their claims via CMS developed claim forms. These forms were developed to ensure uniformity of claim forms submitted by all health care providers. Of the one hundred twenty (120) claims sampled, only one was from a member. There were no exceptions noted during testing of this standard.

Recommendations: None

Standard G 8*NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 8.***Claim files are reserved in accordance with the HMO's established procedures.***W.Va. Code § 33-25A-1 et seq.*

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement.

Results: Pass

Observations: Claims reserves were not established on a per case basis. Claim lag data was prepared by Carelink monthly for inpatient services, outpatient services and physician services/other. This data was reconciled to paid claims and then provided to the actuarial department for use in claim reserve estimates. Based on these historical claim lags, trend forecasts, and monthly input from the claims department regarding changes in payment backlogs, overpayments, underpayments and other known items, claim reserve estimates were developed. The Company's established reserve processes and estimates appeared to be adequate. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard G 9*NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 9.***Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPAA and West Virginia law.***W.Va. Code §§ 33-25A-1 et seq. and 33-24-2*

Comments: Review methodology for this standard is sample and electronic. This standard has an indirect statutory requirement. An HMO must provide claim handling in compliance with its provider contracts as governed under W. Va. Code § 33-25A-7a, and in compliance with W. Va. Code § 33-45-2.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) denied claims from a population of 142,828 such claims incurred during 2007. The results of testing are as follows:

Table G 9 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Denied claims	142,828	60	0	59	1	98%
Total	142,828	60	0	59	1	98%

Observations: For one denied claim the Company failed to process the claim within the allowable time frame provided under W. Va. Code § 33-45-2(a)(1). The Company agreed it had not processed the claim timely.

Recommendations: None

Standard G 10*NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 10.***Canceled benefit checks and drafts reflect appropriate claim handling practices.***W.Va. Code § 33-25A-1 et seq*

Comments: Review methodology for this standard is sample and electronic. This standard has a direct statutory requirement.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) paid claims from a population of 1,388,596 incurred during 2007. The results of testing are as follows:

Table G 10 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Paid claims	1,388,596	60	59	1	0	100%
Total	1,388,596	60	59	1	0	100%

Observations: Carelink did not use drafts for payments of its claims. The Company's monthly payments of claims were completed by check or electronic funds transfers (EFTs). Carelink did not use releases since the claim payments were provided primarily to the providers on a billing basis rather than to a member on a reimbursement basis. There was only one claim submitted from a member and the Company's check was for the proper amount and appeared to be timely. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None**Standard G 11***NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 11.***Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.***W.Va. Code § 33-25A-1 et seq*

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement.

Results: Pass

The Company supplied one (1) applicable litigated claim file for testing. The results of testing are as follows:

Table G 11 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Litigated Claims	1	1	0	1	0	100%
Total	1	1	0	1	0	100%

Observations: During the period under examination, Carelink had one (1) applicable claim for which litigation ensued. It was settled out of court. Testing of the file did not suggest that the Company's actions compelled the claimant to institute litigation. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard G 13 *NAIC Market Regulation Handbook - Chapter XX, § G, Standard 3.*
The HMO complies with the requirements of the Mental Health Parity Act of 1996. *W.Va. Code § 33-16-3a*

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. Mental Health Parity Act (MHPA) requirements do not apply to: (1) small employer groups of 2 to 50 employees; or (2) any group health plan where the required federal notice has been filed documenting that costs increased one (1) percent or more due to the application of the MHPA requirements for at least six (6) consecutive months (special rules apply to plans that are in a combined pool for rating purposes). West Virginia has adopted the federal law by statute. The law does not affect the terms and conditions (such as cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity), relating to the amount, duration, or scope of mental health benefits. MHPA protections apply to benefits for mental health services as defined under the terms of the health plan contract or policy, but do not extend to benefits for substance abuse or chemical dependency. MHPA does not apply to any policies sold in the individual market.

Results: Pass

Observations: Carelink did not use lifetime or annual maximums prior to the enactment of the MHPA. For the period under examination, Carelink's practices and procedures met or exceeded the standards applicable under MHPA. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

H. GRIEVANCE PROCEDURES

Comments: The grievance procedures portion of the examination is designed to evaluate how well the company handles grievances and is based on a review of the Company's responses to various information requests and its grievance files. W.Va. Code § 33-25A-12 requires HMOs to "establish and maintain a grievance procedure, which has been approved by the commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances

initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or non-renewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health care services rendered”.

The Company's procedures for processing grievances were reviewed, as well as random samples of appeals and each level of grievance selected from the company's grievance register. The review of grievance procedures incorporated consumer and provider appeals as well as consumer direct grievances to the company.

Standard H 1

NAIC Market Regulation Handbook – Chapter XX, § H, Standard 1

The health carrier treats as a grievance any written complaint 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 carrier.

W.Va. Code § 33-25A-12 & W.Va. Code St. R. § 114-51-1, et seq.

Comments: Review methodology for this standard is generic and is not file specific. The standard has a direct statutory requirement. The concern tested is that any grievance “initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or non-renewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health services rendered” detected throughout the examination was processed according to the Company's procedures.

Results: Pass

Observations: There were no instances of grievances detected during the review of group membership files, claims files, and utilization management files, which were not processed according to the Company's grievance procedures.

Recommendations: None

Standard H 2

NAIC Market Regulation Handbook – Chapter XX, § H, Standard 2

The health carrier documents grievances and establishes and maintains grievance procedures in compliance with statutes, rules, and regulations.

W.Va. Code § 33-25A-12

Comments: Review methodology for this standard is generic and is not file specific. The standard has a direct statutory requirement. Examiners reviewed Company grievance procedures, files, and reports, in order to determine if the Company met statutory documentation requirements. W.Va. Code § 33-25A-12(b)(11) states that an HMO must maintain an accurate record of formal grievances which will include “a complete description of the grievance, the subscriber's name and address, the provider's name and address and the HMO's name and address; a complete description of the HMO's factual findings and conclusions after completion

of the full formal grievance procedure; a complete description of the HMO's conclusions pertaining to the grievance as well as the HMO's final disposition of the grievance; and a statement as to which levels of the grievance procedure the grievance has been processed and how many more levels of the grievance procedure are remaining before the grievance has been processed through the HMO's entire grievance procedure." The same code section states that grievances are not considered formal until they are written. W.Va. Code § 33-25A-12(e) requires, "Each health maintenance organization shall submit to the commissioner an annual report in a form prescribed by the commissioner which describes such grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes."

Results: Pass

Observations: The Company had documented grievance procedures, and had an Access database that maintained the documentation requirements set forth in W. Va. Code § 33-25A-12. A comparison of the grievance reports filed with the WVOIC under the provisions of W. Va. Code § 33-25A-10, with the Company's reporting forms appeared to indicate the Company was reporting accurately.

Recommendations: None

Standard H 3

NAIC Market Regulation Handbook – Chapter XX, § H, Standard 3

A health carrier files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.

W.Va. Code § 33-25A-12

Comments: Review methodology for this standard is generic and is not file specific. W.Va. Code §33-25A-12(a) requires that a "Health Maintenance Organization shall establish and maintain a grievance procedure, which has been approved by the commissioner, to provide adequate and reasonable procedures for the expeditious resolution of written grievances initiated by enrollees concerning any matter relating to any provisions of the organization's health maintenance contracts, including, but not limited to, claims regarding the scope of coverage for health care services; denials, cancellations or non-renewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health care services rendered.

Results: Pass

Observations: Carelink had filed its grievance procedures with the WVOIC, including the forms used to process a grievance. Testing determined the Company attempted to respond to and resolve all grievances within its filed and contractual guidelines.

Recommendations: None.

Standard H 4*NAIC Market Regulation Handbook – Chapter XX, § H, Standard 4***The health carrier conducts First Level reviews of grievances (including adverse utilization management determinations) in compliance with statutes, rules, and regulations.***W.Va. Code § 33-25A-12*

Comments: The review methodology for this standard is sample. The standard has a direct statutory requirement. W.Va. Code § 33-25A-12 does not distinguish between First Level and Second Level appeals. W.Va. Code § 33-25A-12 outlines the minimum criteria for grievance records.

Results: Pass with recommendations

A random sample of sixty (60) grievance/appeal files was selected from a population of ninety-four (94). Of the sixty (60) files sampled, one file was for an Advantra member (N/A), and therefore was not applicable for testing purposes. The remaining fifty-nine (59) files were tested and noted to contain seven (7) pre-service appeals (included as first level appeals), forty-two (42) files related to first level appeals, nine (9) files containing both a first level appeal and a second level appeal, and one (1) file containing an urgent appeal that resulted from a Pre-Service denial. The results of testing are as follows:

Table H 4 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level I	94	60	1	56	3	97%
Total	94	60	1	56	3	97%

- For two (2) appeals/grievances, the Company failed to respond within its contractual fifteen (15) day time frame for Level I appeals. The Company agreed with this finding.
- The Company failed to overturn a denial of coverage for an emergency room visit at a Level I appeal despite evidence of an emergency medical condition, in violation of W. Va. Code § 33-25A-8d(5F). For details, please see the relevant bulleted item under Standard B.3 above.

Recommendations: The Company should respond to all Level I appeals timely, and should provide a thorough review during that process.

Standard H 5*NAIC Market Regulation Handbook – Chapter XX, § H, Standard 5***The health carrier conducts Second Level reviews of grievances (including adverse utilization management determinations) in accordance with statutes, rules, and regulations.***W.Va. Code § 33-25A-12*

Comments: The review methodology for this standard is sample. The standard has a direct statutory requirement. The West Virginia Code does not distinguish between First Level and Second Level appeals. W.Va. Code § 33-25A-12 outlines the minimum criteria for grievance records.

Results: Pass

A random sample of sixty (60) grievance/appeal files was selected from a population of ninety-four (94). Nine (9) of the files sampled contained both a first level and second level appeal. The results of testing the level II appeals are as follows:

Table H 5 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level II	94	60	51	9	0	100%
Total	94	60	51	9	0	100%

Observations: No exceptions were noted during testing of the Level II appeals.

Recommendations: None

Standard H 7

NAIC Market Regulation Handbook – Chapter XX, § H, Standard 7

The health carrier has procedures for and conducts expedited appeals in compliance with statutes, rules, and regulations.

W.Va. Code § 33-25A-12

Comments: Review methodology for this standard is generic and sample and is file specific. There standard has a direct statutory requirement, which states, “Any subscriber grievance in which time is of the essence shall be handled on an expedited basis, such that a reasonable person would believe that a prevailing subscriber would be able to realize the full benefit of a decision in his or her favor.” Compliance with the Company’s internal procedures was also tested.

Results: Pass

A random sample of sixty (60) grievance/appeal files was selected from a population of ninety-four (94). One of the files sampled was an expedited appeal. The results of testing are as follows:

Table H 7 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Grievance Procedures	94	60	59	1	0	100%
Total	94	60	59	1	0	100%

Observations: There were no exceptions noted during testing of the only expedited appeal file.

Recommendations: None

I. NETWORK ADEQUACY

Comments: The evaluation of standards in this business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to assure that the HMO offering managed care plans maintains service networks that are sufficient to assure that all services are accessible without unreasonable delay. The standards require the HMO to assure the adequacy, accessibility, and quality of health care services offered through their service networks.

Standard I 1

NAIC Market Regulation Handbook - Chapter XX, § 1, Standard 1.

The HMO demonstrates, using reasonable criteria that it maintains a network that is sufficient in number and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.

W.Va. Code § 33-25A-4, W. Va. Code St. R. § 114-53-6

Comments: Review methodology for this standard is generic and electronic. This standard has a direct statutory requirement. W. Va. Code § 33-25A-4 states, “(1) Upon receipt of an application for a certificate of authority, the commissioner shall determine whether the application for a certificate of authority, with respect to health care services to be furnished, has demonstrated: (a) The willingness and potential ability of the organization to assure that basic health services will be provided in a manner to enhance and assure both the availability and accessibility of adequate personnel and facilities; . . .”

Guidelines addressing network adequacy are outlined in Informational Letter 112 issued in November 1998. This standard provides an assurance that an HMO maintains a network that is adequate to meet the needs of its members.

Results: Pass

Observations: The Company’s participating provider directory was tested for compliance with the guidelines established in West Virginia Informational Letter 112 and W. Va. Code St. R. 114-53.6.1. It appeared that Carelink had a network in place that achieved or exceeded the provider to enrollee standards, and the PCP, OBGs, PEDs, and Specialists standards provided under West Virginia Informational Letter 112 and the Code. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard I 2

NAIC Market Regulation Handbook - Chapter XX, § 1, Standard 2.

The HMO has filed an access plan for each managed care plan that the HMO offers in the state, and files updates whenever it makes a material change to an existing managed care plan. The HMO makes the access plans available: (1) on its business premises, (2) to regulators; and (3) to interested parties absent proprietary information upon request.

W.Va. Code § 33-25A-4, W. Va. Code St. R. 114-53-6

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. Failure to provide for adequate access dilutes the effectiveness of an HMO and

may lead to financial difficulties. The standard is intended to assure that the company advises members, regulators, and other interested parties as to the extent of the adequacy of its network.

Results: Pass

Observations: The Company provided documentation supporting its evaluation of the adequacy of its networks as part of its quality improvement plan. Carelink provided annual evaluations for determining the adequacy of provider access, including specialists. These did not indicate a material change in terms of network adequacy for its members. In a response, the Company stated in part, "Carelink evaluates member access to its network as part of its Quality Improvement (QI) plan. . . . A material change in the network access plan would most likely be considered a material change in the QI plan and, therefore, would be filed with WVOIC." During the period under examination, the Company's reviews did not determine a material change in network adequacy. There were no exceptions noted during testing of this standard.

Recommendations: None

Standard I 4 The HMO ensures covered persons have access to emergency services twenty-four (24) hours per day, seven (7) days per week within its network and provides coverage for emergency services outside of its network.	<i>NAIC Market Regulation Handbook - Chapter XX, § 1, Standard 4.</i> <i>W. Va. Code § 33-25A-8d</i>
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Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. This standard is primarily focused on emergency services necessary to screen and stabilize a covered person and should not require prior authorization.

Results: Pass with recommendations

Observations: Carelink provided access to emergency care for members both in and outside of the Carelink network. Carelink's 2008 enrollment guide defined urgent and emergency care. The enrollment guide stated, "If you are experiencing an emergency medical condition, go to the nearest participating hospital emergency room (ER). Nonparticipating hospital emergency rooms should only be used when the delay in receiving care from a participating ER could reasonably be expected to cause the patient's condition to worsen." There were no exceptions noted during testing of this standard.

However, as noted in testing performed at Standard F 2, the 2007 EOC (contract) did not define emergency care services in the same manner as the enrollment Guide and was not in compliance with W. Va. Code § 33-25A-8d. In addition, during testing of Standard L 10, it was found that the Company's UR guidelines allowed for denial of emergency services and claims handling, in violation of W. Va. Code §§ 33-25A-8d and 33-45-2(3). Please see the relevant bulleted item in Standard F 2.

Recommendations: The Company's EOC should cover emergency services similarly to its enrollment guide and permit a member to go to the nearest hospital in an emergency. The EOC permitted access to the nearest (non-participating) hospital only if travel to an in-network hospital was "impossible." The Company should ensure that claims are not denied based on the wording in the EOC.

J. PROVIDER CREDENTIALING

The provider credentialing portion of the examination is designed to assure that companies offering managed care plans have verification programs to ensure that participating health care professionals meet minimum specific standards of professional qualification.

The areas to be considered in this kind of review include the company's written credentialing and re-credentialing policies and procedures, the scope and timeliness of verifications, the role of health professionals in ensuring accuracy, and the oversight of any delegated verification functions.

Standard J 1

The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with statutes, rules, and regulations.

NAIC Market Regulation Handbook – Chapter XX, § J, Standard 1.

W.Va. Code St. R. § 114-53-6

Comments: The review methodology for this standard is generic. This standard has a direct regulatory requirement. Credentialing is the process by which a managed care organization authorizes, contracts with, or employs practitioners who are licensed to provide services to its members. West Virginia Code St. R. 114-53-6.2 requires that a health maintenance organization shall have written policies and procedures for the credentialing and re-credentialing of all health care professionals with whom the health carrier contracts.

Results: Pass

Observations: Carelink had established a program for credentialing and re-credentialing that was described in its credentialing policies and procedures manual. Both procedures appear to comply with the requirements of W. Va. Code St. R. § 114-53-6. Carelink had a credentials' committee, which approved/disapproved and/or recommended credentialing/re-credentialing in accordance with requirements outlined in the Carelink policies and procedures manual. The credentials' committee membership included the medical director. During the period under examination most of the provider credentialing activities were turned over to three contracted provider credentialing entities, Preferred Integrated Provider Access Corporation (PIPAC), Health Partners Network (HPN), and Preferred Care of Virginia's (PCVA). Each of these entities was audited by the Company, and each audit was reviewed by the Company's medical director. No exceptions were noted during testing of this standard.

Recommendations: None

Standard J 2

The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.

NAIC Market Regulation Handbook – Chapter XX, § J, Standard 2.

W. Va. Code § 33-45-2 and W.Va. Code St. R. § 114-53-1 et seq.

Comments: The review methodology for this standard is generic and sample. This standard has a direct statutory requirement. Testing of this standard was completed to determine if providers are properly credentialed prior to their inclusion in the provider directory.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) providers from a population of over 11,162 providers found in its 2007 participating provider directory. The results of testing are as follows:

Table J 2 Provider Credentialing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	11,162	60	0	60	0	100%
Total	11,162	60	0	60	0	100%

Observations: Testing determined that all providers in the sample were licensed in the State of West Virginia prior to the Company contracting with those providers. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard J 3 *NAIC Market Regulation Handbook – Chapter XX, § J, Standard 3.*
The health carrier obtains primary verification of the information required by State law.
W.Va. Code St. R. § 114-53-1, et. seq.

Comments: The review methodology for this standard is sample. This standard has a direct regulatory requirement. Concerns tested with this standard include: An HMO shall obtain and review verification of the following from primary sources:

- a. Current valid license to practice in West Virginia;
- b. When applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- c. A valid (DEA) certificate, as applicable;
- d. Complete work history;
- e. Current adequate malpractice insurance according to the HMO's policy;
- f. Complete professional liability claims history;
- g. Any other information deemed necessary by the HMO in determining whether to contract with a prospective provider.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) providers. The results of testing are as follows:

Table J 3 Provider Credentialing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	11,162	60	0	60	0	100%
Total	11,162	60	0	60	0	100%

Observations: Testing determined that all providers in the sample were licensed in the State of West Virginia. All the files provided at a minimum, the information listed above in “a” through “g.” Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard J 5

NAIC Market Regulation Handbook – Chapter XX, § J, Standard 5.

The health carrier obtains, at least every three (3) years, primary verification of the information required by W. Va. Code St. R. § 114-53-6.8(a).

W.Va. Code St. R. § 114-53-6.8a

Comments: The review methodology for this standard is sample. This standard has a direct statutory requirement. In terms of re-credentialing, an HMO shall develop a process for the periodic verification of credentials which shall be implemented at least every three (3) years. An HMO shall obtain and review verification of the following from primary sources:

- a. Current valid license to practice in West Virginia;
- b. When applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;
- c. A valid (DEA) certificate, as applicable;
- d. Board certification, where applicable;
- e. Current, adequate level of malpractice insurance;
- f. Professional liability claims history
- g. Any other information deemed necessary in determining whether to contract with a provider.

Results: Pass

Testing for this standard was performed based on a random sample of sixty (60) providers. The results of testing are as follows:

Table J 5 Provider Credentialing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	11,162	60	0	60	0	100%
Total	11,162	60	0	60	0	100%

Observation: Testing determined that all providers in the sample were subject to the re-credentialing process by one of the contracted entities during the period under examination. All provider files contained at least the minimum required information documented above in “a” through “g.” Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard J 6*NAIC Market Regulation Handbook – Chapter XX, § J, Standard 6.***The health carrier requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is required to be verified by the health carrier.***W.Va. Code St. R. § 114-53-6*

Comments: The review methodology for this standard is generic. This standard does not have a direct statutory requirement. The focus of this standard is the HMO's requirement for the provider to provide the HMO with notice of any change in the Physician's information that is required to be verified for credentialing and re-credentialing.

Results: Pass

Observation: Carelink required all participating providers to notify Carelink immediately of any changes in the provider's status. This requirement is provided in both the "Provider Policy and Procedure Manual" and the "Participating Physicians Agreement." There were no exceptions noted during testing of this standard.

Recommendations: None

Standard J 7*NAIC Market Regulation Handbook – Chapter XX, § J, Standard 7.***The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.***W.Va. Code St. R. § 114-53-6*

Comments: The review methodology for this standard is generic. This standard does not have a direct statutory requirement. The aim of this standard is to assure that the HMO shall allow a health care provider to correct any erroneous information and request a reconsideration of the provider's credentialing verification application.

Results: Pass

Observations: Carelink's credentialing process consisted of defined policies and procedures that specified the requirements and the processes to evaluate providers. The candidates were informed of their right to review the information submitted in support of their credentialing applications and to correct erroneous information. The provider was notified of this right on the application for appointment and reappointment. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard J 8*NAIC Market Regulation Handbook – Chapter XX, § J, Standard 8.***The health carrier monitors the activities of the entity with which it contracts to perform credentialing functions and ensures the requirements of W. Va. Code St. R. § 114-53-4.4 are met.***W.Va. Code St. R. § 114-53-4.*

Comments: The review methodology for this standard is generic. This standard has a direct regulatory requirement. This standard is focused on the level of the oversight provided by the

HMO when it contracts with an external entity that assumes the provider credentialing function for the HMO. The particular interest is that there shall be evidence of oversight and auditing of the delegated credentialing entity.

Results: Pass

Observations: Carelink delegated the responsibility for primary source verification to three contracted provider entities. The three contracted entities (delegates), PIPAC, HPN and PCVA performed credentialing and re-credentialing activities during the period under examination. Carelink retained oversight and approval of the delegates' credentialing activities. Carelink's credentialing policies required each potential provider delegate to undergo a pre-contractual quality assessment prior to a contract offering. At least quarterly, the delegates were required to submit reports to Carelink regarding the performance of its delegated responsibilities. On an annual basis, Carelink performed an audit of the delegate's practices to ensure compliance with Carelink, the WVOIC, and any other applicable governmental agency standards. The results of the delegates' audits were presented for review to the credentials committee, which included the medical director. There were no exceptions noted during testing of this standard.

Recommendations: None

L. UTILIZATION REVIEW

The utilization management portion of the examination is designed to assure that companies and their designees that provide or perform utilization management services comply with standards and criteria for the structure and operation of utilization management processes. West Virginia Code defines utilization management as a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory management, prospective management, second opinion, certification, concurrent management, case management, discharge planning, external review or retrospective review. The review of utilization management activities included an overview of Carelink's written utilization management policies, procedures in addition to an overview of how utilization management activities practices are being applied to individual cases. Utilization management issues may also surface during the examiners review of claims, complaints, and grievance procedures.

Standard L.1

The health carrier establishes and maintains a utilization management program in compliance with statutes, rules, and regulations.

NAIC Market Regulation Handbook - Chapter XX, § L, Standard 1.

W.Va. Code St R. 114-51-1 et. seq.

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. It is generally not file specific. Carelink's UM program was reviewed for adherence to the guidelines provided under W.Va. Code St. R. § 114-51-1 et seq.

Result: Pass with recommendations

Observations: The policies and procedures for utilization review (UR) indicated the Company provided on-site nurses for the local hospitals as well as a telephonic nurse. Nurses also handled precertification and transplant requests by distributing them to the proper medical personnel. The Company's medical director was the only individual with the authority to deny any service, although, corporate level physicians had the authority to approve or deny transplants. The availability of an external review process is also part of the UM review when needed. The provider manual was provided to all network providers. It contained the services requiring preauthorization as well as the processes to be performed in order to acquire Carelink's pre-approval. The list of preauthorized services was included in the enrollment guide.

- The Company's UR guidelines limited breast reconstruction benefits in a manner that was not in compliance with the mandated benefits provided under W. Va. Code § 33-25A-8F and WHCRA. Please see the relevant bulleted item in Standard F 2 for details.

Recommendation: The Company's UR guidelines should not include benefit restrictions that reduce West Virginia's mandated benefits.

Standard L 2

NAIC Market Regulation Handbook – Chapter XX, § L, Standard 2.

The health carrier files with the commissioner an annual summary report of its utilization management activities.

W.Va. Code St. R. 114-51-4.2

Comments: Review methodology for this standard is generic. This standard has a direct regulatory requirement. It is generally not file specific. W.Va. Code St. R. 114-51-4.2 mandates that HMO's file an annual evaluation and work plan concurrent with its application for renewal of its Certificate of Authority.

Results: Fail

Observations: Carelink did not provide a description of the health maintenance organization's utilization management program to the WVOIC annually with its Certificate of Authority renewal during the period under examination, in violation of W. Va. Code St. R. § 114-51-4.2. The Company's response stated in part, "It appears that Carelink was not aware of the annual filing requirement for its Utilization Review Program until 2008 when we did make this filing for 2008. However, Carelink does have Utilization Management Program information for 2005, 2006, and 2007 that was previously provided to the examiners prior to the commencement of the examination. . . ."

Recommendation: The Company should file a description of its utilization management program with its annual Certificate of Authority renewal application in compliance with W. Va. Code St. R. § 114-51-4.2.

Standard L 3*NAIC Market Regulation Handbook – Chapter XX, § L, Standard 3.***The health carrier provides information about its utilization management program to members in a timely manner.***W.Va. Code § 33-25A-12*

Comments: Review methodology for this standard is generic. This standard has an indirect statutory requirement. It is generally not file specific. The W.Va. Code only requires communication of its UM program to the extent of providing enrollees with information concerning its grievance procedures, including phone numbers to points of contact as outlined in W. Va. Code § 33-25A-12. There were no exceptions noted during testing of this standard.

Result: Pass

Observations: Carelink provides a description of its grievance procedures in its enrollment guides and its EOC as required under W. Va. Code § 33-25A-12.

Recommendation: None

Standard L 4*NAIC Market Regulation Handbook – Chapter XX, § L, Standard 4.***The health carrier conducts provider related utilization management activities in a timely manner and in compliance with statutes, rules, and regulations.***W.Va. Code St. R. 114-53-4.5*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. It is generally not file specific. This standard is primarily concerned that provider contracts and Company Utilization review procedures do not provide incentives or disincentives that would prevent providers from providing adequate care to members, due to inappropriate UM decisions. W.Va. Code St. R. 114-53-4.5 does not permit an HMO to restrict any provider's communication of medical advice to a member, or provide any providers with incentives or disincentives in plans that include specific payment to the provider as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific enrollee or groups of enrollees with similar medical conditions.

Results: Pass

From the 2007 population of 1,537 concurrent review and retrospective (allowed and disallowed) review determinations, a random sample of sixty (60) files was selected for testing. The results of testing are as follows:

Table L 4 Utilization Review						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	1,537	60	0	60	0	100%
Total	1,537	60	0	60	0	100%

Observations: Testing determined that Carelink acted in compliance with its internal UR guidelines (standards) for each UR case included in the sample for concurrent review and retrospective review. In addition, for each file tested, it appeared the Company acted timely. Therefore, there were no exceptions noted during testing of this standard.

Recommendation: None

Standard L 5

NAIC Market Regulation Handbook – Chapter XX, § L, Standard 5.

The health carrier makes utilization management decisions in a timely manner and as required by state statutes, rules, and regulations and the provisions of HIPAA.

W Va. Code St. R. 114-51-4.8a

Comments: Review methodology for this standard is sample. It is generally file specific. This standard does not have direct statutory requirements as W. Va. Code St. R. 114-51-4.8a does not outline a specific time requirement. This standard is primarily concerned that the Company adheres to time frames for decisions outlined in its Utilization Review procedures. Carelink has established time frames for Utilization Review decisions based upon the type of review. Precertification utilization review decisions may be categorized as either urgent or non-urgent; urgent precertification Utilization Review requires the Company to render a decision within one (1) business day of receiving all necessary information; the standard for non-urgent precertification decisions is two (2) business days. The Company’s standard for rendering decisions on concurrent reviews is one (1) business day. Carelink’s policy mandates that retrospective reviews be processed within thirty (30) calendar days.

Results: Pass

From the 2007 population of 1,537 concurrent review and retrospective (allowed and disallowed) review determinations, a random sample of sixty (60) files was selected for testing. In addition, the Company supplied the population of twelve (12) preauthorization requests for breast reconstruction and transplants during the period under examination. A sample of five breast reconstruction files was obtained for testing. The results of testing are as follows:

Table L 5 Utilization Review						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	1,537	60	0	60	0	100%
Pre-Authorization	12	5	0	5	0	100%
Total	1,537	60	0	60	0	100%

Observations: Testing determined that Carelink acted in compliance with its internal UM policy standards for each case sampled for concurrent review and retrospective review. In addition, for each file tested it appeared the Company acted timely. Therefore, there were no exceptions noted during testing of this standard.

Recommendation: None

Standard L 6*NAIC Market Regulation Handbook – Chapter XX, § L, Standard 6.***The health carrier provides written notice in compliance with statutes, rules, and regulations for an adverse determination.***W.Va. Code St. R. 114-51-4.8b*

Comments: Review methodology for this standard is sample and it is generally file specific. This standard has a direct statutory requirement. W.Va. Code St. R. 114-51-4.8b outlines criteria for adverse UM determination notification, by stating, “In those instances in which a health maintenance organization denies medical services, a written notice of denial shall be sent immediately to all involved parties, which shall include, but not be limited to, the subscriber, the primary care physician, and the facility, if appropriate. The written notice of denial shall include the reason for denial and an explanation of the appeal process.”

Results: Pass

From the 2007 population of 1,537 concurrent and retrospective (allowed and disallowed) review determinations, a random sample of sixty (60) files was selected for testing. In addition, the Company supplied a total of twelve (12) preauthorization requests for breast reconstruction and transplants during the period under examination. A sample of five breast reconstruction files was obtained for testing. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	1,537	60	0	60	0	100%
Pre-Authorization	12	5	0	5	0	100%
Total	1,549	65	0	65	0	100%

Observations: Testing of the file sample determined that each adverse decision was provided in writing, and was issued timely. Therefore, there were no exceptions noted during testing of this standard.

Recommendation: None**Standard L 7***NAIC Market Conduct Examiners Handbook – Chapter XX, § L, Standard 7.***The health carrier makes reconsideration decisions in a timely manner and in compliance with state statutes, rules, and regulations.***W.Va. Code St. R. 114-51-4.8a*

Comments: Review methodology for this standard is sample. It is generally file specific. This standard does not have statutory requirements as W. Va. Code St. R. 114-51-4.8a does not outline a specific time requirement. This standard is primarily concerned that the Company adheres to time frames for decisions outlined in its Utilization Review procedures. Carelink substantially revised its reconsideration process during the examination period, thus the standard was tested for two different sets of criteria. Prior to June 2002, the Company’s reconsideration process was essentially a written appeal from the provider; providers were required to forward additional documents or notes to the company. The Company then had thirty (30) days to render a decision. After June 2002, the Company adopted a more streamlined “Peer to Peer” review

procedure. In the new procedure, providers telephonically contact the Medical Director or Preauthorization Coordinator within two (2) business days of the adverse decision. At that point, the Medical Director has one (1) business day to render a decision. Adverse determinations require written notification as outlined in standard L-6. If the results of peer-to-peer review are not satisfactory to the provider, the provider may initiate an appeal on behalf of the enrollee.

Results: Pass

From the 2007 population of 1,537 concurrent and retrospective (allowed and disallowed) review determinations, a random sample of sixty (60) files was selected for testing. In addition, the Company supplied the population of twelve (12) preauthorization requests for breast reconstruction and transplants received during the period under examination. A sample of five breast reconstruction files was obtained for testing. The results of testing are as follows:

Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	1,537	60	60	0	0	N/A
Pre-Authorization	12	5	5	0	0	N/A
Total	12	65	65	0	0	N/A

Observations: Testing of the samples determined that none of the files had a request for reconsideration by the member or provider after an adverse decision. Therefore, there were no exceptions noted during testing of this standard.

Recommendation: None

<p>Standard L 10 The health carrier conducts utilization review activities and provides for emergency services in compliance with applicable statutes, rules and regulations.</p>	<p><i>NAIC Market Regulation Handbook – Chapter XX, § L, Standard 10.</i> <i>W.Va. Code § 33-2-9 & W.Va. Code § 33-25A-17</i></p>
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Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. W. Va. Code § 33-25A-8d states in part, “(a) Notwithstanding any provision of any policy, provision, contract, plan or agreement to which this article applies, any entity regulated by this article shall provide as benefits to all subscribers and members coverage for emergency services. A policy, provision, contract, plan or agreement may apply to emergency services the same deductibles, coinsurance and other limitations as apply to other covered services: *Provided*, That preauthorization or precertification shall not be required. . . .”

Results: Fail

Observations: Testing determined the Company’s UR guidelines for emergency services would sometimes restrict compliance with W. Va. Code § 33-25A-8d. The UR provision stated, “A claim is denied for notes if the diagnosis does not match the auto-approved list, no referral exists in the system, and no notes are attached to ER claim. Notes will be reviewed for medical necessity by a (MCRN) Medical Claims Review Nurse or the Director.” The Company’s initial response stated in part, “Carelink does not settle its emergency claims exactly how it is noted in Procedure #4 of the policy UM-036. As is stated in Section 1.26 of Carelink’s 2005-6 Provider

Manual and Section 4.5 of Carelink's 2007 Provider Manual, which is part of the provider's contract, "Certain procedures may require the submission of additional documentation before payment is made. In cases of this nature, the claim will be closed, and we will request notes or an invoice. Provider must then submit notes or invoice in order for the claim to be reviewed. These must be submitted within 1) 90 days of the date of the request or 2) the original timely filing period applicable to the claim..." The UM policy in question will be revised to correspond to what is in the provider manual and is actually occurring." In addition it stated, "Revisions have not yet been made to UM-036; however, when they are made, the revisions will be substantially similar to the language above from the Provider Manual." Therefore, as a result of the market conduct examination the Company will revise its UR guidelines.

The Company provided six thousand forty-three (6,043) emergency services claims that were denied for the reasons provided in its UR guidelines above. A Company response stated, "There were 616 duplicate claims and 2,370 claims that were eventually paid." Therefore, of the six thousand forty-three (6,043) emergency services claims closed for notes or denied, three thousand fifty-seven (3,057) remained denied and two thousand three hundred seventy (2,370) were eventually paid. However, the Company stated in part, "... Carelink included all claims where services were rendered in an emergent setting when the situation was not considered an "emergency medical condition" that were either originally closed for notes or were denied. We also included those claims where the place of service was ER that were submitted as duplicates and the subsequent adjustments to pay some claims that were originally closed or denied. Inclusion of claims that were originally closed . . . does not mean that Carelink felt there was insufficient information to consider claims clean as originally submitted." The Company also stated in part, "... Carelink does have sufficient information at the time the claims are submitted to adjudicate the claims to deny. However, by closing the claims for notes, Carelink is giving the providers additional opportunity to demonstrate that there were extenuating circumstances to consider these claims as emergent. Denied claims can eventually end up getting paid for any number of reasons including as a result of an appeal, reconsideration, or claims error. These claims are all clean claims when processed but are adjusted at a later time."

W. Va. Code § 33-45-1(2) defines a "clean claim," "Clean claim" means a claim: (A) That has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or (B) with respect to which an insurer has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with section two of this article. W. Va. Code § 33-45-2(3) states, "An insurer shall, within thirty days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. The insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which the insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, an insurer shall either pay or deny the claim within thirty days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the insurer fails to timely notify the person submitting the claim within thirty

days of receipt of the claim of the additional information . . .” The Company’s responses indicated it closed or denied emergency claims in a manner contrary to the above requirements. As provided in W. Va. Code § 33-45-2, an issuer is only permitted to deny a claim when a claim for health care services rendered pursuant to a provider contract is not a covered benefit. The Company either closed or denied two thousand three hundred seventy (2,370) emergency claims that were eventually paid.

Recommendations: The Company should ensure that its UR guidelines comport with its provider contracts and ensure that claims are handled uniformly, in compliance with W. Va. Code §§ 33-25A-8d and 33-45-2(3). An issuer should “pend” claims for additional information, rather than close or deny a claim for which it has a contractual obligation to pay.

Standard L 11

NAIC Market Conduct Examiners Handbook – Chapter XX, § L, Standard 11.

The health carrier monitors the activities of the utilization management organization or entity with which the carrier contracts and ensures that the contracting organization complies with state statutes, rules and regulations.

W.Va. Code St. R. 114-51-4

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. It is generally not file specific. The W.Va. Code requires that the HMO is accountable for and must oversee any and all delegated activities of the delegated UM program.

Result: Pass

Observations: Carelink delegated UM activity for mental health services to Mental Health Network (MHN). MHN regularly provided reports to Carelink. Carelink conducted annual site visits to MHN to determine if its utilization standards were compliant with the standards set forth by the American Accreditation Healthcare Commission (URAC). There were no exceptions noted during testing of this Standard.

Recommendation: None

LIST OF RECOMMENDATIONS

Recommendation A 3

The Company should ensure that its antifraud procedures provide for investigations and reporting to the WVOIC in compliance with W. Va. Code § 33-41-1.

Recommendation A 6

Carelink should perform regular audits, not less than annually, of its producer licensing and appointment vendor(s) to assure the contracted level of performance is met and ensure the process remains in compliance with West Virginia law.

Recommendation A 7

The Company should devise an adequate means for distinguishing its HMO plans from PPO plans when providing information for examination, in compliance with W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4, and should provide files for efficient market regulation in compliance with NAIC standardized testing.

Recommendation A 9

The Company should cooperate with the examination and provide files when requested, in compliance with W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4.

Recommendation C 1

The Company should ensure that its advertising materials and its website provide information that is not misleading, deceptive or inaccurate.

Recommendation C 2

The Company's small group solicitation materials should indicate that all small employer groups are guaranteed renewable. None of the Company's materials should state that a tax form is mandatory in order for an otherwise eligible employer to gain coverage under a small group health plan.

Recommendation D 1

It is recommended that Carelink establish internal controls to ensure that its producer listings are current and that all underwritten applications are received from West Virginia licensed and appointed producers.

Recommendation E 9

The Company should provide verification that it has corrected its CCCs to both include the name of the group health plan and any waiting/affiliation periods when applicable. In addition, the Company should provide all CCCs in a timely manner.

Recommendation F 1

It is recommended that Carelink underwrite each employer group to ensure that industry codes are assigned properly in order to ensure rating fairness for all groups.

Recommendation F 2

The Company should establish underwriting guidelines and procedures that comply with the requirements of West Virginia law and HIPAA. The Company should provide an annual open

enrollment period for individuals to enroll for coverage. Carelink's EOC should not include provisions which would limit or negate mandated benefits in West Virginia.

Recommendation F 3

The Company should pay its producers the commissions and any applicable bonuses it failed to pay for max-rated groups during the period under examination.

Recommendation F 4

Once the Company has established its underwriting guidelines it should enforce those guidelines fairly for all employers and members. Additionally, the Company should have paid producer commissions fairly for all small groups issued.

Recommendation F 7

The Company should provide all interested small employers with an application. Neither customer service representatives nor agents should make eligibility determinations on the Company's behalf. If applications are received and small employers are declined based on eligibility factors, the Company should comply with W. Va. Code St. R. § 115-15-4.3b and maintain files and applications to support the decisions it has made

Recommendation F 8

The Company's underwriting guidelines should not restrict guaranteed renewability of large or small group health plans in a manner that is not in compliance with West Virginia law and HIPAA.

Recommendation F 9

The Company's proposals should not permit coverage to be rescinded for reasons which would not be allowed under its filed and approved group contracts and applications, West Virginia law and HIPAA.

Recommendation F 12

The Company should provide all small employers with applications when the Company is solicited through its producers or customer service representatives, thereby preventing producers and customer service representatives from deterring small employers from requesting coverage. Only in this manner can the Company retain records to support that such small employers were denied coverage based on allowable provisions under West Virginia law and HIPAA.

Recommendation H 4

The Company should respond to all Level I appeals timely, and should provide a thorough review during that process.

Recommendation I 4

The Company's EOC should not state that in an emergency, a member should go to a participating hospital unless the member's condition makes that impossible. The enrollment guide correctly states that a person may go to the nearest hospital. The Company should not deny an emergency services claims without proper claims handling to ensure that benefits are not denied for a contractually covered benefit.

Recommendation L 1

The Company's UR guidelines should not provide benefits for breast reconstruction that are more restrictive than permitted in W. Va. Code § 33-25A-8F and WHCRA.

Recommendation L 2

The Company should file a description of its utilization management program with its Certificate of Authority renewals in compliance with W. Va. Code St. R. § 114-51-4.2.

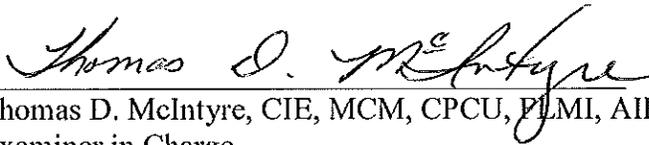
Recommendation L 10

The Company should ensure that its UR guidelines comport with its provider contracts and require uniform claims handling in order to comply with W. Va. Code §§ 33-25A-8d and 33-45-2(3). An issuer should "pend" claims for additional information, rather than close or deny a claim for which it has a contractual obligation to pay.

EXAMINER'S SIGNATURE AND ACKNOWLEDGMENT

The examiner would like to acknowledge the cooperation and assistance extended by the Company during the course of the examination.

In addition to the undersigned, Yvonne Sainsbury, AIE, AIRC, Mark A. Hooker AIE, MCM, CPCU, CWCP, AAI, AU, AIS, LUTCF, Charles L. Swanson, and Brad Beam also participated in the examination.



Thomas D. McIntyre, CIE, MCM, CPCU, PLMI, AIRC, APA, ACS, ARA
Examiner in Charge

EXAMINER'S AFFIDAVIT

State of West Virginia

County of Kanawha

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

I, Thomas D. McIntyre, being duly sworn, state as follows:

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

The affiant says nothing further.

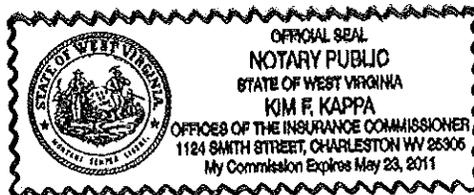
Thomas D. McIntyre

Thomas D. McIntyre, CIE, MCM, CPCU, FIMI, AIRC, APA, ACS, ARA
Examiner in Charge

Subscribed and sworn before me by Thomas D. McIntyre on this 9th day of November, 2009.

Kim F. Kappa

Notary Public



My commission expires May 23, 2011

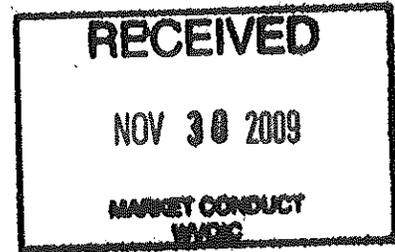


CARELINK HEALTH PLANS

A Coventry Health Care Plan

November 24, 2009

Ms. Jane L. Cline, Insurance Commissioner
Offices of the West Virginia Insurance Commissioner
1124 Smith Street
Charleston, West Virginia 25301



**RE: Carelink Health Plans, Inc. (NAIC #95408) ("Carelink")
Response to Market Conduct Examination Report**

Dear Ms. Cline:

We are in receipt on November 12, 2009, of the Market Conduct Examination Report on Carelink Health Plans, Inc. (Carelink) as of December 31, 2007. Carelink continues its commitment to comply with all applicable laws in West Virginia and strives to improve its efforts in this regard. We appreciate the diligence of the examiners and the assistance they provided us throughout the examination.

Carelink's management continues to work diligently to improve the infrastructure of Carelink to ensure that deficiencies are corrected and to provide its members with high quality, cost-effective HMO products. We hope that these changes and the efforts being taken to improve Carelink's operation are considered when the West Virginia Office of the Insurance Commissioner (WVOIC) reviews our responses to the recommendations in the report. Carelink's responses to the report's recommendations are discussed below.

Recommendation A 3

The Company should ensure that its antifraud procedures provide for investigations and reporting to the WVOIC in compliance with W. Va. Code § 33-41-1.

Carelink has revised its antifraud procedures to provide for investigations and reporting to the WVOIC in compliance with WV Code § 33-41-1, et seq.

Recommendation A 6

Carelink should perform regular audits, not less than annually, of its producer licensing and appointment vendor(s) to assure the contracted level of performance is met and ensure the process remains in compliance with West Virginia law.

Carelink has established a policy to perform routine audits to make sure producers are licensed and appointed in compliance with West Virginia laws.

Recommendation A 7

The Company should devise an adequate means for distinguishing its HMO plans from PPO plans when providing information for examination, in compliance with W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4, and should provide files for efficient market regulation in compliance with NAIC standardized testing.

Education has been done with appropriate staff to provide only fully-insured HMO files for future market conduct examinations.

Recommendation A 9

The Company should cooperate with the examination and provide files when requested, in compliance with W. Va. Code § 33-2-9 and W. Va. Code St. R. § 114-15-4.

Education has been done with appropriate staff to ensure that the appropriate information requested is provided in a timely manner for future market conduct examinations.

HMO products are underwritten by Carelink Health Plans, Inc. PPO products are underwritten by Coventry Health and Life Insurance Company and administered by Carelink Health Plans, Inc.

500 Virginia Street East, Suite 400
Charleston, WV 25301
304.348.2900 Toll-free: 888.388.1744

www.carelinkhealthplans.com

2001 Main Street, Suite 202
Wheeling, WV 26003
304.234.3481 Toll-free: 800.896.9612

Recommendation C 1

The Company should ensure that its advertising materials and its website provide information that is not misleading, deceptive or inaccurate.

Since mid-2006, Carelink has had a communications review team that reviews advertisements prior to them being filed with the WVOIC and prior to them being used. Part of this review is for compliance with applicable West Virginia laws.

In response to the issues specifically addressed in the report under Standard C 1:

1. The website information was changed as discussed in the report to clarify that the product Carelink makes available to individuals and families is underwritten by Coventry Health and Life Insurance Company, not Carelink.
2. As stated in the report, other advertising materials cited in by the examiners are no longer in use.

Recommendation C 2

The Company's small group solicitation materials should indicate that all small employer groups are guaranteed renewable. None of the Company's materials should state that a tax form is mandatory in order for an otherwise eligible employer to gain coverage under a small group health plan.

1. Carelink's small group quoting tool is in the process of being revised to indicate that all small group policies are guaranteed renewable.
2. While the examiners were onsite, all correspondence stating that Wage and Tax forms were required to be provided by small employers were changed to indicate that documentation that proves an employer is a small employer and compliance with group participation rules, such as a current Wage and Tax form, should be provided to Carelink. The Wage and Tax form is now used only as an example of documentation that can be submitted as proof that the group is a small employer, and that the group meets applicable participation requirements.

Recommendation D 1

It is recommended that Carelink establish internal controls to ensure that its producer listings are current and that all underwritten applications are received from West Virginia licensed and appointed producers.

Carelink has revised its policy concerning producers to ensure that its producer listings are current and that all underwritten applications are received from West Virginia licensed and appointed producers. The Group Application was also revised to include producer information in order to identify the appropriate producer for each group.

Recommendation E 9

The Company should provide verification that it has corrected its CCCs to both include the name of the group health plan and any waiting/affiliation periods when applicable. In addition, the Company should provide all CCCs in a timely manner.

1. Certificates of Creditable Coverage ("CCCs") have been revised to include the name of the group health plan and any waiting/affiliation periods when applicable.
2. Carelink is finalizing a policy to ensure that CCCs are provided timely.

Recommendation F 1

It is recommended that Carelink underwrite each employer group to ensure that industry codes are assigned properly in order to ensure rating fairness for all groups.

Carelink is finalizing a policy that discusses how SIC codes should be properly assigned in order to ensure rating fairness for all groups.

Recommendation F 2

The Company should establish underwriting guidelines and procedures that comply with the requirements of West Virginia law and HIPAA. The Company should provide an annual open enrollment period for individuals to enroll for coverage. Carelink's EOC should not include provisions which would limit or negate mandated benefits in West Virginia.

Carelink has revised its underwriting guidelines and procedures that comply with the requirements of West Virginia law and HIPAA. The examiners' concerns are specifically addressed below.

Carelink continues to respectfully disagree that it needs to provide an annual open enrollment period for individuals to enroll for coverage as set out in WV Code § 33-25A-11(1). It was Carelink's understanding that an annual open enrollment period was established to allow individuals portability with their health insurance coverage. However, with the enactment of HIPAA in 1996, portability and creditable coverage was no longer an issue. Since Carelink does not offer individual coverage, Carelink asked the WVOIC whether or not WV Code § 33-25A-11(1) applies to us. We were advised that it did not and this was affirmed by email (copy enclosed.) Carelink recommends that WV Code § 33-25A-11(1) be repealed and commits to working with the WVOIC and the State Legislature to that end.

Regarding concerns with Carelink's *Evidence of Coverage* ("EOC") including provisions which would limit or negate mandated benefits in West Virginia, Carelink has revised its EOC to remove the egregious language. It should be noted, however, that Carelink's EOC was filed and approved by the WVOIC prior to use. Carelink relied on that approval to mean that all provisions within the document were compliant with all applicable West Virginia laws.

In response to the issues specifically addressed in the report under Standard F 2:

1. Carelink has revised its underwriting guidelines to state that the restriction that small groups have less than 10% COBRA members does not apply to West Virginia.
2. Carelink has revised its underwriting guidelines to state that the restriction that small groups have to be in business 6 months does not apply to West Virginia.
3. Carelink has revised its underwriting guidelines to state that the restriction that small groups have to have Workers Compensation insurance does not apply to West Virginia.
4. Carelink is in the process of revising its Contingency Page for new small group quotes to indicate that misstatements or omissions by the group during the quoting period that rise to the level of fraud of material misrepresentation may result in denied claims or rescission of coverage. The statement cited in the report has been removed altogether from the renewal Contingency Page.
5. Carelink has amended its EOC to remove any limitations on the number of mastectomy bras or prosthetic breasts a member may obtain.
6. Carelink has revised its Group Agreement/Policy to comply with WV Code § 33-16D-7(e).
7. Carelink has revised its Underwriting Guidelines to state that off cycle benefit changes are not allowed in West Virginia unless the group terminates its current contract and enters into a new contract with Carelink.
8. Carelink has amended its EOC to state that a member's coverage may be terminated for failure to pay at least 3 copayments within a 12 month period in compliance with WV Code § 33-25A-4-2(b), instead of failure to pay a copayment.
9. Carelink has amended its Group Agreement/Policy to comply with WV Code § 33-6-17.
10. Carelink has amended its Group Agreement/Policy to state, "For groups size 51+, Group is required to maintain at least a 25% membership penetration when more than one carrier who is not an Affiliate is offered." Also added to the second paragraph under Group Responsibilities, "When more than one carrier who is not an Affiliate is offered, the employee's contribution level for Carelink or an Affiliate shall be no greater than the employee's contribution level for the alternate carrier, unless approved in advance by Carelink's Underwriting Department." This document has been filed with the WVOIC and is awaiting approval by the WVOIC. The underwriting guidelines have also been revised accordingly.
11. Carelink amended its underwriting guidelines to be consistent with the Group Agreement/ Policy which allows Carelink to re-rate a group with a change of at least 10% in its group's census. Carelink re-asserts that neither HIPAA nor WV law prohibit premium rate changes during a contract year, in accordance with the Group Agreement/Policy. The reviewer asserts that HIPAA and WV law prohibit a change in premium at anytime other than renewal. We respectfully disagree. We have found nothing in HIPAA, its implementing regulations, nor Department of Labor guidance that prohibits premium changes throughout the contract year. WV law does not prohibit such changes either. As correctly stated by the reviewer in Request for Information #101A, WV law prohibits changes to a "health benefit plan" at any time other than renewal. However, also as pointed out by the reviewer, WV Reg. § 114-54-2.12 defines a "health benefit plan" as:

"Health benefit plan" means benefits consisting of medical care provided directly, through insurance or reimbursement, or indirectly, including items and services paid for as medical care, under any hospital or medical expense incurred policy or certificate; hospital, medical or

health service corporation contract; health maintenance organization contract; or plan provided by a multiple-employer trust or a multiple-employer welfare arrangement. "Health benefit plan" does not include excepted benefits. *[Emphasis added.]*

As indicated by the bolded and underlined text, "health benefit plan" refers to the covered medical care and services and the payment/reimbursement for such services by a carrier. The definition of health benefit plan does not include the premium charged for such health benefit plan. Therefore, we respectfully disagree with the reviewer's interpretation of HIPAA and WV law regarding premium changes made in accordance with Carelink's Group Agreement/Policy and underwriting guidelines.

12. Carelink's subrogation language in its EOC has been revised as recommended in the report.

Recommendation F 3

The Company should pay its producers the commissions and any applicable bonuses it failed to pay for max-rated groups during the period under examination.

Carelink has identified all producers who had max-rated groups from 2005 through 2007 and is in the process of paying these producers the additional commissions on these cases.

Recommendation F 4

Once the Company has established its underwriting guidelines it should enforce those guidelines fairly for all employers and members. Additionally, the Company should have paid producer commissions fairly for all small groups issued.

Carelink has provided education to the appropriate staff and revised its underwriting guidelines, as well as its Group Agreement/Policy, to ensure that the guidelines are applied fairly for all employers and members.

As discussed in our response to Recommendation F 3, Carelink is in the process of paying commissions to producers for max-rated cases from 2005 – 2007 in order to pay commissions fairly for all small groups issued. As discussed in the report, Carelink began paying producers a uniform commission for all small group business in 2008.

In response to the issues specifically addressed in the report under Standard F 4:

1. Education has been done with the appropriate staff to ensure that verification is performed at renewal to determine that groups continue to meet all applicable underwriting guidelines.
2. Carelink has amended its Group Agreement/Policy and its Underwriting Guidelines to indicate that for non-contributory groups, there must be 100% participation, less valid waivers. This is consistent with Carelink's current practice. The Group Agreement/Policy has been filed with the WVOIC and is awaiting approval.
3. Carelink has amended its Group Application and Group Agreement/Policy to state that a group must contribute at least 50% of the employee only premium. Our small group and large group quoting tools have been amended as well.
4. Carelink has reviewed all group contracts to ensure that all of them meet West Virginia's dependent eligibility requirements. As stated in the report, all group contracts have been compliant since July 2007.

Recommendation F 7

The Company should provide all interested small employers with an application. Neither customer service representatives nor agents should make eligibility determinations on the Company's behalf. If applications are received and small employers are declined based on eligibility factors, the Company should comply with W. Va. Code St. R. § 115-15-4.3b and maintain files and applications to support the decisions it has made

In 2008, Carelink implemented a policy to capture information on groups that it declines to quote. WV Reg. § 114-15-4.3(b) states, "A declined underwriting file shall be maintained and shall include an application, any documentation supporting the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation supporting the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application for coverage need not be maintained for purposes of this rule." As a result, Carelink will maintain a list of those groups that are declined a quote and will maintain a file with the appropriate information as required by the regulation.

Recommendation F 8

The Company's underwriting guidelines should not restrict guaranteed renewability of large or small group health plans in a manner that is not in compliance with West Virginia law and HIPAA.

Carelink's underwriting guidelines, correspondence to its groups, and its policy forms have been revised to ensure guaranteed renewability of both large and small group health plans in accordance with applicable West Virginia laws and HIPAA.

In response to the issues specifically addressed in the report under Standard F 8:

1. Carelink revised its letters concerning required documentation, such as Wage and Tax Statements, as discussed in our response to Recommendation C 2.
2. Carelink has amended its Group Agreement/Policy to be compliant with WV Code § 33-16D-7(e) as discussed in our response to Recommendation F 2.
3. Carelink has amended its Group Agreement/Policy and underwriting guidelines to clarify our participation and contribution requirements for slice business as discussed in response to Recommendation F 2.

Recommendation F 9

The Company's proposals should not permit coverage to be rescinded for reasons which would not be allowed under its filed and approved group contracts and applications, West Virginia law and HIPAA.

Carelink is in the process of revising the information on its small group quoting tool for both new and renewing groups to clarify when we would rely on information provided during the quoting process when retracting claims or rescinding coverage as discussed in our response to Recommendation F 2.

Recommendation F 12

The Company should provide all small employers with applications when the Company is solicited through its producers or customer service representatives, thereby preventing producers and customer service representatives from deterring small employers from requesting coverage. Only in this manner can the Company retain records to support that such small employers were denied coverage based on allowable provisions under West Virginia law and HIPAA.

As stated in our response to Recommendation F 7, in 2008, Carelink implemented a policy to capture information on groups that it declines to quote. WV Reg. § 114-15-4.3(b) states, "A declined underwriting file shall be maintained and shall include an application, any documentation supporting the decision to decline an issuance of a policy, any binder issued without the insurer issuing a policy, any documentation supporting the decision not to add additional coverage when requested and, if required by law, any declination notification. Notes regarding requests for quotations that do not result in a completed application for coverage need not be maintained for purposes of this rule." As a result, Carelink will maintain a list of those groups that are declined a quote and will maintain a file with the appropriate information as required by the regulation.

Recommendation H 4

The Company should respond to all Level I appeals timely, and should provide a thorough review during that process.

Carelink does not feel that there should be a recommendation for Standard H 4 as discussed below.

1. Carelink agreed that 2 first level appeals were untimely. As demonstrated by the high compliance rate, it appears that the untimely appeals were isolated incidents. However, education has been done with the appropriate staff to stress the importance of processing first level appeals timely.
2. The reason there is a recommendation that Carelink perform a thorough review during the first level appeal process appears to be because of one appeal. The appeal discussed in the report was reviewed as a WVOIC complaint, not as part of the appeals sample. Carelink does not agree that the appeal was not thoroughly reviewed during the first level appeal process. The first level appeal committee reviewed all the information presented to them and upheld the original denial decision based on their review of the information and according to each panel member's personal judgment. Carelink asserts that the examiner is expressing her personal opinion about the appeal decision rendered by the first level appeal committee in this case. This should not be an indictment of the thoroughness of the whole first level appeal process. The fact that the examiner does not agree with the decision or that the appeal was overturned upon review by the second level appeal committee does not mean that the appeal was not reviewed thoroughly at the first level. In addition, since only one first level appeal reviewed by the examiners even caused the examiners concern about the

thoroughness of Carelink's review, it can be considered an isolated incident which does not merit a recommendation.

Recommendation I 4

The Company's EOC should not state that in an emergency, a member should go to a participating hospital unless the member's condition makes that impossible. The enrollment guide correctly states that a person may go to the nearest hospital. The Company should not deny an emergency services claims without proper claims handling to ensure that benefits are not denied for a contractually covered benefit.

In response to the specific issues addressed in the report under Standard I 4:

1. Carelink amended its EOC to remove the language the examiners felt was misleading dealing with where a member should seek care when an emergency medical condition arises.
2. As discussed in the report, Carelink previously amended its policy on processing ER claims to close, instead of deny, claims for services that are received through the ER that are submitted with diagnosis that may be for non-emergent conditions. Claims for services rendered in an emergency setting which, based on the diagnosis submitted on the claim it is not clear that the member's condition meets the definition of "emergency medical condition" set forth in the EOC, are closed as not being clean claims and necessary additional information is requested (typically notes from the treating provider(s)). By closing these claims and requesting additional information, Carelink is in compliance with WV Code § 33-45-1, et seq. Closing a claim enables the claims system to communicate to the provider that additional information is being requested. Pending a claim simply suspends adjudication of the claim without any requirement of communication to the provider nor does it allow Carelink to use its established automated communication system (i.e., the remittance advice) to the provider. There is no difference to the member between a closed or pended claim, nor do we think the statute prohibits closing a claim or mandates that we pend a claim. However, there is a systematic difference between a closed and a pended claim; one (closing a claim) allows for automatic and quick communication with the provider via normal communication processes, and the other (pending a claim) requires manual communication (taking more time) via a new process which we do not believe is nearly as efficient, accurate or timely as the established provider communication system. The examiners' argument about "pending" versus closing claims appears to be one of semantics. WV Code § 33-45-2(a)(3) states that within thirty (30) days of receiving a claim that is not clean, an insurer/HMO must request, in writing from the person submitting the claim, "any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim." The above described process is compliant with this statute and as a result, Carelink respectfully disagrees that the statute prohibits an insurer from closing the claim until the requested information is received. As a result, Carelink continues to believe that its current claims handling practice for emergency claims is compliant with West Virginia law.

Recommendation L 1

The Company's UR guidelines should not provide benefits for breast reconstruction that are more restrictive than permitted in W. Va. Code § 33-25A-8F and WHCRA.

As stated in the report, Carelink retired its policy on prosthetic breasts and mastectomy bras and amended its EOC to remove its limits on mastectomy bras and prosthetic breasts in order to comply with WV Code § 33-25A-8F and the WHCRA. Carelink should now be in full compliance with these laws.

Recommendation L 2

The Company should file a description of its utilization management program with its Certificate of Authority renewals in compliance with W. Va. Code St. R. § 114-51-4.2.

Beginning in 2008, Carelink filed descriptions of its utilization management program as required in WV Reg. § 114-51-4.2.

Recommendation L 10

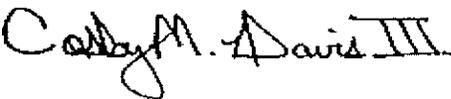
The Company should ensure that its UR guidelines comport with its provider contracts and require uniform claims handling in order to comply with W. Va. Code §§ 33-25A-8d and 33-45-2(3). An issuer should "pend" claims for additional information, rather than close or deny a claim for which it has a contractual obligation to pay.

By revising its policy on processing ER claims, Carelink feels that it has ensured that its UR guidelines, provider contracts, and its claims handling are compliant with WV Code §§ 33-25A-8d and 33-45-2(3). As discussed in our

response to Recommendation I 4, claims for services rendered in an emergency setting which, based on the diagnosis submitted on the claim it is not clear that the member's condition meets the definition of "emergency medical condition" set forth in the EOC, are closed as not being clean claims and necessary additional information is requested (typically notes from the treating provider(s)). By closing these claims and requesting additional information, Carelink is in compliance with WV Code § 33-45-1, et seq. Closing a claim enables the claims system to communicate to the provider that additional information is being requested. Pending a claim simply suspends adjudication of the claim without any requirement of communication to the provider nor does it allow Carelink to use its established automated communication system (i.e., the remittance advice) to the provider. There is no difference to the member between a closed or pended claim, nor do we think the statute prohibits closing a claim or mandates that we pend a claim. However, there is a systematic difference between a closed and a pended claim; one (closing a claim) allows for automatic and quick communication with the provider via normal communication processes, and the other (pending a claim) requires manual communication (taking more time) via a new process which we do not believe is nearly as efficient, accurate or timely as the established provider communication system. The examiners' argument about "pending" versus closing claims appears to be one of semantics. WV Code § 33-45-2(a)(3) states that within thirty (30) days of receiving a claim that is not clean, an insurer/HMO must request, in writing from the person submitting the claim, "any information or documentation that the insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim." The above described process is compliant with this statute and as a result, Carelink respectfully disagrees that the statute prohibits an insurer from closing the claim until the requested information is received. As a result, Carelink continues to believe that its current claims handling practice for emergency claims is compliant with West Virginia law.

Carelink welcomes this opportunity to become better educated regarding the HMO laws in West Virginia. We would like to assure you that Carelink has an on-going commitment to compliance. It is our hope that you will keep in mind that Carelink has completed or is finalizing its implement of the examiners' suggestions and recommendations. We are confident that you will give careful consideration to the issues we have addressed above and look forward to your response.

Sincerely,



Cosby M. Davis, III
President

cc: Mr. Mark Hooker
Offices of the West Virginia Insurance Commissioner
Legal Division, Regulatory Actions Section
1124 Smith Street
Charleston, West Virginia 25301

Enclosure

Email correspondence with the WVOIC on WV Code § 33-25A-11

From: Fred Holliday [mailto:Fred.Holliday@wvinsurance.gov]
Sent: Friday, August 08, 2008 11:17 AM
To: Seton, Denise
Cc: TONYA GILLESPIE
Subject: RE: Carelink question about 33-25A-11

Denise,

It is my understanding that the open enrollment only applies to HMOs that market an individual product.

Fred

Fred Holliday
Health Policy and Rate Analyst
West Virginia Offices of the Insurance Commissioner
P. O. Box 50540
Charleston, WV 25305-0540
Phone 304-558-6279 (Ext. 1135) Fax 304-558-1610
E-mail fred.holliday@wvinsurance.gov

From: Seton, Denise [mailto:DASeton@cvty.com]
Sent: Friday, August 08, 2008 9:06 AM
To: Fred Holliday
Subject: Carelink question about 33-25A-11

Hi Fred!

I was hoping you might be able to help me with a question that has come up at Carelink. We are currently undergoing a Market Conduct Examination and a question came up regarding 33-25A-11 of the HMO Act requiring HMOs to provide an open enrollment period. Does this provision only apply to HMOs that write individual coverage? It appears the intent of the open enrollment period is to allow individuals an opportunity to obtain and enroll in individual coverage.

Would you or Tonya be able to provide some guidance on this provision?

Hope all is well in Charleston.

Denise A. Seton

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