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

IN RE:
THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.
NAIC #95677

ADMINISTRATIVE PROCEEDING #
11-MAP-02001

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 **The Health Plan of the Upper Ohio Valley, Inc.** (hereinafter "HPUOV") for the examination period ending December 31, 2008 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, as amended.

2. HPUOV is a non-profit prepaid managed care program, is an individual practice association type of health maintenance organization ("HMO")

located in St. Clairsville, Ohio and is authorized by the West Virginia Office of the Insurance Commissioner to transact its business as permitted under Chapter 33 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 HPUOV for the period ending December 31, 2008, was conducted in accordance with West Virginia Code § 33-2-9 by examiners duly appointed by the Insurance Commissioner. The Market Conduct Examination of the Company began on June 15, 2009 and concluded on February 9, 2010.

2. On March 11, 2011, 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 April 8, 2011, a true copy of the Report of Market Conduct Examination was sent to HPUOV by certified and electronic mail and was received by HPUOV on April 13, 2011.

4. On April 8, 2011, HPUOV 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 focused on the methods used by the Company to manage its operations for each of the business areas

examined which includes how the Company complies with West Virginia statutes and rules or other associated federal law. The examination covered seventy-eight (78) standards and the Company passed seventy (70) of these standards. None of the passed standards were accompanied by recommendations. The remaining eight (8) standards examined fell short of the error tolerance standard established for this examination and therefore, failed those standards. Of the eight (8) standards, one (1) was associated with Company Operations and Management, one (1) was associated with Complaint Handling and six (6) were associated with Underwriting and Rating.

6. On April 18, 2011, HPUOV responded to the Report of Market Conduct Examination and did not dispute the facts pertaining to findings, comments, results, observations, or recommendations contained in the Report of Market Conduct Examination.

7. HPUOV hereby waives additional notice and review of the Report of Market Conduct Examination, notice of administrative hearing, any and all rights to an administrative hearing, and to appellate review of any matters contained herein this Agreed Order.

8. 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 HPUOV has incurred violations of West Virginia Code including but not limited to: §§33-2-9, 33-2-9(g), 33-16D-4 & 7, 33-15-2b, 33-25A-14a and W.Va. Code of State Rules §114-15-4. Additionally, issues with The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") federal law were also implicated.

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

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

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 HPUOV'S Response thereto, the Insurance Commissioner and HPUOV 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 HPUOV as set forth below.

It is accordingly **ORDERED** as follows:

(A) The Report of Market Conduct Examination of HPUOV for the period ending December 31, 2008, is hereby **ADOPTED** and **APPROVED** by the Insurance Commissioner.

(B) It is **ORDERED** that HPUOV 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 and/or the Report of Market Conduct Examination adopted herein where applicable.

(C) It is further **ORDERED** that HPUOV shall continue to monitor its compliance with the West Virginia Code, the West Virginia Code of State Rules and all 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, HPUOV 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 HPUOV shall ensure compliance with the West Virginia Code and the Code of State Rules. HPUOV shall specifically cure those violations and deficiencies identified in the Report of Market Conduct including providing appropriate restitution (where applicable) or other handling of the issue so as to bring the violations into compliance and conformity with the Commissioner's recommendations and any applicable law(s).

(F) It is further **ORDERED** that HPUOV shall file a Corrective Action Plan which will be subject to the approval of the Insurance Commissioner. The Corrective Action Plan shall detail HPUOV'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. HPUOV 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 HPUOV 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.

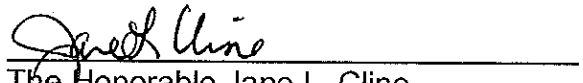
(G) The Insurance Commissioner has determined and it has been agreed by HPUOV and therefore, it is hereby **ORDERED** that HPUOV shall pay an administrative penalty to the State of West Virginia in the amount of **Five Thousand Dollars ($5,000.00)** for non-compliance with the West Virginia Code as described 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 The Health Plan of the Upper Ohio

Valley, Inc.

(l) Finally it is hereby **ORDERED** that to the extent the Report of Examination and this subsequent AGREED ORDER conflict with the Patient Protection and Affordable Care Act of 2010 ("PPACA"), the PPACA shall be controlling and HPUOV shall not be responsible for any violations or corrective action concerning such conflict.

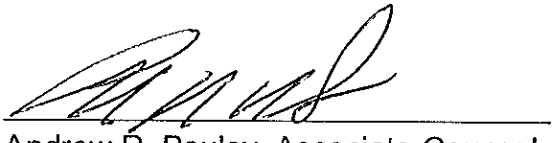
Entered this 23rd day of June, 2011.



The Honorable Jane L. Cline
Insurance Commissioner

REVIEWED AND AGREED TO BY:

On Behalf of the WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER:



Andrew R. Pauley, Associate Counsel
Attorney Supervisor, APIR

Dated: 6/9/11

On Behalf of THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.:

By: Philip D. WRIGHT
[Print Name]

Its: PRESIDENT / CEO

Signature: Philip D. Wright

Date: 6/3/11

NAIC# 65677
Exam# WV014-M19

THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC. (HPUOV)
MARKETING & SALES CORRECTIVE ACTION PLAN (SECTIONS C, D & F)
Period Ending December 31, 2008

Recommendation A 7
The Company should retain all files: including the underwriting and declination of files in compliance with West Virginia record retention statutes and rules.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented the proper retention process and revised our departmental policies and procedures.

Recommendation C 2
The Company's agent manual should have language that allows guaranteed availability for all small employer groups, and should not allow for declination of eligible small employer groups when the employer could or would not supply a quarterly wage report. The Company should pay commissions fairly for all small groups.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the mandate for the quarterly wage report and revised our agent manual and policies and procedures. HPUOV has remitted appropriate commissions retrospectively to those affected Agents in regards to max-rated small groups. Proof of remittance detail forwarded to Mark Hooker.

Recommendation F 2
The Company should revise its forms, policies and procedures to ensure a 180 day notice period is provided as required under W.Va. Code §§ 33-16-31 and 33-16D-7, in the event the Company exits the employer group market.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately began updating our forms, policies and procedures.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-25A-14a and 33-16-3(a), by revising its EOCs and its policies and procedures to provide for thirty (30) days notice before termination of an enrollee's coverage and ensure that an enrollee's coverage is not cancelled for misrepresentations on any form other than the enrollee's application.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented the 30 days notice requirement and began revising our EOCs and policies and procedures.

Recommendation F 2
The Company should ensure that none of its forms, practices or procedures provide for non-renewal of any small group plan other than as provided for under W.Va. Code § 33-16-31, 33-16D-7, 45 CFR § 146.152 and HCFA Transmittal No. 99-03(V). The reference to "any" plan year in the Company's suggested revision should not be used to retrospectively non-renew any small group, because small groups cannot be terminated for falling to one employee except at the plan year renewal.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented a non-renew policy only at the plan year renewal and revised our forms, polices and procedures.

Recommendation F 2
The Company should include in bold print in its EOC, the statement required under W.Va. Code § 33-25A-8(1)(c), concerning the examination of the enrollee's medical records.

Corrective Action
At the time the reviewer brought the above to our attention, we began revising our documents.

Recommendation F 2
The Company should revise its definition of "Dependent Children" to comply with W.Va. Code §§ 33-16-1a, 33-16-11 and the IRC, and revise its practices and procedures to ensure that any qualifying child subject to legal guardianship/custody is granted coverage if requested.

Corrective Action
The Company is still in discussion with the Commission on the interpretation of the WV Code, reviewer stated we must cover all qualified dependent children and relatives as defined by IRC.

Recommendation F 2
The Company should comply with W.Va. Code § 33-16-3j and the Newborns and Mothers Health Protection Act (NMHPA), by revising its contracts and policies and procedures to ensure that every contract covering inpatient care in connection with childbirth for a mother and her newborn child, provides that coverage regardless of network restrictions.

Corrective Action
The is in reference to our language under Emergency/Urgent Care Services where we listed "The Plan does not cover the following services outside the Service Area...Normal, full-term delivery or post-partum care of a baby" Marketing agreed to delete this language.

Recommendation F 2
The Company should revise all applicable forms containing an exclusion of chiropractic and podiatric services to remove the exclusions and to include those services as covered services. The Company should revise its practices and procedures to ensure that these basic health care services are covered without discrimination among providers, as required under W.Va. Code §§ 33-25A-2 and 33-25A-31. The Company should review its claims received during the examination period and retroactively pay any claims received for these services.

Corrective Action
The Company never excluded coverage for chiropractic and podiatric services, these services were listed as covered services under the "Schedule of Benefits". These services where not specifically listed as basic benefits under the definition of basic benefits. We agreed to add as part of the definition.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its practices and procedures and the EOCs to remove any restriction requiring hospital and physician services to have been initiated and rendered within six months of the accident and any statement requiring the injury or accident to have occurred while the individual was a member of the Plan. The Company should ensure that no claim relating to accidental dental injuries is denied on the basis of the restrictions in the EOCs.

Corrective Action

The above language was deleted in January 1, 2006 and polices and procedures were revised. However, we failed to delete the language from our Basic and Standard EOCs. We agreed to delete and did a claims check to assure claims were not denied in error.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its contracts and its policies and procedures to ensure that neither the Lifetime Benefits Maximum nor Lifetime Maximum Benefit apply to basic health care services. The Company should cease applying these restrictions to enforce contracts immediately, and should retroactively pay claims for any basic health care services for which coverage was denied, including services denied after an individual changed employers or moved between group and individual plans.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately removed the restrictions and began revising our contracts and polices and procedures. The above was only applied to one employer group and one non-group plan and we did a claims check to assure claims were not denied due to the above language.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16D-4, 33-16D-2(r) and HIPAA, by revising all relevant employer applications and its policies and procedures to ensure that no eligible small groups are denied issue of a small group plan based on any requirement for employees to be covered by workers' compensation coverage, if such employees are exempt from this requirement under W.Va. Code St. R. § 85-8-4.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately removed this restriction and began revising our polices and procedures. HPUOV never denied anyone enrollment because they were exempt from workers' compensation coverage.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-14a and HIPAA, by deleting its mandate requiring the employer to enroll its Medicare beneficiaries in one of its Medicare plan options and should revise its practices and procedures to ensure that coverage for active Medicare employees and dependent Medicare beneficiaries does not change from that applicable to other active employees and their dependents.

Corrective Action
The Company offered this population our Advantage Plans plus coverage to Medicare that was secondary with the same active employee benefits at a reduced rate. We removed the word "mandate" from our documents.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16A-1 and 33-16A-14, by including West Virginia's conversion privilege in every group contract (EOC) and identify it as pertaining to residents of West Virginia.

Corrective Action
Company did offer conversion privilege to all applicable WV residents. Reviewer stated that by citing an OH reg specifically and not WV was misleading. We immediately began revising our documents.

Recommendation F 2
The Company should revise its forms, policies and procedures to provide for a minimum limiting age of twenty-five (25) for dependents, and ensure no dependent child under the age of twenty-

five (25) is denied or terminated from coverage on the basis of the policy's limiting age. Any other option available to the employer may exceed that age, but not reduce it.

Corrective Action
Company offered coverage for dependent children to age 25 cited unless specified differently by the group agreement. Some WV employers had other policies in place that had restrictions as far as student status etc. Company questioned how can an insurance law mandate employer groups do otherwise. We were advised by the reviewer that the employer could go else where to seek coverage. We immediately implemented and began revising our documents and policies and procedures.

Recommendation F 2
The Company should ensure coverage for all qualified dependent children in compliance with W.Va. Code § 33-16-1a.

Corrective Action
The Company is still in discussion with the Commission on the interpretation of the WV Code, reviewer stated we must cover all qualified dependent children and relatives as defined by IRC.

Recommendation F 2
The Company should comply with W.Va. Code St. R. § 114-64-8, by filing the required actuarially certified applications and annual report of the fiscal impact of mental health parity expenses and revise its policies and procedures to ensure that these filing requirements are met annually. In addition, it should not implement cost containment measures until it has received the commissioner's approval to do so.

Corrective Action
Company agreed and immediately amending our documents and copays.

Recommendation F 2
The Company should comply with W.Va. Code § 33-16E-4 and include coverage for prescription contraceptive devices in all prescription drug riders and every contract that includes coverage for prescription drugs.

Corrective Action
At the time the reviewer brought the above to our attention, we implemented immediately and began revising our documents and policies and procedures.

Recommendation F 2
The Company should comply with W.Va. Code St. R. § 114-39-5.1(g), by revising its policies and procedures to ensure a live donor's expenses for an organ transplant are payable to the extent that benefits remain, and are available after the recipient's own expenses have been paid.

Corrective Action
At the time the reviewer brought the above to our attention, we implemented immediately and began revising our documents and policies and procedures.

Recommendation F 2
The Company should revise its forms, policies and procedures to ensure coverage is provided for substance-related disorders, anorexia and bulimia, and that such are defined and paid as serious mental illnesses, in compliance with W.Va. Code § 33-16-3a.

Corrective Action
The Company never excluded coverage for substance-related disorders, anorexia and bulimia. These services where not specifically listed as basic benefits under the definition of basic benefits. We agreed to add as part of the definition.

Recommendation F 2
The Company's EOCs for its individual plans and the individual forms should provide for guaranteed renewability in compliance with W.Va. Code § 33-15-2d and HIPAA by eliminating its "ongoing eligibility" provision for termination.

Corrective Action
At the time the reviewer brought the above to our attention, we ceased the above immediately.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16-3h, 33-16-3f and Code St. R. § 114-29-4, by revising its forms, policies and procedures to provide the benefits mandated under these laws for TMJ, CMD and rehabilitative services, unless the Company has provided a waiver form or other opportunity for the employer to refuse these benefits in writing and the employer has declined the coverage(s) in writing.

Corrective Action
The Company covered TMJ services for all employer and non-employer groups as part of our benefit packages. At the time the reviewer brought the above to our attention, we immediately implemented and began revising our documents and policies and procedures.

Recommendation F 3
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. In addition, the Company should provide verification of its corrected commission and bonus schedule.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the above and revised our agent manual and policies and procedures. HPUOV has remitted appropriate commissions retrospectively to those affected Agents in regards to max-rated small groups. Proof of remittance detail forwarded to Mark Hooker.

Recommendation F 4
The Company should pay producer commissions and bonuses fairly for all small groups issued.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the above and revised our agent manual and policies and procedures. HPUOV has remitted appropriate commissions retrospectively to those affected Agents in regards to max-rated small groups. Proof of remittance detail forwarded to Mark Hooker.

Recommendation F 4
The Company should only terminate small employers that fall to one enrollee at the end of the group plan year in compliance with guaranteed renewability provisions in West Virginia law and HIPAA.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented a non-renew policy only at the plan year renewal and revised our forms, polices and procedures.

Recommendation F 4

The Company should retain all declination records to support it is not restricting guaranteed availability in the small group market for compliance with W.Va. Code § 33-16D-4 and HIPAA.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented the proper retention process and revised our departmental policies and procedures.

Recommendation F 4
The Company should correct its guidelines, procedures and practices that allowed for restricting guaranteed availability for eligible small groups for compliance with W.Va. § 33-16D-4(b) and HIPAA.

Corrective Action
At the time the reviewer brought to our attention, we immediately implemented the necessary changes and began revising our documents and polices an procedures.

Recommendation F 4
The Company should eliminate its review "ongoing eligibility" (eligibility Inquiry Form) in the individual market to ensure compliance with guaranteed renewability provisions in W.Va. Code § 33-15-2d and HIPAA.

Corrective Action
At the time the reviewer brought to our attention, we ceased the above immediately.

Recommendation F 4
The Company should determine federal eligibility in compliance with W.Va. Code § 33-15-2b and HIPAA.

Corrective Action
We agreed that we did make an error in denying one application during the review period.

Recommendation F 7
The Company should maintain declination files in compliance with W.Va. Code St. R. § 115-15-4.3b, which would provide evidence for the validity of Company small group declinations.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented the proper retention process and revised our departmental policies and procedures.

Recommendation F 7
The Company should not deny coverage to small employers that provide evidence they are an eligible small group for compliance with St. R. § 114-54-9.1(a) and W.Va. Code § 33-16D-4 and HIPAA.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the mandate for the quarterly wage report and revised our agent manual and policies and procedures.

Recommendation F 7
The Company should allow all federally eligible individuals guaranteed issue coverage in compliance with W.Va. Code § 33-15-2b.

Corrective Action
We agreed that we did make an error in denying one application during the review period.

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.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented a non-renew policy only at the plan year renewal and revised our forms, polices and procedures.

Recommendation F 8
The Company should only allow termination of small group coverage in compliance with West Virginia statutes and rules and HIPAA.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented a non-renew policy only at the plan year renewal and revised our forms, polices and procedures.

Recommendation F 8
The Company should only terminate coverage in the individual market when allowed in compliance with W.Va. Code § 33-15-2d and HIPAA. The Company should discontinue "ongoing eligibility" checks in the individual market.

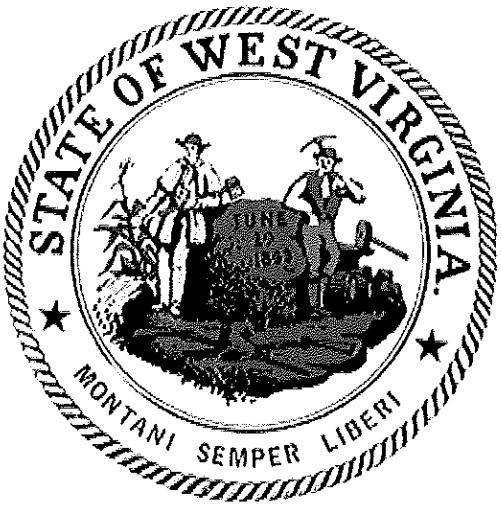
Corrective Action
At the time the reviewer brought to our attention, we ceased the above immediately.

Recommendation F 12
The Company should allow all eligible small employers coverage in compliance with West Virginia statutes and rules and HIPAA, and it should maintain records to validate it is providing coverage for all small employers that solicit the Company in compliance with the guaranteed issue provisions of West Virginia statutes and rules and HIPAA.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented the proper retention process and revised our departmental policies and procedures.

Report of Market Conduct Examination

As of December 31, 2008



The Health Plan of the Upper Ohio Valley, Inc.
52160 National Road, East
St. Clairsville, OH 43950

NAIC COMPANY CODE 95677
Examination Number WV014-M19

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March 11, 2011

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, 2008 of the business affairs of

THE HEALTH PLAN OF THE UPPER OHIO VALLEY, INC.
52160 National Road, East
St. Clairsville, OH 43950

hereinafter referred to as the "Company" or "HPUOV". 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 Procedures
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 15, 2009 and concluded on February 9, 2010. The examination covered seventy-eight (78) standards from the 2009 NAIC Market Regulation Handbook. The Company passed seventy (70) of these standards. None of the passed standards were accompanied by recommendations. The remaining eight (8) standards examined fell short of the error tolerance standard established for this examination and therefore, failed those standards. Of the eight (8) failed standards, one (1) was associated with Company

Operations and Management, one (1) was associated with Complaint Handling, and six (6) were associated with Underwriting and Rating.

The following list summarizes issues raised in this report:

- The Company's underwriting guidelines and agents manual 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 HPUOV records management plan failed to require documents be retained in compliance with W.Va. Code St. R. § 114-15-4 and W.Va. Code § 33-2-9. In addition, the Company did not retain records of declined small employer applications in compliance with W.Va. Code § 33-2-9(g) and W.Va. Code St. R §§ 114-15-4.2 & 4.3b.

- 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 should eliminate its proof of "ongoing eligibility," provision that provides for termination of an individual policy to ensure the guaranteed renewable requirements of West Virginia statutes and rules, and HIPAA.

- The Company failed to provide some mandated benefits or provisions in compliance with West Virginia statutes and rules, including but not limited to: basic health care services, organ transplants, serious mental illnesses, contraceptive devices, TMJ and CMD and rehabilitative services waiver, and qualified dependents and age limits for dependents.

- The Company's policy forms, and its policies and procedures allowed for termination of small employer groups within thirty (30) days notice when a group fell to one covered employee. In compliance with West Virginia statutes and rules, and HIPAA guaranteed renewable provisions, the small employer should not be terminated until the first renewal following the plan year.

- The Company failed to determine who was a federally eligible individual for guaranteed issue in the individual market in compliance with W.Va. Code § 33-15-2b and HIPAA.

- The Company should not allow the employer to enroll its Medicare eligible employees and dependents in one of the Company's Medicare plan options for compliance with W.Va. Code § 33-25A-14a and HIPAA.

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, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to the State of West Virginia insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed.

During the examination process, the Company agreed to: remediate a claim error, change its records retention practices, correct language associated with its certificates of coverage ("COCs"), correct underwriting guidelines, agency manual, and agent 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, 2003. The report of that examination disclosed ten (10) 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-8
It is recommended that HPUOV formally withdraw its Point of Service ("POS") for use in West Virginia.

> *This examination determined the Company adequately addressed this recommendation. The Company moved its POS plans to a wholly underwritten plan.*

Recommendation C-4
It is recommended that the Company offer all grievants an opportunity to meet in person to discuss the grievance.

> *This examination determined the Company adequately addressed this recommendation. The Company offered all grievants an opportunity to meet in person in compliance with W.Va. Code St. R. 114-53-5.10.*

Recommendation D-2
It is recommended that the Company eliminate discriminatory restrictions from its Agents Manual.

> *This examination determined the Company appeared to adequately address this recommendation by eliminating the restrictions for employer small groups that were raised during testing of the agents' manual during the last examination. However, the Company's guidelines and agent manual provided other restrictions for guaranteed issue (i.e. commission payments, wage reports, management only groups and percentage of employees for employer small groups during the period under examination (see testing performed at F 7).*

Recommendation F-2
It is recommended that HPUOV establish an internal control mechanism to ensure that its group plans are only serviced by producers 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 accepting small group*

applications. For all the group plans tested during the examination, the producers were licensed and appointed.

Recommendation J-1
It is recommended that HPUOV ensure its small groups are only charged rates, which are filed and approved by the Insurance Commissioner. It is further recommended restitution in an amount equal to what the group paid over the Company's filed rates with interest to be determined by the Commissioner.

This examination determined the Company adequately addressed this recommendation. The Company returned premium to employer groups as recommended, and only issued small group plans with rates that were filed and approved by the WVOIC.

Recommendation J-5
It is recommended that the company conform its underwriting guidelines to be consistent with W.Va. Code §§ 33-25A-24(d) and 33-16D-3.

This examination determined the Company failed to adequately address this recommendation. The Company's underwriting guidelines provided restrictions for guaranteed issue for employer small groups during the period under examination (see testing performed at F 7).

Recommendation J-9
It is recommended that HPUOV create written procedures to ensure due diligence "eligibility" reviews are conducted to ascertain if an applicant qualifies for guaranteed issue products. It is further recommended that HPUOV develop written underwriting criteria describing specific medical conditions that result in rating differences, coverage limitations or denials.

This examination determined the Company attempted to adequately address this recommendation. The Company provided written procedures for medical conditions to attempt assurance that all applicants with similar medical conditions are underwritten fairly. In addition, the Company provided written procedures for determining which applicants are federally eligible individuals; however, it still applied an "ongoing eligibility" requirement that failed to allow for continuance of guaranteed issue products.

Recommendation J-10
It is recommended that HPUOV discontinue its use of "The Health Plan Eligibility Inquiry Form" and conform its termination practices to W.Va. Code § 33-25A-14(2) and HIPAA.

This examination determined the Company failed to address this recommendation. The Company continued use of its inquiry form and allowed for termination practices that were not in compliance with W.Va. Code § 33-25A-14(2) and HIPAA.

Recommendation K-6
It is recommended that HPUOV comply with W.Va. Code St. R. 114-51-4.8b.

This examination determined the Company adequately addressed this recommendation. The Company provided written notice of denial to all applicants denied coverage, and all policyholders received notice of the appeal process.

Recommendation K-11
It is recommended that HPUOV annually review UM activity of delegate organization regardless of accreditation status.

This examination determined the Company adequately addressed this recommendation. The Company performed annual reviews of its delegate organization.

HISTORY AND PROFILE

The Company was organized on August 8, 1978 by the issuance of a certificate of incorporation by the Secretary of State of West Virginia. The Company was organized as a non-profit tax-exempt organization under the provisions of the Internal Revenue Code, Section 501(c) (3). A certificate of authority was issued by the WVOIC on July 9, 1979 and the Company commenced business on November 1, 1979. On March 3, 1980, the Company was authorized to transact business in the State of Ohio, and on July 9, 1980, the Company was federally qualified under the provisions of Title XIII of the Public Service Act.

The Company, a prepaid managed care program, is an individual practice association type of health maintenance organization ("HMO"). The Company was originally located in Wheeling, West Virginia. In 1985, after regulatory approval, the Company relocated to its present location in St. Clairsville, Ohio.

On December 7, 1993, the Company formed a wholly owned insurance agency, HP Agency Inc., an Ohio corporation. Capital stock certificates were issued on February 28, 1994.

On March 1, 1999, HPUOV formed a wholly owned subsidiary named THP Insurance Company that was subsequently granted a certificate of authority on April 13, 1999 by the WVOIC to transact accident and sickness insurance.

Effective July 1, 2003, the Company acquired the HomeTown Insurance Group of companies, which included a non-profit insurer, HomeTown Health Plan ("HHP"). The WVOIC approved the transaction on June 11, 2003.

The Company markets to employer groups and offers a conversion plan in the individual market when applicable. Its plans are typically provided as one-year contracts, wherein the Company provides health benefit services to employees and individuals that select coverage. The Company offers Medicare Advantage plans, and also provides Administrative Services Only contracts ("ASO"), which are services for employee benefit plans providing a full range of health care options without assuming insurance risk. As of December 31, 2008, HPUOV was the third largest provider of accident and sickness coverage in West Virginia with approximately sixteen percent (16%) of the market share.

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 and 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: The Company had both internal and external audit processes in place during the period under examination. The Company had committees that met regularly throughout the year to create, review, and revise its internal policies when deemed necessary. 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**

Observations: The Company had developed and implemented guidelines for identifying, reporting, and addressing suspected fraudulent activities. HPUOV's guidelines included internal fraud, wasteful and/or abusive practices by providers and membership fraud. The Company had also developed procedures for notifying the WVOIC when required.

Recommendations: None

Standard A 4	*NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 4.*
The regulated entity has a valid disaster recovery plan.	*W.Va. Code §§ 33-2-9 & 33-25A-17*

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	*NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 6.*
The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.	*W.Va. Code St. R. § 114-53-4.*

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**

Observations: HPUOV 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 was not allowed to be bound by producers.

Recommendations: None

Standard A 7	*NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 7.*
Records are adequate, accessible, consistent, and orderly and comply with state record retention requirements.	*W.Va. Code § 33-2-9*

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: **Fail**

Observations:

- The Company provided its Records Management Plan. The HPUOV plan failed to require documents be retained in compliance with W.Va. Code St. R. § 114-15-4 and W.Va. Code § 33-2-9. The Company response stated in part, "...the revised Records Management Plan (attached). Additionally, staff have been further educated on the need to retain records consistent with the revised policy and as directed by the rules and noted this past September in the West Virginia Informational Letter No. 172." "...I agree with the above." As a result of the market conduct examination, the Company has revised its record retention policies.

- For forty-four (44) small group declined files, the Company failed to retain any documents for those files, and for another small group declined file it failed to retain adequate documentation in violation of W.Va. Code St. R. §114-15-4.3(b). Failure to maintain documents for five (5) years or from the date of the last examination was also not in compliance with W.Va. Code St. R. §114-15-4 and W.Va. Code § 33-25A-17. The Company provided declination guidelines that stated, "HPUOV Retention Policy is to destroy declined or rejected quotes one (1) year after declination or rejection." The Company agreed to correct its practices and procedures for retaining documentation for declined files to comply with all West Virginia statutes and rules. Therefore, as a result of the market conduct examination the Company agreed to update its practices and procedures for retaining group declined files

- The Company failed to provide supporting documentation for seven (7) small groups terminated, which was not in compliance with W.Va. Code § 33-25A-17 and W.Va. Code St. § 114-15-4 (see testing performed at Standard F 8).

The Company failed to retain records for an individual plan terminated, which was not in compliance with W.Va. Code St. R. § 114-15-4 and W.Va. Code § 33-25A-17.

Recommendations: The Company should retain all files, including underwriting and declined files in compliance with W.Va. Code § 33-25A-17 and W.Va. Code St. § 114-15-4.

Standard A 8	*NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 8.*
The regulated entity is licensed for the lines of business that are being written.	*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: HPUOV was a licensed Health Maintenance Organization in the State of West Virginia during the period under examination.

Recommendations: None

Standard A 9	*NAIC Market Regulation Handbook – Chapter XVI, § A, Standard 9.*
The regulated entity cooperates on a timely basis with examiners performing the examination.	*W.Va. Code §§ 33-2-9 & 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**

Observations: The Company was cooperative throughout the examination. It provided adequate workspace and responses to requests in a timely manner.

Recommendations: None

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 & 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 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 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, 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 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 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 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, 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: HPUOV had developed a written plan for disposition of complaints. 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

Standard B 3 *NAIC Market Regulation Handbook – Chapter XVI, § B, Standard 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.
W.Va. Code St. R. § 114-53-5.10

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**

The Company provided eighteen (18) WVOIC complaints received during the period under examination. Three (3) were prior to the examination period, four (4) were from ASO members,

and eight (8) were not HPUOV commercial accounts. Therefore, those fifteen (15) files were not tested (N/A). The Company provided fifty-eight (58) informal/internal complaints, and all were sampled. Two were ASO members, and therefore those files were not tested (N/A). The results of testing are as follows:

Table B 3: Finalize and Dispose of WVOIC Complaints						
Type	Population	Sample	N/A	Pass	Fail	% Pass
OIC Complaints	18	18	15	3	0	100%
Internal Complaints	58	58	2	56	0	100%
Total	76	76	17	59	0	100%

Observations: There were no exceptions noted during testing of complaints.

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

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: **Pass**

There were fifty-one (51) brochures, magazines ads, newspaper ads and banners provided by the Company and all were tested. In addition, the Company's website was tested. Therefore, fifty-two (52) advertising items were tested. 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	52	0	52	0	100%
Total	52	0	52	0	100%

Observations: None of the Company's brochures or its website misrepresented its plans or provided information that was misleading.

Recommendations: None

Standard C 2	*NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 2.*
The regulated entity 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 one (1) producer material 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	1	0	0	1	0%
Total	1	0	0	1	0%

Observations: The Company indicated that the agent manual was the only internal producer training and marketing material. Testing determined the agent manual contained the commission schedule that was failed in testing performed at Standard F 3.

In addition, the agent manual allowed for declination of eligible small employer groups when the employer could or would not supply a quarterly wage report, which would restrict the guaranteed availability provisions of W.Va. Code St. R. § 114-54-9.1(a), W.Va. Code § 33-16D-4 and HIPAA

Recommendations: The Company's agent manual should have language that allows guaranteed availability for all small employer groups, and should not allow for declination of eligible small employer groups when the employer could or would not supply a quarterly wage report.

The Company should pay commissions fairly for all small groups

Standard C 3	*NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 3.*
The regulated entity 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: West Virginia does not mandate outlines of coverage for group products. The Company provided its explanation of coverage ("EOC") for its plans and testing of these forms was completed at Standard F 2.

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) & 33-12-18 and 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: **Pass**

The Company provided a listing of eighty-eight (88) appointed producers, and all were tested for this standard. The results of testing are as follows:

Table D 1: Producer Licensing Sample Results					
Type	Population	N/A	Pass	Fail	% Pass
Producers	88	0	88	0	100.0%
Total	88	0	88	0	100.0%

Observations: Testing determined that the Company listing of appointed producers agreed with the WVOIC listing. Therefore, no exceptions were noted during testing.

Recommendations: None

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 a sample of forty-nine (49) newly issued small groups, and forty-two (42) newly issued individual plans sold during the period under examination. The results of testing are as follows:

Table D 2 Producer Licensing sample results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Small Groups	49	49	0	49	0	100%
Newly Issued Individual Plans	42	42	0	42	0	100%
Total	91	91	0	91	0	100%

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

Recommendations: None

Standard D 3 *NAIC Market Regulation Handbook – Chapter XVI, § D, Standard 3.*
Termination of producers complies with statutes regarding notification to the producer and notification to the state if applicable.
W.Va. Code § 33-12-25a and 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 HPUOV. The Company stated that none of its

producers were terminated for cause. Therefore, there were no exceptions were noted during testing of this standard.

Recommendations: None

Standard D 5	*NAIC Market Regulation Handbook – Chapter XVI, § D, Standard 5.*
Records of terminated producers adequately document reasons for terminations.	*W.Va. Code § 33-12-25a and 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 five (5) producers terminated during the period under examination and all were sampled and tested. The results of testing are as follows:

Table D 5 Producer Licensing Sample Results

Type	Population	N/A	Pass	Fail	% Pass
Producers Terminated	5	0	5	0	100.0%
Total	5	0	5	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. However, one terminated producer was on the Company's listing of active agents and when questioned, the Company responded in part, "...agrees no (sic) noted on the Company list as terminated but disagree, not properly reported to OIC, see attached copy...." Therefore, the Company sent notice to the WVOIC and forgot to delete the producers name from its listings, and therefore 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 forty-nine (49) newly issued small groups, and forty-two (42) newly issued individual plans. The results of testing are as follows:

Table E 1 Policyholder Service sample results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Small Groups	49	49	0	49	0	100%
Newly Issued Individual Plans	42	42	0	42	0	100%
Total	91	91	0	91	0	100%

Observations: Typically, the coverages issued by 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-two (62) terminated small groups, and the thirteen (13) individual plans terminated. All policies were 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 Groups Terminated	62	62	0	62	0	100%
Individual Plans Terminated	13	13	0	13	0	100%
Total	75	75	0	75	0	100%

Observations: Testing of the employer small group and individual terminated plans determined the Company was terminating coverage timely. There were no exceptions noted during testing of this standard.

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 incoming mail was screened and then sent to the Company's most appropriate unit for response, based on the nature of the correspondence. Therefore, there were no exceptions noted during testing of this standard.

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 the forty-nine (49) newly issued small groups, and forty-two (42) newly issued individual plans. The results of testing are as follows:

Table E 5 Policyholder Service Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Small Groups	49	49	0	49	0	100%
Newly Issued Individual Plans	42	42	0	42	0	100%
Total	91	91	0	91	0	100%

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

Recommendations: None

Standard E 7 *NAIC Market Regulation Handbook - Chapter X VI, § 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-two (62) terminated small groups, and the thirteen (13) individual plans terminated. None of the individual policies required a return of unearned premium (N/A). However, six (6) of the small group policies had a return of unearned premium and therefore, those files were tested. The results of testing are as follows:

Table E 7 Policyholder Service Sample Results						
Type	**Population**	**Sample**	**N/A**	**Pass**	**Fail**	**% Pass**
Small Groups Terminated	62	62	56	6	0	100%
Individual Plans Terminated	13	13	13	0	0	100%
Total	75	75	69	6	0	100%

***Observations*:** There were no instances during testing where it was determined that the Company had not returned unearned premium timely and in accordance with West Virginia law. The Company indicated that generally, premium is collected for a month in advance and coverage is provided through month end. 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 & 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 a sample of sixty-two (62) terminated small groups, and the thirteen (13) individual plans terminated. The results of testing are as follows:

Table E 8 Policyholder Service Sample Results						
Type	**Population**	**Sample**	**N/A**	**Pass**	**Fail**	**% Pass**
Small Groups Terminated	62	5	0	N/A	N/A	N/A
Individual Plans Terminated	13	13	0	N/A	N/A	N/A
Total	75	18	0	N/A	N/A	N/A

Observations: For the terminated files sampled and tested, none of the files were terminated and then reinstated. 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 & 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: **Pass**

Testing for this standard was performed based on a sample of sixty-two (62) terminated small groups, and the thirteen (13) individual plans terminated. The results of testing are as follows:

Table E 9 Policyholder Service Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Groups Terminated	62	5	0	5	0	100%
Individual Plans Terminated	13	13	0	13	0	100%
Total	75	18	0	18	0	100%

Observations: All of the certificates of creditable coverage ("CCCs") tested were issued in compliance with West Virginia statutes and rules, and HIPAA Therefore, no exceptions were noted during testing of this standard

Recommendations: None

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.

Standard F 1	*NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 1.*
The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company-rating plan.	*W.Va. Code §§ 33-25A-8, 33-25A-24-5 & 33-16D-5*

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**

Testing for this standard was performed based on forty-nine (49) newly issued small groups, and forty-two (42) newly issued individual policies. The results of testing are as follows:

Table F 1 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Newly Issued Individual Plans	42	42	0	42	0	100%
Newly Issued Small Groups	49	49	0	49	0	100%
Total	91	91	0	91	0	100%

Observations: No exceptions were noted during testing of rating for the newly issued small and individual policies.

Recommendations: None

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

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 guides, group and individual contracts and the applications were reviewed to determine if mandated disclosures, benefits and provisions were in compliance with West Virginia laws and HIPAA. The following failures were noted:

- HPUOV failed to comply with W.Va. Code §§ 33-25A-14a and 33-16-3, by providing for the termination of an enrollee's coverage without the required thirty (30) days written notice, for any material misrepresentation on forms other than the enrollment form. The Company stated in part, "We agree... " The Company commented, "EOC language was previously approved by the State"

- HPUOV failed to comply with W.Va. Code §§ 33-16-3l(a), 33-16D-7 and HIPAA, by providing in its Evidences of Coverage ("EOC") for the immediate termination upon written notice of a small group's coverage for failure to comply with contribution and participation rules. The Company's response stated, "HPUOV will delete this sentence from all EOC's and in the same section, new paragraph, add 'HPUOV will refuse to renew a group that fails to comply with a material plan provision relating to contribution or group participations rules." The same termination issue was provided in the employer

small group master application and the small group application. For both issues the Company stated, "HPUOV will change to "A small employer is defined as 'an employer who employed an average of at least two but no more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year.' If a small employer group does not have at least two covered employees on the first day of any plan year, coverage will be terminated as of the next renewal date. The terminated individual will be given the option to elect a non-group conversion policy." The Company commented, "EOC language was previously approved by the State"

- HPUOV failed to comply with W.Va. Code § 33-25A-8(1)(c), by not including a statement in the Evidences of Coverage ("EOC"), that the enrollee is deemed to have consented to the examination of his or her medical records for certain purposes by the health maintenance organization or its designee. The Company's response stated, "The Health Plan will include the specified language in the next EOC filing."

- HPUOV failed to comply with W.Va. Code § 33-16-1a and § 33-16-11, by providing in EOCs for denial of eligibility of a child subject to legal guardianship/custody unless both natural parents were physically or mentally handicapped to the point where they could not take care of the child. The Company failed to provide a valid definition for a dependent child, and its language allowed for denial of coverage for a qualifying child. The Company's response stated, "Agree and will delete this language in all our EOCs."

- The Company's EOC failed to comply with W.Va. Code §§ 33-25A-4 and 33-25A-31, by excluding coverage for the services of chiropractors and podiatrists, thereby discriminating among providers of basic health care services. The Company initially disagreed, but later responded in part, "HPUOV agrees regarding chiropractors and podiatrists.... HPUOV will revise our documents. HPUOV agrees the definition section did not list details regarding Basic Benefits, but feels as though the Schedule of Benefits was thorough... HPUOV will revise the definition of Basic Benefits."

- HPUOV failed to comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by imposing maximum payment amounts on basic health care services. The Company was not allowed to apply basic health care services to the lifetime benefits maximum or the lifetime maximum benefit apply to basic health care services after an individual changed employers or moved between group and individual plans. The Company initially disagreed, but later stated, "HPUOV was under the impression that we were compliant; evidently there was a misunderstanding between HPUOV and the State. HPUOV will revise policies/procedures and documents The Company commented, "EOC language was previously approved by the State"

- The Company failed to comply with W.Va. Code §§ 33-16-31 and 33-16D-7, by providing in some EOCs for ninety (90) rather than 180 days' notice to the commissioner, policyholders and insureds if the Company exits the employer group market. The Company's response stated, "Will revise the HMO to disclose The Company commented, "EOC language was previously approved by the State"

- HPUOV failed to comply with W.Va. Code §§ 33-16-3f, 33-25A-8b and W.Va. Code St. R. § 114-29-4 in its group policies, by not providing a waiver form for employers to decline coverage for temporomandibular/ craniomandibular disorders, or an opportunity for employers to reject coverage for rehabilitation services, or all mandated benefits for the above services if a waiver form was not signed by the employer. The Company stated it agreed and would remedy. The Company commented, "EOC language was previously approved by the State

- The Company's guidelines and policies failed to comply with the dependent age limit provided for under W.Va. Code § 33-16-1a. The Company allowed employers to choose an age limits more restrictive than permitted by West Virginia law. The Company disagreed by stating, "THP & HPUOV are compliant to the fact the we (sic) provide coverage for dependents to the age 25 as insurance law mandates; unless the DOL mandates employers to cover to age 25, THP & HPUVO fail to see how we as a carrier can enforce insurance law on an employer that we both agree is regulated by the DOL." It is agreed that the DOL regulates employers. However, West Virginia statutes and rules regulate what an insurer is allowed to provide in a West Virginia policy, and by providing any employer group with dependent age restrictions of less than 25 years of age the Company did not comply with W.Va. Code § 33-16-1a. An insurer was not allowed to sell a policy in West Virginia that contained provisions that were contrary to West Virginia insurance law.

- The Company failed to provide language that would ensure coverage for all qualified dependent children in violation of W.Va. Code § 33-16-1a. There were several issues raised as to how the Company failed to provide coverage for all qualified dependents. A Company's responses stated in part, "THP/HPUOV will revise language to address 'qualifying child.' Neither THP or HPUOV has ever considered scholarship money part of a child's income. THP/HPUOV has always considered children of the noncustodial parent eligible for coverage." Concerning the requirement for the parents of a custodial parent to be mentally or physically handicapped to the point where they cannot take care of the child the Company stated, "Agree. THP will delete this language in all our COIs. THP/HPUOV will revise language and policies to comply with 501/502 in all COIs & EOCs." Concerning the dependent age limit for handicapped dependent children, the Company stated, "THP/HPUOV will revise language in all COIs & EOCs. THP/HPUOV has always considered children with severe mental illness as handicapped. THP/HPUOV will revise language to better clarify in all COIs & EOCs." Concerning a Dependent child's income, the Company agreed to make corrections. The Company also stated, "THP/HPUOV agrees that some areas may need revision for better clarification and that some areas need revised to comply with 501/152." The Company commented, "EOC/COI language was previously approved by the State"

- Concerning mental health parity, the Company's group plans failed to comply with W.Va. Code St. R. § 114-64-8, by implementing cost containment measures for mental health expenses, before filing: (1) actuarially certified applications to apply those measures, and (2) annual reports of the fiscal impact of such expenses on its group health plans. The Company's response stated in part, "THP & HPUOV were not aware that we needed approval to apply containment measures... THP & HPUOV will remove these

measures to be compliant with parity The Company commented, "EOC/COI language was previously approved by the State"

- HPUOV failed to provide prescription drug riders to employer group members for contraceptive devices coverage in violation of W.Va. Code § 33-16E-4. The Company's response stated, "THP/HPUOV agrees with the contraceptive devices and will remedy." The Company commented the drug rider language was previously approved by the State.

- The Company failed to comply with W.Va. Code St. R. §§ 114-12-5.1(j) and 114-39-5.1(g), by denying coverage in its group and individual policies for all donor-related expenses for organ transplants. The Company's response stated in part, "HPUOV agrees and will remedy... HPUOV/THP agrees we are not covering the benefit incorrectly." Therefore, as a result of the examination the Company has agreed to correct its practices and procedures, and policy language to accurately provide coverage for organ transplants.

- HPUOV failed to comply with W.Va. Code § 33-16-3a, by omitting from its EOCs, the benefits mandated to be provided for some serious mental illnesses, namely substance-related disorders and anorexia and bulimia. The Company's response stated that it covers treatment for serious mental illnesses. However, the EOC language allowed for denial of coverage for some mandated serious mental illness coverage.

- The Company failed to provide benefits in compliance with W.Va. Code § 33-16-3j and the Newborns and Mothers Health Protection Act ("NMHPA"), by denying coverage for the birth and inpatient stay of a newborn and mother and postpartum care of the newborn in the case of a normal, full-term delivery outside the service area. Maternity benefits must be provided regardless of network restrictions. The Company's response stated in part, "I agree with the above.... Copy of corrective action taken is attached." Therefore, as a result of the examination the Company has agreed to supply maternity benefits in compliance with W.Va. Code § 33-16-3j and NMHPA.

- Failure to comply with W.Va. Code § 33-25A-4, by limiting coverage for basic health care services, to services initiated and rendered within six months of the accident in the event of an accidental dental injury. The EOCs provided restrictions requiring hospital and physician services to have been initiated and rendered within six months of the accident and any statement requiring the injury or accident to have occurred while the individual was a member of the Plan. The Company's response stated in part, "...It was never our intention to impose a pre-x nor deny services, it's a matter of deterring abuse, HPUOV remains in disagreement...." The Company commented, "EOC language was previously approved by the State."

- The Company's "Employer Master Application, 2 – 50 Eligible Lives," and its practices and procedures allowed for denying eligible employer small groups guaranteed issue of a small group health plan for not having workers' compensation coverage, which was not in compliance with W.Va. Code §§ 33-16D-4, 33-16D-2(r), and HIPAA. The Company agreed stating in part, "To our knowledge, no employer groups were denied coverage due to this requirement. However, we will remove this language and requirement from our documents due to the findings...."

- The Company's EOCs for the Basic and Standard Plans, Non-Group Individual Plans and Open Enrollment Plan, and the Eligibility Inquiry Form and Open Enrollment Questionnaire provided for non-renewal of these individual market contracts in violation of W.Va. Code § 33-15-2d, HIPAA (P.L. 104-191, Part B, "Individual Market Rules," Section 2743, and 45 CFR § 148.122). The Company had an "ongoing eligibility" provision for termination of an individual plan. The Company initially disagreed, and then later responded, "HPUOV will revise our policies/procedures and documents." As a result of the examination, the Company agreed to correct its policies, procedures and documents to comply with the mandated guaranteed renewability of contracts in the individual market.

- HPUOV's group plans failed to comply with W.Va. Code § 33-25A-14a and HIPAA, which prohibits discrimination against any enrollee based on group coverage, by permitting the disenrollment of Medicare eligible employees from the coverage applicable to other active employees and mandating that those individuals enroll in a plan chosen by the employer from one of the Company's Medicare options. The Company is not allowed to mandate disenrollment of group Medicare eligible employees, and it is not allowed to mandate enrollment of Medicare options at the option of the employer. It is the employee's decision. In addition, by elimination of an enrollee from the group, the Company could affect the employer's minimum participation, which may lead to the termination of the employer's coverage. The Company's response to this issue stated in part, "...may however affect minimum participation." The Company's responses stated it disagreed that its actions were a violation by stating, "*One of the options for the Medicare entitled employee is selecting a Medicare offset plan, whereby the benefits are identical to the non-Medicare entitled employees, but premium is reduced by virtue of the fact that Medicare is the "primary payer" and HPUOV is secondary.*" The Company failed to agree to correct its language, practices and procedures to comply with W.Va. Code § 33-25A-14a and HIPAA.

- The HPUOV group contracts provided notice of Ohio's conversion privilege and not a continuation of coverage provision under W.Va. Code §§ 33-16A-1 and 16A-14. The Company's response stated in part, "HPUOV agrees that the mention of Ohio could be misleading to WV residents; however, HP has always offered conversion to this population. HPUOV will revise documents. Therefore, as a result of the examination the Company agreed to revise its group contracts to comply with West Virginia law.

Recommendations:

The Company should revise its forms, policies and procedures to ensure a 180 day notice period is provided as required under W.Va. Code §§ 33-16-31 and 33-16D-7, in the event the Company exits the employer group market.

The Company should comply with W.Va. Code §§ 33-25A-14a and 33-16-3(a), by revising its EOCs and its policies and procedures to provide for thirty (30) days notice before termination of an enrollee's coverage and ensure that an enrollee's coverage is not cancelled for misrepresentations on any form other than the enrollee's application.

The Company should ensure that none of its forms, practices or procedures provide for non-renewal of any small group plan other than as provided for under W.Va. Code § 33-16-3l, 33-16D-7, 45 CFR § 146.152 and HCFA Transmittal No. 99-03(V). The reference to "any" plan year in the Company's suggested revision should not be used to retrospectively non-renew any small group, because small groups cannot be terminated for falling to one employee except at the plan year renewal.

The Company should include in bold print in its EOC, the statement required under W.Va. Code § 33-25A-8(1)(c), concerning the examination of the enrollee's medical records.

The Company should revise its definition of "Dependent Children" to comply with W.Va. Code §§ 33-16-1a, 33-16-11 and the IRC, and revise its practices and procedures to ensure that any qualifying child subject to legal guardianship/custody is granted coverage if requested.

The Company should comply with W.Va. Code § 33-16-3j and the Newborns and Mothers Health Protection Act (NMHPA), by revising its contracts and policies and procedures to ensure that every contract covering inpatient care in connection with childbirth for a mother and her newborn child, provides that coverage regardless of network restrictions.

The Company should revise all applicable forms containing an exclusion of chiropractic and podiatric services to remove the exclusions and to include those services as covered services. The Company should revise its practices and procedures to ensure that these basic health care services are covered without discrimination among providers, as required under W.Va. Code §§ 33-25A-2 and 33-25A-31. The Company should review its claims received during the examination period and retroactively pay any claims received for these services.

The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its practices and procedures and the EOCs to remove any restriction requiring hospital and physician services to have been initiated and rendered within six (6) months of the accident and any statement requiring the injury or accident to have occurred while the individual was a member of the Plan. The Company should ensure that no claim relating to accidental dental injuries is denied on the basis of the restrictions in the EOCs.

The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its contracts and its policies and procedures to ensure that neither the Lifetime Benefits Maximum nor Lifetime Maximum Benefit apply to basic health care services. The Company should cease applying these restrictions to enforce contracts immediately, and should retroactively pay claims for any basic health care services for which coverage was denied, including services denied after an individual changed employers or moved between group and individual plans.

The Company should comply with W.Va. Code §§ 33-16D-4, 33-16D-2(r) and HIPAA, by revising all relevant employer applications and its policies and procedures to ensure that no eligible small groups are denied issue of a small group plan based on any requirement for employees to be covered by workers' compensation coverage, if such employees are exempt from this requirement under W.Va. Code St. R. § 85-8-4.

The Company should comply with W.Va. Code § 33-25A-14a and HIPAA, by deleting its mandate requiring the employer to enroll its Medicare beneficiaries in one of its Medicare plan

options and should revise its practices and procedures to ensure that coverage for active Medicare employees and dependent Medicare beneficiaries does not change from that applicable to other active employees and their dependents.

The Company should comply with W.Va. Code §§ 33-16A-1 and 33-16A-14, by including West Virginia's conversion privilege in every group contract (EOC) and identify it as pertaining to residents of West Virginia.

The Company should revise its forms, policies and procedures to provide for a minimum limiting age of twenty-five (25) for dependents, and ensure no dependent child under the age of twenty-five (25) is denied or terminated from coverage on the basis of the policy's limiting age. Any other option available to the employer may exceed that age, but not reduce it.

The Company should ensure coverage for all qualified dependent children in compliance with W.Va. Code § 33-16-1a.

The Company should comply with W.Va. Code St. R. § 114-64-8, by filing the required actuarially certified applications and annual report of the fiscal impact of mental health parity expenses and revise its policies and procedures to ensure that these filing requirements are met annually. In addition, it should not implement cost containment measures until it has received the commissioner's approval to do so.

The Company should comply with W.Va. Code § 33-16E-4 and include coverage for prescription contraceptive devices in all prescription drug riders and every contract that includes coverage for prescription drugs.

The Company should comply with W.Va. Code St. R. § 114-39-5.1(g), by revising its policies and procedures to ensure a live donor's expenses for an organ transplant are payable to the extent that benefits remain, and are available after the recipient's own expenses have been paid.

The Company should revise its forms, policies and procedures to ensure coverage is provided for substance-related disorders, anorexia and bulimia, and that such are defined and paid as serious mental illnesses, in compliance with W.Va. Code § 33-16-3a.

The Company's EOCs for its individual plans and the individual forms should provide for guaranteed renewability in compliance with Va. Code § 33-15-2d and HIPAA, by eliminating its "ongoing eligibility" provision for termination.

The Company should comply with W.Va. Code §§ 33-16-3h, 33-16-3f and Code St. R. § 114-29-4, by revising its forms, policies and procedures to provide the benefits mandated under these laws for TMJ, CMD and rehabilitative services, unless the Company has provided a waiver form or other opportunity for the employer to refuse these benefits in writing and the employer has declined the coverage(s) in writing.

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: **Fail**

Testing for this standard was performed based on review of agency contracts and the Company's commission schedules.

Observations: Testing of the Company commission schedules indicated the Company was cutting commissions and bonuses for max-rated small groups, which may have restricted guaranteed issue and renewability in the small group market. During the period under examination, the Company failed to pay commissions fairly to its producers for max-rated small groups, which could have restricted the mandates within W.Va. Code § 33-16D-4, W.Va. Code St. R. § 114-54-9.1(a) and HIPAA. The Company's reduction of commissions and elimination of the bonus program for max-rated groups was not allowed and has been recognized as a method of avoiding the guaranteed availability mandate applicable to all eligible small groups. The Company's response stated, "The Health Plan agrees, and effective immediately will eliminate the MRB provision of our Agent Compensation Agreement and begin compensating agents equilaterally." Therefore, the Company corrected its commission payment structure as a result of the market conduct examination (see testing performed at Standard C 2).

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. In addition, the Company should provide verification of its corrected commission and bonus schedule.

Standard F 4 *NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 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.
W.Va. Code §§ 33-2-9 & 33-25A-17

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 included all underwriting files sampled and tested, and the Company's practices and procedures, underwriting guidelines, evidence of coverage, enrollment guides, group and individual contracts and applications to determine if apparent unfairly discriminatory practices were occurring or allowed in non-compliance with West Virginia laws and HIPAA.

Observations:

- 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 (see the testing performed at Standards C 2 & F 3).

- The Company was terminating an employer and enrollee's coverage when a small group fell to one covered employee with thirty (30) days notice. An insurer can only terminate coverage at the group's plan year renewal for compliance with W.Va. Code §§ 33-25A-14a, 33-16-3l, 33-16D-7, 45 CFR § 146.152 and HCFA Transmittal No. 99-03(V). The Company agreed to discontinue the language and practice (see testing performed at Standard F 2 & F 7).

- The Company's guidelines for declined small group applications stated, "THP Retention Policy is to destroy declined or rejected quotes one (1) year after declination or rejection." This practice allowed for declining employers where testing could not be completed to determine if the employer groups were eligible small groups and therefore, guaranteed coverage in compliance with W.Va. § 33-16D-4(b) and HIPAA (see testing performed at Standard F 7). The Company's guidelines allowed for restricting guaranteed availability for eligible small groups based on whether the employer would, or could supply a copy of a current health care invoice or a copy of the group's most recent Quarterly Wage Statement. The Company agrees to revise as "must supply Quarterly Wage Statement or other viable alternative(s)."

- In addition, guaranteed issue of small employers was also restricted by the Company's underwriting guidelines that allowed for declination when a certain percentage of out of area subscribers was enrolling, when the group has management only employees enrolling, and when the employer did not have workers' compensation coverage. The Company's underwriting guidelines and its practices restricted eligible employer from gaining small group coverage in violation of W.Va. § 33-16D-4(b) and HIPAA (see testing performed at Standard F 7).

- The Company required small employers to enroll its Medicare beneficiaries in one of its Medicare plan options, which was not in compliance with W.Va. Code § 33-25A-14a and HIPAA (see testing performed at Standard F 2). The Company retained a practice and provision the last examination addressed, by allowing for checks of "ongoing eligibility" (eligibility Inquiry Form) for its individual plans, which allowed for termination that would not have been in compliance with guaranteed renewability in W.Va. Code § 33-15-2d and HIPAA (see testing performed at Standard F 2).

- The Company's individual market declination letter and its practices and procedures provided that an applicant must have at least 18 months of creditable coverage under a group health plan within 63 days of enrollment application. As long as the applicant has 18 months of creditable coverage (individual or group) without a break in coverage, and the last coverage was group coverage the individual is a federally eligible individual. During the period under examination the Company failed to determine federal eligibility in compliance with W.Va. Code § 33-15-2b and HIPAA (see testing performed at Standard F 7).

Recommendations: The Company should pay producer commissions and bonuses fairly for all small groups issued.

The Company should only terminate small employers that fall to one enrollee at the end of the group plan year in compliance with guaranteed renewability provisions in West Virginia law and HIPAA.

The Company should retain all declination records to support it is not restricting guaranteed availability in the small group market for compliance with W.Va. Code § 33-16D-4 and HIPAA.

The Company should correct its guidelines, procedures and practices that allowed for restricting guaranteed availability for eligible small groups for compliance with W.Va. § 33-16D-4(b) and HIPAA.

The Company should eliminate its review "ongoing eligibility" (eligibility Inquiry Form) in the individual market to ensure compliance with guaranteed renewability provisions in W.Va. Code § 33-15-2d and HIPAA.

The Company should determine federal eligibility in compliance with W.Va. Code § 33-15-2b and HIPAA.

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 & 33-25A-17 and 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 sixty-four (64) small employer groups declined coverage, and the population of fifty-three (53) individual plans declined coverage. 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.	64	64	0	11	53	17%
Individual declined apps.	53	53	0	52	1	98%
Total	117	117	0	63	54	54%

Observations:

- The Company's declined small group applications stated, "HPUOV Retention Policy is to destroy declined or rejected quotes one (1) year after declination or rejection." The Company followed its guidelines for forty-four (44) files tested, and therefore those files were not available for testing to determine if the declination of coverage was completed in compliance W.Va. Code St. R. § 114-54-9.1(a) and W.Va. Code § 33-16D-4, and HIPAA (see results of testing at A 7). The Company agreed it should have retained the documents, and therefore, as a result of the market conduct examination the Company agreed to correct it practices and procedures by maintaining declined files in compliance with W.Va. Code St. R. § 114-15-4 and W.Va. Code § 33-25A-17.

- The Company's underwriting guidelines stated an employer group could only gain coverage if the employer provided a copy of the current carrier's most recent invoice and a copy of the group's most recent Quarterly Wage Statement. The Company guidelines could restrict an eligible employer from gaining small group coverage.

- The Company declined coverage for five (5) eligible small groups on the basis that the employer could, or would not supply a quarterly wage report

- In addition, for two (2) of the files the Company indicated it declined because it could not write management only groups. For one of the five (5) files above, the Company failed to retain enough records in the file to determine if the small employer would have met the Company's participation guidelines. Therefore, that file was also failed for record retention in violation of W.Va. Code § 114-15-4.3. An insurer is not allowed to mandate that groups from 2 to 50 employees either provide a quarterly wage statement, or a current carrier's most recent invoice, because it may restrict employers right to coverage provided under W.Va. § 33-16D-4(b) and HIPAA. Some eligible employer groups may not have a previous invoice or quarterly wage report because of the ownership of a business, or the length the employer has been in business. To deny an eligible employer small group coverage would not have been in compliance with West Virginia statutes and rules, and HIPAA.

  The Company stated it agreed to make corrections to its underwriting guidelines. However, the new guidelines supplied by the Company continued to mandate both forms as quoting requirements, and the Company argued the declinations were valid because it was necessary to get invoices and quarterly wage reports for verification purposes.

Therefore, the guidelines were not corrected in compliance with West Virginia statutes and rules, and HIPAA.

- The Company's Small Group underwriting guidelines indicated employer small group coverage would be denied when more than ten percent (10%) of the total number of enrolled subscribers were out-of-area subscribers. Three (3) of the sampled files were declined because of the number of out-of-area employees. Neither W.Va. Code § 33-16D-4(b), W.Va. Code St. R. § 114-54-9.1(a), or HIPAA permitted an insurer to deny coverage to a small group of two (2) or more eligible employees on the basis of the percentage of out-of-area members in the employer's group. In addition, for one (1) file the Company failed to retain the documents associated with the declination in violation of W.Va. Code St. R. § 114-15-4.3(b). While the Company may refuse coverage to employees who do not reside, live or work in the carrier's service area, it may not deny a small group plan to an employer who wishes to cover his eligible employees (two or more) who do reside, live or work in the service area, regardless of the number of out-of-area employees. The Company stated it agreed it should not have declined the three (3) files or failed to retain documents for the one (1) file, and as a result of the market conduct examination the Company agreed to correct it practices and procedures associated with declining employers for the number of out-of-area employees.

- For one (1) HPUOV individual plan the denial letter stated, "This applicant's prior coverage was not group coverage." However, the applicant's previous coverage was group coverage. The Company's response stated in part, "The Health Plan agrees the initial denial was sent in error...."

- In addition, for the same applicant (and all declination letters) the Company's declination letter stated the applicant must have at least 18 months of creditable coverage under a group health plan within 63 days of enrollment application. As long as the applicant has 18 months of creditable coverage (individual or group) without a break in coverage, and the last coverage was group coverage the individual is a federally eligible individual. The Company investigated and determined that this individual was the only individual denied coverage for this reason. However, the Company denied a federally eligible individual guaranteed issue coverage in violation of W.Va. Code § 33-15-2b. As a result of the market conduct examination the Company agreed to correct its individual practices and policies concerning federally eligible individuals and to update its declination letters.

Recommendations: The Company should maintain declination files in compliance with W.Va. Code St. R. § 115-15-4.3b, which would provide evidence for the validity of Company small group declinations.

The Company should not deny coverage to small employers that provide evidence they are an eligible small group for compliance with St. R. § 114-54-9.1(a) and W.Va. Code § 33-16D-4 and HIPAA.

The Company should allow all federally eligible individuals guaranteed issue coverage in compliance with W.Va. Code § 33-15-2b.

Standard F 8	*NAIC Market Regulation Handbook – Chapter XVI, § F, Standard 8.*
Cancellation/nonrenewal, discontinuance and declination notices comply with policy provisions, state laws and the regulated entity's guidelines.	*W.Va. Code §§ 33-2-9 & 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: **Fail**

Testing for this standard was performed based on the population of sixty-two (62) terminated small groups and the population of thirteen (13) individual policies 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 Small Groups	62	62	0	54	8	87%
Terminated Individual Policies	13	13	0	11	2	85%
Total	75	75	0	65	10	87%

Observations:

- Testing of the Company's small group terminated plans revealed there were eight (8) small employers terminated when the employer dropped to one (1) covered employee. The Company's Underwriting Guidelines under Medical Underwriting, allowed for small group termination when coverage fell below two (2) enrolled employees as of the first of the following month. To terminate coverage at the next renewal or in 30 days, if not at the date of the plan year renewal was a violation of W.Va. Code § 33-16D-7, W.Va. Code St. § 114-54-6 and HIPAA. In addition, there were seven (7) other terminated group files failed, because the Company failed to provide supporting documentation for a valid termination of the small group. Therefore, those files were failed because a valid termination could not be supported by the Company, and

the files were also failed because documents were not maintained in compliance with W.Va. Code § 33-25A-17 and W.Va. Code St. § 114-15-4. The Company's response stated, "Some of the contracts were cancelled in the middle of the contract year based on our guidelines. In the future, contracts will only be terminated at the end of the plan year. We agree that some of the documents appear to be missing, and the Company will retain all pertinent documents it the future." The Company agreed to correct its termination guidelines and retain documents to support a valid termination of small group coverage as a result of the market conduct examination.

- The Company's termination notice stated the policyholder was terminated for becoming eligible for Medicare. To terminate coverage in the individual market for this reason was not in compliance with W.Va. Code § 33-15-2d and HIPAA, because all individual plans are guaranteed renewable and cannot be cancelled for either Medicare entitlement or eligibility. The Company disagreed citing W.Va. Code § 33-16A-5. However, that statute considers when coverage was required to be issued, and for this policyholder coverage had already been issued, and once coverage was issued the individual plan was guaranteed renewable. Therefore, the file was failed.

- The Company failed to maintain a termination notice in violation of W.Va. Code St. R. § 114-15-4 and W.Va. Code § 33-25A-17. Without the documents the Company could not provide verification of the validity of the termination for compliance with W.Va. Code § 33-15-2d and HIPAA. The Company agreed that it was unable to produce documents to support the validity of the termination.

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.

The Company should only allow termination of small group coverage in compliance with West Virginia statutes and rules and HIPAA.

The Company should only terminate coverage in the individual market when allowed in compliance with W.Va. Code § 33-15-2d and HIPAA. The Company should discontinue "ongoing eligibility" checks in the individual market.

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 & 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**

Observations: The Company stated that it did not rescind coverage for any of its group or individual policies during the period under examination.

Recommendations: None

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, 33-16D-5 & 33-25A-14 and W.Va. Code St. R. § 114-54-3*

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 an HMO, which does not apply preexisting conditions exclusions for any of its members covered under any of its health plans. However, in Standard F 2 testing, the Company agreed to eliminate a provision that allowed for preexisting conditions limitation.

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 & 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: 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 and 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**

There was a population of sixty-four (64) small employer groups declined files and all were sampled for testing. 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	64	64	0	11	53	17%
Total	64	64	0	11	53	17%

Observations:

- The Company failed to retain records for forty-four (44) small employers declined coverage. Therefore, those files were failed because it could not be determined if the employer small groups were declined coverage in compliance with W.Va. Code §§ 33-16D-4 & 7, and HIPAA (see testing performed at Standard F 7).

- The Company failed to pay commissions and bonuses fairly to its producers for max-rated small groups, thereby restricting the mandates of W.Va. Code §§ 33-16D-4 & 7, and HIPAA (see testing performed at Standard F 3).

- The Company declined coverage for five (5) eligible small groups on the basis that the employer could, or would not supply a quarterly wage report. In addition, for two (2) of the files the Company indicated it declined because it could not write management only small groups. An insurer is not allowed to mandate that groups from 2 to 50 employees either provide a quarterly wage statement, or a current carrier's most recent invoice, because it may restrict and eligible employer's right to coverage provided under W.Va. § 33-16D-4(b) and HIPAA (see testing performed at Standard F 7).

- Three (3) of the sampled files were declined because of the number of out-of-area employees. Neither W.Va. Code § 33-16D-4(b), W.Va. Code St. R. § 114-54-9.1(a), or HIPAA permitted an insurer to deny coverage to a small group of two or more eligible employees on the basis of the percentage of out-of-area members in the employer's group. While the Company may refuse coverage to employees who do not reside, live or work in the carrier's service area, it may not deny a small group plan to an employer who wishes to cover his eligible employees (two or more) who do reside, live or work in the service area, regardless of the number of out-of-area employees (see testing performed at Standard F 7).

Recommendations: The Company should allow all eligible small employers coverage in compliance with West Virginia statutes and rules and HIPAA, and it should maintain records to validate it is providing coverage for all small employers that solicit the Company in compliance with the guaranteed issue provisions of West Virginia statutes and rules and HIPAA.

Standard F 13 *NAIC Market Regulation Handbook – Chapter XX, § F, Standard 2.*
Pertinent information on applications that form a part of the policy is complete and accurate.
W.Va. Code §§ 33-25A-14, 33-25A-24 & 33-16D-5

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 population of forty-nine (49) newly issued small groups, and the population of forty-two (42) newly issued individual policies. 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 Individual Plans	42	42	0	42	0	100%
Newly Issued Small Groups	49	49	0	49	0	100%
Total	91	91	0	91	0	100%

Observations: Testing of the small employer group issued applications determined they were legible, identified the producer and requested information in a clear manner.

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 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 & 33-15-2b and 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**

Recommendations: None

G. CLAIMS PRACTICES

Comments: The evaluation of standards in this business area is based on HPUOV's responses to informational items requested by the examiner, discussions with HPUOV 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. 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	*NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 3.*
Claims are resolved in a timely manner.	*W.Va. Code § 33-45-2*

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) in-network paid claims from a population of 701,004, sixty (60) out-of-network paid claims from a population of 10,596, sixty (60) in-network denied claims from a population of 81,894, sixty (60) out-of-network denied claims from a population of 8,409, sixty (60) individual paid claims from a population of 4,201, and sixty (60) individual denied claims from a population of 269. The results of testing are as follows:

Table G 3 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network Paid Claims	701,004	60	0	60	0	100%
Out-of-Network Paid Claims	10,596	60	0	59	1	98%
In-Network CWOP Claims	81,894	60	0	60	0	100%
Out-of-Network CWOP Claims	8,409	60	0	60	0	100%
Individual Paid Claims	4,201	60	0	60	0	100%
Individual CWOP Claims	269	60	0	60	0	100%
Total	806,373	360	0	359	1	99%

Observations: One of the claims tested failed to be paid timely, which was not in compliance with W.Va. Code § 33-45-2(a)(1). The Company's response indicated it agreed it had not paid the claim timely and that interest was properly paid for the claim. There were no other paid or denied files failed for timeliness.

Recommendations: None

Standard G 4 *NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 4.*
The HMO responds to claim correspondence in a timely manner.
W.Va. Code § 33-45-2

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

Results: **Pass**

Observations: HPUOV'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 *NAIC Market Regulation Handbook – Chapter XVI, § G, Standard 5.*
Claim files are adequately documented.
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) in-network paid claims from a population of 701,004, sixty (60) out-of-network paid claims from a population of 10,596, sixty (60) in-network denied claims from a population of 81,894, sixty (60) out-of-network denied claims from a population of 8,409, sixty (60) individual paid claims from

a population of 4,201, and sixty (60) individual denied claims from a population of 269. The results of testing are as follows:

Table G 5 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network Paid Claims	701,004	60	0	60	0	100%
Out-of-Network Paid Claims	10,596	60	0	60	0	100%
In-Network CWOP Claims	81,894	60	0	60	0	100%
Out-of-Network CWOP Claims	8,409	60	0	60	0	100%
Individual Paid Claims	4,201	60	0	60	0	100%
Individual CWOP Claims	269	60	0	60	0	100%
Total	806,373	360	0	360	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.

Recommendations: None

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

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

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) in-network paid claims from a population of 701,004, sixty (60) out-of-network paid claims from a population of 10,596, and sixty (60) individual paid claims from a population of 4,201. The results of testing are as follows:

Table G 6 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network Paid Claims	701,004	60	0	60	0	100%
Out-of-Network Paid Claims	10,596	60	0	59	1	98%
Individual Policy Paid Claims	4,201	60	0	60	0	100%
Total	715,801	180	0	179	1	99%

Observations: For one (1) file, the Company incorrectly processed an emergency visit, which was not in compliance with W.Va. Code § 33-45-2(3). The Company agreed by stating in part, "Claim processed incorrectly processed for...notified provider...."

Recommendations: None

Standard G 7 *NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 7.*
Company claim forms are appropriate for the type of product.
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**

Testing for this standard was performed based on a random sample of: sixty (60) in-network paid claims from a population of 701,004, sixty (60) out-of-network paid claims from a population of 10,596, sixty (60) in-network denied claims from a population of 81,894, sixty (60) out-of-network denied claims from a population of 8,409, sixty (60) individual paid claims from a population of 4,201, and sixty (60) individual denied claims from a population of 269. The results of testing are as follows:

Table G 7 Claims Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network Paid Claims	701,004	60	0	60	0	100%
Out-of-Network Paid Claims	10,596	60	0	60	0	100%
In-Network CWOP Claims	81,894	60	0	60	0	100%
Out-of-Network CWOP Claims	8,409	60	0	60	0	100%
Individual Paid Claims	4,201	60	0	60	0	100%
Individual CWOP Claims	269	60	0	60	0	100%
Total	806,373	360	0	360	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 360 claims sampled, all claims forms utilized were appropriate. 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 HPUOV 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. & 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) in-network denied claims from a population of 81,894 , sixty (60) out-of-network denied claims from a population of 8,409, and sixty (60) individual denied claims from a population of 269. The results of testing are as follows:

Table G 9 Claims Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network CWOP Claims	81,894	60	0	60	0	100%
Out-of-Network CWOP Claims	8,409	60	0	60	0	100%
Individual CWOP Claims	269	60	0	60	0	100%
Total	90,572	180	0	180	0	100%

Observations: All of the tested of group and individual denied claims were handled in compliance with West Virginia statutes and rules.

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) in-network paid claims from a population of 701,004, sixty (60) out-of-network paid claims from a population of 10,596, and sixty (60) individual paid claims from a sample of 4,201. The results of testing are as follows:

Table G 10 Claims Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
In-Network Paid Claims	701,004	60	0	60	0	100%
Out-of-Network Paid Claims	10,596	60	0	60	0	100%
Individual Paid Claims	4,201	60	0	60	0	100%
Total	715,801	180	0	180	0	100%

Observations: The Company's monthly payments of claims were completed by check or electronic funds transfers (EFTs). Claim payments were provided primarily to the providers on a billing basis rather than to a member on a reimbursement basis. The paper claims tested determined the checks were 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 stated there were no litigated files.

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

Observations: HPUOV stated there were no litigated files during the period under examination. 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: For the period under examination, HPUOV's practices and procedures met or exceeded the standards applicable under MHPA. Therefore, there were no exceptions noted during testing of this standard. However, as noted in Standard F 2, the Company was omitting mandated group policy benefits for some serious mental illnesses in violation of W.Va. Code § 33-16-3a.

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 nonrenewals 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 and 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 nonrenewals 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 nonrenewals of enrollee coverage; observance of an enrollee's rights as a patient; and the quality of the health care services rendered."

Results: **Pass**

Observations: HPUOV 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 resolved 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**

The Company provided seventy (70) grievance/appeal files, and all were sampled. During testing it was determined that thirty-nine (39) of the files were from ASO plans or prior to the period under examination. Therefore, those files were not tested. The results of testing are as follows:

Table H 4 Grievance Procedures

Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level I	70	70	39	31	0	100%
Total	70	70	39	31	0	100%

Observations: There were no exceptions noted during testing of the appeals/grievances. The Company's responses were timely and its actions appeared to comply with West Virginia statutes and rules.

Recommendations: None

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**

The Company provided seventy (70) grievance/appeal files, and all were sampled. During testing it was determined that thirty-nine (39) of the files were from ASO plans or prior to the period under examination. Of the thirty-one (31) Level I grievances/appeals tested, only three (3) became Level II appeals/grievances. Therefore, those three (3) files were tested. The results of testing are as follows:

Table H 5 Grievance Procedures

Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level II	3	3	0	3	0	100%
Total	3	3	0	3	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. This 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**

The Company provided seventy (70) grievance/appeal files, and all were sampled. During testing it was determined that thirty-nine (39) of the files were from ASO plans or prior to the period under examination. Therefore, those files were not tested (N/A). Of the thirty-one (31) files tested, none were expedited appeals.

Observations: There were no expedited appeals during the period under examination.

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, § I, 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 and 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 HPUOV 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, § I, 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 and 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. HPUOV 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. 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	*NAIC Market Regulation Handbook - Chapter XX, § I, Standard 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.	*W.Va. Code § 33-25A-8d*

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**

Observations: The Company provided access to emergency care for members both in and outside of the HPUOV network. HPUOV's EOCs and contracts provided its members that were experiencing an emergency medical condition, to go the nearest participating hospital emergency room ("ER"). In addition, they indicated that nonparticipating hospital emergency rooms should only be used when delays 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.

Recommendations: None

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 *NAIC Market Regulation Handbook – Chapter XX, § J, Standard 1.*
The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with statutes, rules, and regulations.
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. W.Va. 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: HPUOV had established a program for credentialing and re-credentialing that was described in its "Credentials Committee Review Guidelines" manual. Both procedures appear to comply with the requirements of W.Va. Code St. R. § 114-53-6. HPUOV had a credentials' committee (chaired by Medical Director and had at least five (5) participating providers), which approved/disapproved and/or recommended credentialing/re-credentialing in accordance with requirements outlined in the HPUOV policies and procedures manual. No exceptions were noted during testing of this standard.

Recommendations: None

Standard J 2 *NAIC Market Regulation Handbook – Chapter XX, § J, Standard 2.*
The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.
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 an arbitrary sample of one page out of the 2008 provider directory, forty-eight (48) providers. 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	48	0	48	0	100%
Total	11,162	48	0	48	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 an arbitrary sample of one page out of the 2008 provider directory, forty-eight (48) 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	48	0	48	0	100%
Total	11,162	48	0	48	0	100%

Observations: Testing determined that all providers in the sample were licensed in the State of West Virginia. All the provider 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 an arbitrary sample of one page out of the 2008 provider directory, forty-eight (48) 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	48	0	48	0	100%
Total	11,162	48	0	48	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: HPUOV required all participating providers to notify it immediately when there were changes in the provider's status. This requirement was provided in both the provider manual, and the provider 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: HPUOV'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: The Company's Plan Executive Management Team is responsible for oversight of credentialing functions and activities. The Board of Directors has appointed personnel as members of this team, and it included the medical director(s). 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 HPUOV'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	*NAIC Market Regulation Handbook – Chapter XX, § L, Standard 1.*
The health carrier establishes and maintains a utilization management program in compliance with statutes, rules, and regulations.	*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. HPUOV's UM program was reviewed for adherence to the guidelines provided under W.Va. Code St. R. § 114-51-1 et seq.

Result: **Pass**

Observations: The policies and procedures for utilization review (UR) indicated the Company provided 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 availability of an external review process was 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 HPUOV's pre-approval. The list of preauthorized services was included in the enrollment guide.

Recommendation: None

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: **Pass**

Observations: The Company's 2008 Utilization Management Program policies and procedures for utilization review (UR) provided a listing of fifty-three (53) function areas including, but not limited to utilization management program, medical advisory committee, role of medical director and criteria for medical appropriateness. Ancillary services required pre-authorization from the medical director, and the medical director was the only individual with the authority to deny services when medical appropriateness was questioned. 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 HPUOV's pre-approval. The list of preauthorized services was included in the enrollment guide. There were no exceptions noted during this testing.

Recommendation: None

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: HPUOV provided 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, § I, 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**

Testing of Level II appeals provided one (1) concurrent review and one (1) retrospective review determinations.. Testing of Level I appeals provided fifteen (15) concurrent review and twelve (12) retrospective review determinations. Therefore, those twenty-nine (29) files were tested and because no errors were noted during this testing, an additional sample of concurrent or retrospective review files was not deemed necessary. The results of testing are as follows:

Table L 4 Utilization Review

Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	29	29	0	29	0	100%
Total	29	29	0	29	0	100%

Observations: Testing determined that HPUOV 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. HPUOV 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. HPUOV's policy mandates that retrospective reviews be processed within thirty (30) calendar days.

***Results:* Pass**

Testing of Level II appeals provided one (1) concurrent review and one (1) retrospective review determinations. Testing of Level I appeals provided fifteen (15) concurrent review and twelve (12) retrospective review determinations. Therefore, those twenty-nine (29) files were tested and because no errors were noted during this testing, an additional sample of concurrent or retrospective review files was not deemed necessary. The results of testing are as follows:

Table L 5 Utilization Review

Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	29	29	0	29	0	100%
Total	29	29	0	29	0	100%

Observations: Testing determined that HPUOV 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**

Testing of Level II appeals provided one (1) concurrent review and one (1) retrospective review determinations. Testing of Level I appeals provided fifteen (15) concurrent review and twelve (12) retrospective review determinations. Therefore, those twenty-nine (29) files were tested and because no errors were noted during this testing, an additional sample of concurrent or retrospective review files was not deemed necessary. The results of testing are as follows:

Table L 6 Utilization Review						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	29	29	0	29	0	100%
Total	29	29	0	29	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. HPUOV 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 K-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**

Testing of Level II appeals provided one (1) concurrent review and one (1) retrospective review determinations. Testing of Level I appeals provided fifteen (15) concurrent review and twelve (12) retrospective review determinations. Therefore, those twenty-nine (29) files were tested and because no errors were noted during this testing, an additional sample of concurrent or retrospective review files was not deemed necessary. The results of testing are as follows:

Table L 7 Utilization Review						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Utilization Review	29	29	0	29	0	100%
Total	29	29	0	29	0	100%

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

Standard L 10 *NAIC Market Regulation Handbook – Chapter XX, § L, Standard 10.*
The health carrier conducts utilization review activities and provides for emergency services in compliance with applicable statutes, rules and regulations.
W.Va. Code §§ 33-2-9 & 33-25A-17

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...." However, for one (1) claim file the Company incorrectly processed an emergency visit (see testing performed at Standard G 6).

Results: Pass

Observations: Testing determined the Company's UM guidelines for emergency services provided for emergency services in compliance with W.Va. Code § 33-25A-8d. The UM emergency service provision stated, "The Plan provides coverage of emergency services to screen and stabilize the member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. In addition, The Plan provides coverage of emergency services if an authorized person, acting on behalf of The Plan, has authorized the provision of emergency services."

Recommendations: None

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*:** The Company's UM guidelines for mental health services stated its utilization standards were provided in compliance with the standards set forth by the Utilization Review Accreditation Commission (URAC). The Company's and provider responsibilities are outlined in the "Practitioners Procedure Manual", which indicated that through utilization management the Company assists members in optimizing their benefits by reviewing and authorizing appropriate services to meet their behavioral health care needs. The Company monitors the activities through the pre-authorization or concurrent review authorization of care, and the review of continued care from Company staff through evaluations from participating providers. There were no exceptions noted during testing of this Standard.

Recommendation: None

LIST OF RECOMMENDATIONS

Recommendation A 7
The Company should retain all files; including underwriting and declination files in compliance with West Virginia record retention statutes and rules.

Recommendation C 2
The Company's agent manual should have language that allows guaranteed availability for all small employer groups, and should not allow for declination of eligible small employer groups when the employer could or would not supply a quarterly wage report. The Company should pay commissions fairly for all small groups.

Recommendation F 2
The Company should revise its forms, policies and procedures to ensure a 180 day notice period is provided as required under W.Va. Code §§ 33-16-3l and 33-16D-7, in the event the Company exits the employer group market.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-25A-14a and 33-16-3(a), by revising its EOCs and its policies and procedures to provide for thirty (30) days notice before termination of an enrollee's coverage and ensure that an enrollee's coverage is not cancelled for misrepresentations on any form other than the enrollee's application.

Recommendation F 2
The Company should ensure that none of its forms, practices or procedures provide for non-renewal of any small group plan other than as provided for under W.Va. Code § 33-16-3l, 33-16D-7, 45 CFR § 146.152 and HCFA Transmittal No. 99-03(V). The reference to "any" plan year in the Company's suggested revision should not be used to retrospectively non-renew any small group, because small groups cannot be terminated for falling to one employee except at the plan year renewal.

Recommendation F 2
The Company should include in bold print in its EOC, the statement required under W.Va. Code § 33-25A-8(1)(c), concerning the examination of the enrollee's medical records.

Recommendation F 2
The Company should revise its definition of "Dependent Children" to comply with W.Va. Code §§ 33-16-1a, 33-16-11 and the IRC, and revise its practices and procedures to ensure that any qualifying child subject to legal guardianship/custody is granted coverage if requested.

Recommendation F 2
The Company should comply with W.Va. Code § 33-16-3j and the Newborns and Mothers Health Protection Act (NMHPA), by revising its contracts and policies and procedures to ensure that every contract covering inpatient care in connection with childbirth for a mother and her newborn child, provides that coverage regardless of network restrictions.

Recommendation F 2
The Company should revise all applicable forms containing an exclusion of chiropractic and podiatric services to remove the exclusions and to include those services as covered services. The Company should revise its practices and procedures to ensure that these basic health care services are covered without discrimination among providers, as required under W.Va. Code §§ 33-25A-2 and 33-25A-31. The Company should review its claims received during the examination period and retroactively pay any claims received for these services.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its practices and procedures and the EOCs to remove any restriction requiring hospital and physician services to have been initiated and rendered within six months of the accident and any statement requiring the injury or accident to have occurred while the individual was a member of the Plan. The Company should ensure that no claim relating to accidental dental injuries is denied on the basis of the restrictions in the EOCs.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-4 and 42 CFR § 417.101, by revising its contracts and its policies and procedures to ensure that neither the Lifetime Benefits Maximum nor Lifetime Maximum Benefit apply to basic health care services. The Company should cease applying these restrictions to enforce contracts immediately, and should retroactively pay claims for any basic health care services for which coverage was denied, including services denied after an individual changed employers or moved between group and individual plans.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16D-4, 33-16D-2(r) and HIPAA, by revising all relevant employer applications and its policies and procedures to ensure that no eligible small groups are denied issue of a small group plan based on any requirement for employees to be covered by workers' compensation coverage, if such employees are exempt from this requirement under W.Va. Code St. R. § 85-8-4.

Recommendation F 2
The Company should comply with W.Va. Code § 33-25A-14a and HIPAA, by deleting its mandate requiring the employer to enroll its Medicare beneficiaries in one of its Medicare plan options and should revise its practices and procedures to ensure that coverage for active Medicare employees and dependent Medicare beneficiaries does not change from that applicable to other active employees and their dependents.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16A-1 and 33-16A-14, by including West Virginia's conversion privilege in every group contract (EOC) and identify it as pertaining to residents of West Virginia.

Recommendation F 2
The Company should revise its forms, policies and procedures to provide for a minimum limiting age of twenty-five (25) for dependents, and ensure no dependent child under the age of twenty-five (25) is denied or terminated from coverage on the basis of the policy's limiting age. Any other option available to the employer may exceed that age, but not reduce it.

Recommendation F 2
The Company should ensure coverage for all qualified dependent children in compliance with W.Va. Code § 33-16-1a.

Recommendation F 2
The Company should comply with W.Va. Code St. R. § 114-64-8, by filing the required actuarially certified applications and annual report of the fiscal impact of mental health parity expenses and revise its policies and procedures to ensure that these filing requirements are met annually. In addition, it should not implement cost containment measures until it has received the commissioner's approval to do so.

Recommendation F 2
The Company should comply with W.Va. Code § 33-16E-4 and include coverage for prescription contraceptive devices in all prescription drug riders and every contract that includes coverage for prescription drugs.

Recommendation F 2
The Company should comply with W.Va. Code St. R. § 114-39-5.1(g), by revising its policies and procedures to ensure a live donor's expenses for an organ transplant are payable to the extent that benefits remain, and are available after the recipient's own expenses have been paid.

Recommendation F 2
The Company should revise its forms, policies and procedures to ensure coverage is provided for substance-related disorders, anorexia and bulimia, and that such are defined and paid as serious mental illnesses, in compliance with W.Va. Code § 33-16-3a.

Recommendation F 2
The Company's EOCs for its individual plans and the individual forms should provide for guaranteed renewability in compliance with Va. Code § 33-15-2d and HIPAA by eliminating its "ongoing eligibility" provision for termination.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-16-3h, 33-16-3f and Code St. R. § 114-29-4, by revising its forms, policies and procedures to provide the benefits mandated under these laws for TMJ, CMD and rehabilitative services, unless the Company has provided a waiver form or other opportunity for the employer to refuse these benefits in writing and the employer has declined the coverage(s) in writing.

Recommendation F 3
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. In addition, the Company should provide verification of its corrected commission and bonus schedule.

Recommendation F 4
The Company should pay producer commissions and bonuses fairly for all small groups issued.

Recommendation F 4
The Company should only terminate small employers that fall to one enrollee at the end of the group plan year in compliance with guaranteed renewability provisions in West Virginia law and HIPAA.

Recommendation F 4
The Company should retain all declination records to support it is not restricting guaranteed availability in the small group market for compliance with W.Va. Code § 33-16D-4 and HIPAA.

Recommendation F 4
The Company should correct its guidelines, procedures and practices that allowed for restricting guaranteed availability for eligible small groups for compliance with W.Va. § 33-16D-4(b) and HIPAA.

Recommendation F 4
The Company should eliminate its review "ongoing eligibility" (eligibility Inquiry Form) in the individual market to ensure compliance with guaranteed renewability provisions in W.Va. Code § 33-15-2d and HIPAA.

Recommendation F 4
The Company should determine federal eligibility in compliance with W.Va. Code § 33-15-2b and HIPAA.

Recommendation F 7
The Company should maintain declination files in compliance with W.Va. Code St. R. § 115-15-4.3b, which would provide evidence for the validity of Company small group declinations.

Recommendation F 7
The Company should not deny coverage to small employers that provide evidence they are an eligible small group for compliance with St. R. § 114-54-9.1(a) and W.Va. Code § 33-16D-4 and HIPAA.

Recommendation F 7
The Company should allow all federally eligible individuals guaranteed issue coverage in compliance with W.Va. Code § 33-15-2b.

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 8
The Company should only allow termination of small group coverage in compliance with West Virginia statutes and rules and HIPAA.

Recommendation F 8
The Company should only terminate coverage in the individual market when allowed in compliance with W.Va. Code § 33-15-2d and HIPAA. The Company should discontinue "ongoing eligibility" checks in the individual market.

Recommendation F 12
The Company should allow all eligible small employers coverage in compliance with West Virginia statutes and rules and HIPAA, and it should maintain records to validate it is providing coverage for all small employers that solicit the Company in compliance with the guaranteed issue provisions of West Virginia statutes and rules and HIPAA.

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, Thomas Ballard, CIE, MCM, FLMI, CFE, ALHC, Charles L. Swanson, MCM, and Brad Beam, MCM, also participated in the examination.

Thomas D. McIntyre

Thomas D. McIntyre, CIE, MCM, CCP, CPCU, FLMI, AIRC, APA, ACS, ARA

EXAMINER'S AFFIDAVIT

State of New Jersey

County of Burlington

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 HPUOV Insurance Company.

2. I have reviewed the examination work papers and examination report, and the examination of HPUOV Insurance Company 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, CCP, CPCU, FLMI, AIRC, APA, ACS, ARA

Subscribed and sworn before me by Thomas D. McIntyre on this 9th day of March 2011.

Susan Keenan

Notary Public

My commission expires 9/29/2015

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April 18, 2011

Ms. Jane L. Cline
Insurance Commissioner
WV Insurance Commission
P.O. Box 50540
Charleston, WV 25305-0540

RE: REPORT OF MARKET CONDUCT EXAMINATION AS OF DECEMBER 31, 2008
NAIC COMPANY CODE 95677
EXAMINATION NUMBER WV014-M19

Dear Ms. Cline:

The Health Plan of the Upper Ohio Valley, Inc. is in receipt of the aforementioned report and agrees to the findings.

Please note, the NAIC Company Code on the report reads 65677, the correct code is 95677.

Sincerely,

Larai A. Doughty
Manager, Marketing Services

ld

c: Phil Wright, President, Health Plan
Dave Mathieu, VP Marketing, Health Plan
Mark Hooker, Chief Market Conduct Examiner, WV Insurance Commissioner

SCANNED

certificate of mailing

RECEIVED
APR 20 2011
MARKET CONDUCT
WVOIC