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

IN RE:
THP INSURANCE COMPANY
NAIC #60016

ADMINISTRATIVE PROCEEDING #
11-MAP-02002

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 **THP Insurance Company** 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. THP INSURANCE COMPANY is a for-profit corporation and issued a certificate of authority to transact life, accident and sickness insurance in the State of West Virginia 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 THP INSURANCE COMPANY 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 March 18, 2010.

2. On March 9, 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 THP INSURANCE COMPANY by certified and electronic mail and was received by THP INSURANCE COMPANY on April 13, 2011.

4. On April 8, 2011, THP INSURANCE COMPANY 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. The examination covered seventy-eight (78) standards and

the Company passed sixty-nine (69) of these standards with four (4) of the passed standards being accompanied by recommendations for actions the Company could adopt to improve its operations. The remaining nine (9) standards examined fell short of the error tolerance standard established for this examination and therefore, failed those standards. Of the nine (9) standards, one (1) was associated with Company Operations and Management, one (1) was associated with Marketing and Sales, and seven (7) were associated with Underwriting and Rating.

6. On April 18, 2011, THP INSURANCE COMPANY 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. THP INSURANCE COMPANY 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 of the subject matter and the parties to this proceeding.

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

3. That THP INSURANCE COMPANY has incurred violations of West Virginia Code including but not limited to: §§33-2-9, 33-16D-4 & 7, 33-15-2b, 33-25A-14a, 33-45-2(a) 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 THP INSURANCE COMPANY as well as all other provisions of state and federal regulation that THP INSURANCE COMPANY is subjected to by virtue of their Certificate of Authority to operate in the State of West Virginia.

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 THP INSURANCE COMPANY'S response thereto, the Insurance Commissioner and THP INSURANCE COMPANY 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 THP INSURANCE COMPANY as set forth below.

It is accordingly **ORDERED** as follows:

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

(B) It is **ORDERED** that THP INSURANCE COMPANY will **CEASE AND DESIST** from failing to comply with the statutes, rules and regulations of the State of West Virginia or other relevant federal law 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 THP INSURANCE COMPANY 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, THP INSURANCE COMPANY 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 THP INSURANCE COMPANY shall ensure compliance with the West Virginia Code and the Code of State Rules. THP INSURANCE COMPANY 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 THP INSURANCE COMPANY shall file a Corrective Action Plan which will be subject to the approval of the Insurance Commissioner. The Corrective Action Plan shall detail THP INSURANCE COMPANY'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. THP INSURANCE COMPANY shall implement reasonable changes to the Corrective Action Plan if requested by the Insurance Commissioner within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan. The Insurance Commissioner shall provide notice to THP INSURANCE COMPANY if the Corrective Action Plan is disapproved and the reasons for such disapproval within thirty (30) days of the Insurance Commissioner's receipt of the Corrective Action Plan.

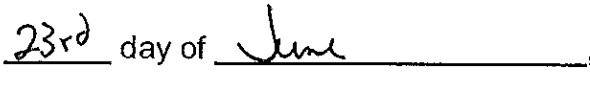
(G) The Insurance Commissioner has determined and it has been agreed by THP INSURANCE COMPANY and therefore, it is hereby **ORDERED** that THP INSURANCE COMPANY shall pay an administrative penalty to the State of West Virginia in the amount of **Five Thousand Dollars ($5,000.00)** for non-compliance 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 THP Insurance Company.

(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 THP Insurance Company shall not be responsible for any violations or corrective action concerning such conflict.

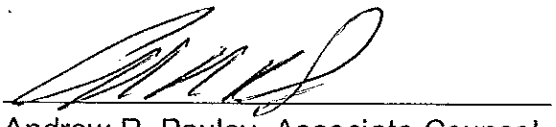
Entered this 23rd day of June, 2011.



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 THP INSURANCE COMPANY:

By: Philip D. WRIGHT
[Print Name]

Its: PRESIDENT/CEO

Signature: Philip D. Wright

Date: 6/3/11

NAIC# 60016
Exam# WV014-M18

THP INSURANCE COMPANY (THP), 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. THP 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 conversion forms and policies and procedures to comply with W.Va. Code § 33-16A-8 and HMHPA, and ensure that claims for childbirth and routine nursery care are paid if the pregnancy existed at the time of conversion.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented and began revising our documents. We did a claims check to assure claims were not denied.

Recommendation F 2
The Company should eliminate conversion language relating to the imposition of preexisting conditions limitation and should revise it polices and procedures to ensure that no such limitation is imposed.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented and began revising our documents. We did a claims check to assure claims were not denied.

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-6-6 and 33-15-4 by revising its group and conversion policies, and it policies and procedures to ensure that no policy is voided and no claim is denied based on an applicant's statements unless those statements are made on the application for coverage and a copy of the application has been attached to or otherwise made a part of the policy when issued.

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

Recommendation F 2
The Company should comply with W.Va. Code §§ 33-15-4c and 33-16-3g by revising forms, policies and procedures to ensure that mammograms are paid subject to the same deductibles, coinsurance and other limitations that apply to other covered services. The Company should review its claims payment for mammography during the period under examination, and should reimburse any insured whose claims have been limited by contract wording.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented and began revising our documents. We did a claims check to assure claims were not denied.

Recommendation F 2
The Company should revise every form and individual policy that requires proof of the policyholder's "ongoing eligibility," and any provision that provided for termination of any individual policy, and revise its practices and procedures to ensure that its policies are guaranteed renewable, in compliance with state and federal laws.

Corrective Action
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 2
The Company should comply with W.Va. Code §§ 33-16-A-10 and 33-15-4a, by offering a conversion policy providing the benefits required under those Codes.

Corrective Action
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 2
The Company should revise its conversion policies to state that any preexisting condition not excluded under the group policy from which conversion was made will be covered under the conversion policy.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately implemented and began revising our documents. We did a claims check to assure claims were not denied.

Recommendation F 2
The Company should revise its policy forms, policies and procedures to ensure that employer groups are terminated only a renewal in the event participation fails to meet the Company's participation requirements. In the case of a group of two (2) that falls to one (1) covered employee, termination may only be effected at the first renewal following the new plan year.

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.

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 §§ 33-16-3h, 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 2
The Company should revise its PPO and POS policies to reflect the requirements of W.Va. Code § 33-16-1a, and should review its policies and procedures to ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date in compliance with W.Va. Code § 33-16-3k.

Corrective Action
We supplied documentation that we were processing correctly but the reviewer had a wording issues. We agree to change effective date to enrollment date which we considered one in the same.

Recommendation F 2
The Company should revise its forms, polices 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 based on 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 revise its policies to ensure that qualifications for dependent child eligibility complies with W.Va. Code § 33-16-1a. In addition, the Company should revise its policies and procedures to ensure that no qualifying dependent child is denied coverage, or terminated from coverage due to the policy language.

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 § 33-16-3k, by revising its practices and procedures and its policies to remove any restriction requiring hospital and physician serviced to have been initiated and rendered within six (6) months of the accident.

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 Conversion COIs. 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 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 stated as covered. We agreed to specifically address.

Recommendation F 2
The Company should revise its policy forms, policies and procedures to ensure that air ambulance service is always covered in a true emergency.

Corrective Action
The Company did/does provide coverage for the above it just wasn't specifically stated as covered. We agreed to specifically address.

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. THP 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. THP 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 (1) 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 5
The Company should comply with W.Va. Code §§ 33-29-5 and 33-15-2 by revising its contracts, riders and policies and procedures to ensure that a form number appears on each form and to ensure that each policy's Table of Contents contains page numbers.

Corrective Action
We agreed and began revising our contracts, rider and polices and procedures.

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 of being an eligible employer small group for compliance with St. R. § 114-54-9.1(a) and W.Va. Code § 33-16D-4.

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 8
It is recommended THP provide evidence its corrected its guidelines to only allow termination at the plan year renewal when an employer group falls to one (1) covered employee.

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 10
The Company should comply with W.Va. Code § 33-16-3k by revising its practices and procedures and policies to remove any restriction requiring hospital and physician services to have been initiated an rendered within six (6) months of the accident.

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 Conversion COIs. We agreed to delete and did a claims check to assure claims were not denied in error.

Recommendation F 12
The Company should retain records in compliance with W.Va. Code §§ 33-16D-4.

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 12
The Company should pay commissions and bonuses fairly to its producers for max-rate small groups.

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. THP 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 12
The Company should not decline small groups on the basis that the employer could not or would not supply a quarterly wage report or an insurer's most recent invoice.

Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the mandate for the quarterly wage report or insurer's most recent invoice and revised our agent manual and policies and procedures.

Recommendation F 12
The Company should not decline management only small groups if they are eligible small employers.

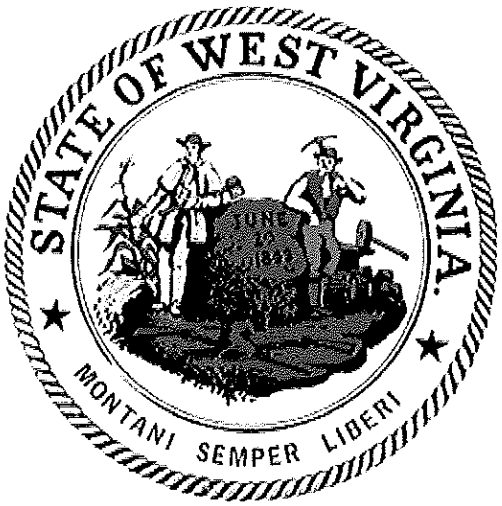
Corrective Action
At the time the reviewer brought the above to our attention, we immediately ceased the mandate and revised our agent manual and policies and procedures.

Recommendation F 12
The Company should not decline an eligible small employer based on the percentage of out-of-area members in the employer's group.

At the time the reviewer brought the above to our attention, we immediately ceased the mandate and revised our agent manual and policies and procedures.

Report of Market Conduct Examination

As of December 31, 2008



THP Insurance Company
52160 National Road, East
St. Clairsville, OH 43950

NAIC COMPANY CODE 60016
Examination Number WV014-M18

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March 9, 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

THP INSURANCE COMPANY
52160 National Road, East
St. Clairsville, OH 43950

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

SCOPE OF EXAMINATION

The basic business areas examined 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 determined 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 March 18, 2010. The examination covered seventy-eight (78) standards from the 2009 NAIC Market Regulation Handbook. The Company passed sixty-nine (69) of these standards with four (4) of the passed standards being accompanied by recommendations for actions the Company could adopt to improve its operations. The remaining nine (9) standards examined fell short of the error tolerance standard established for this examination and therefore, failed those standards. Of the nine (9) failed standards, one (1) was associated with Company Operations and Management, one (1) was associated with Marketing and Sales, and seven (7) 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 Company's policy forms, policies and procedures allowed for termination of small employer groups within thirty (30) days notice when a group fell to one (1) 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 THP 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 violation of W. Va. Code § 33-2-9(g) and W. Va. Code St. R §§ 114-15-4.2 and 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.
- Conversion policies should be offered and issued in compliance with West Virginia statutes and rules.
- The Company continued 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 was not marketing individual products, but still have guaranteed renewable individual policies in force.
- The Company failed to file small and large group rates with the WVOIC during the period under examination prior to issuing or renewing policies with those rates. The Company filed its current rates during the period under examination.
- The Company failed to provide some mandated benefits or provisions in compliance with West Virginia statutes and rules, including but not limited to: mammograms, preexisting conditions, TMJ and CMD and rehabilitative services waiver, and qualified dependents and age limits for dependents.
- The Company failed to pay some claims timely and accurately, and pay interest when applicable in compliance with W. Va. Code § 33-45-2(a).
- The Company should ensure that policyholders are not paying amounts greater than an out-of-network, out of pocket maximum amount in compliance with W. Va. Code § 33-45-2(a).
- The Company should eliminate any benefit provisions that restrict preexisting conditions in a manner that does not comply with West Virginia statutes and rules, 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 claims errors for members, change its records retention practices, correct language associated with its certificates of coverage ("COCs"), correct underwriting guidelines, and correct commission payments for its max-rated small groups.

COMPLIANCE WITH PREVIOUS EXAMINATION FINDINGS

The prior examination of the Company by the West Virginia Offices of the Insurance Commissioner ("WVOIC") was conducted as of December 31, 2003. The report of that examination disclosed five (5) recommendations for corrective actions to be completed by the Company. The determination of the Company's actions subsequent to the recommendations was noted by this current examination and is as follows:

Recommendation A-8
It is recommended that THP amend its premium tax returns to include the entire premium for its POS product and pay any additional premium taxes to the West Virginia Insurance Commissioner.

> *This examination determined the Company adequately addressed this recommendation. The Company paid the premium taxes and it filed for, and received approval to write a Preferred Provider Organization ("PPO") plan during November of 2003.*

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 agent's 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 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 THP establish an internal control mechanism to ensure that its group plans are only serviced by agents who are properly appointed by the Company.

> *This examination determined the Company adequately addressed this recommendation. The Company established internal controls for ensuring producers were licensed and appointed prior to accepting small group applications. For all group plans tested during the examination, the producers were licensed and appointed.*

Recommendation J-1
It is recommended that THP 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 failed to adequately address this recommendation. The Company returned premiums to employer groups as recommended; however, it issued small group plans with rates that were not filed and approved by the WVOIC.*

Recommendation J-5
It is recommended that the Company conform its underwriting guidelines to be consistent to W. Va. § 33-16D-3.

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

HISTORY AND PROFILE

The Company incorporated on March 1, 1999, and organized as a for-profit corporation. On April 13, 1999, the WVOIC issued a certificate of authority to transact life and accident and sickness insurance in the State of West Virginia. The Company is a member of a holding company system, with the Health Plan of the Upper Ohio Valley ("HPUOV") being the parent company. The Company offers Point of Service ("POS") and Preferred Provider Organization ("PPO") plans in the group market. It is not marketing in the individual market. Under the terms of the POS product, a member has the option to receive services from physicians and hospitals outside HPUOV's network. The Company pays the out-of-network claims whereas HPUOV pays the in-network claims. The Company also provides a PPO Medicare Advantage plan. Its plans are typically provided as one-year contracts.

HPUOV performs the day-to-day operations of the Company under the terms of an administrative services agreement that became effective May 17, 1999. Some of the functions that HPUOV performs under the agreement include accounting, regulatory services, marketing, financial reporting, claims processing and related support services. In return for these services, the Company pays a monthly fee based on a fixed percentage of premiums.

As of December 31, 2008, THP was the sixth largest provider of Group Accident and Sickness coverage in West Virginia with approximately one percent (1%) 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 § 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: THP had both internal and external audit processes in place during the period under examination. THP 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 §§ 33-41-1 et 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. THP'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*

Comments: 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 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 § 33-12-25*

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: THP 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 records retention requirements.	*W. Va. Code St. R. § 114-15-4 & W. Va. Code § 33-2-9*

Comments: The review methodology for this standard is generic. The standard has 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 THP plan failed to require that 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 revised its record retention policies.

The Company failed to retain any documents for forty-four (44) small group declined 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). In addition, for another declined file the Company failed to retain sufficient documents to support a valid declination. Failure to maintain documents for five 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 § 33-2-9. The Company provided declination guidelines that stated, "THP 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 associated with declined files for compliance with West Virginia statutes and rules. As a result of the market conduct examination, THP agreed to update its practices and procedures for retaining employer group declined files. The Company also failed to retain documents associated with a terminated individual plan, which was not in compliance with W. Va. Code St. R. § 114-15-4. The Company agreed.

Recommendations: The Company should retain all files, including underwriting files, in compliance with West Virginia record retention statutes and rules.

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 §§ 33-3-1 et. seq.*

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

Results: **Pass**

Observations: THP was a licensed Accident and Sickness insurer 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*

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 St. R. §§ 114-57-1, et seq.*

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

Recommendations: None

Standard A 16	*NAIC Market Regulation Handbook– Chapter XVI, § A, Standard 16.*
The company has policies and procedures in place so that nonpublic personal health information will not be disclosed except as permitted by law unless a customer or a consumer who is not a customer has authorized the disclosure.	*W. Va. Code St. R. § § 114-57-1, et seq.*

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

Results: **Pass**

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

Recommendations: None

Standard A 17	*NAIC Market Regulation Handbook– Chapter XVI, § A, Standard 17.*
Each Licensee shall implement a written information security program for the protection of nonpublic customer information.	*W. Va. Code St. R. § 114-62-1, et seq.*

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

Results: **Pass**

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

Recommendations: None

B. COMPLAINT HANDLING

Comments: Evaluation of the standards in this business area is based on Company responses to various information requests and complaint files at the Company. Insurers are subject to W. Va. Code § 33-11-4 (Unfair Trade Practices Act) and therefore there are specific periods required for responses to complaints received at the Offices of the Insurance Commissioner. Some complaints become appeals and testing of appeals are included 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 § 33-11-4*

Comments: The review methodology for this standard is generic and sample. The standard does not have a direct regulatory requirement. The standard is concerned with whether the Company actions comply with the requirements under W. Va. Code § 33-11-4.

Results: **Pass**

Observations: THP had developed a written plan for disposition of complaints, and it appeared adequate. 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 § 33-11-4*

Comments: The review methodology for this standard is generic. The standard does not have 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 two (2) WVOIC complaints, and both were sampled and tested. The results of testing the two (2) WVOIC complaint files determined that both passed as indicated below. All internal complaints were treated as grievances (see testing performed at "H. Grievance Procedures"). 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	2	2	0	2	0	100%
Total	2	2	0	2	0	100%

Observations: No exceptions were noted during testing of WVOIC 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 insurer 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 § 33-11-4*

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 THP 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: The fifty-one advertising materials utilized during the period under examination, and the website did not misrepresent plans or provide information that was misleading. Therefore, no exceptions were noted during testing of this standard.

Recommendations: None

Standard C 2	*NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 2.*
Regulated entity internal producer training materials are in compliance with applicable statutes, rules and regulations.	*W. Va. Code § 33-11-4*

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 insurer 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. This could have restricted 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. It should not decline eligible small employer groups when the employer could or would not supply a quarterly wage report. In addition, the Company should pay commissions fairly for all small groups.

Standard C 3	*NAIC Market Regulation Handbook - Chapter XVI, § C, Standard 3.*
Regulated entity communications to producers are in compliance with applicable statutes, rules and regulations.	*W. Va. Code § 33-11-4*

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 insurer 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 § 33-28-6*

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 insurer to its insureds through outlines of coverage.

Results: **Pass**

Observations: West Virginia does not mandate outlines of coverage for group products. The Company provided its certificates of coverage ("COCs") 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 § 33-12-18 and W. Va. Code St. R. §§ 114-2-1 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-seven (87) 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	87	0	87	0	100.0%
Total	87	0	87	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 §§ 33-12-1et seq.

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 on the population of sixty-eight (68) newly issued small groups. The Company was not marketing in the individual market 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	68	68	0	68	0	100%
Total	68	68	0	68	0	100%

Observations: Testing determined that all the producers associated with the newly issued employer 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 placements of insurance by unlicensed producers.

Results: **Pass**

Observations: The Company's listing of terminated producers revealed the WVOIC was notified of producers that were terminated by THP. The Company stated that none of its producers was terminated for cause. Therefore, there were no exceptions 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. § 114-15-4.5

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 that 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 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 was terminated for cause. However, one terminated producer was on the Company's listing of active agents and when questioned, the Company responded in part, "THP agrees no *(sic)* noted on the Company list as terminated but disagree, not properly reported to OIC, see attached copy...." The Company sent notice to the WVOIC and forgot to delete the producer's 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 sixty-eight (68) newly issued small groups. The Company was not marketing in the individual market during the period under examination. 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	68	68	0	68	0	100%
Newly Issued Individual Plans	0	0	0	0	0	100%
Total	68	68	0	68	0	100%

Observations: Typically, when coverage was issued the Company strived to have enrollment guides (member handbooks) and ID cards available for employer groups or members, on or before the effective date of coverage. In addition, premium was due prior to coverage issuance,

and in all instances premium notices appeared to provide employers with an adequate amount of advance notice. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard E 2 *NAIC Market Regulation Handbook - Chapter XVI, § E, Standard 2.*
Insured-requested cancellations are timely.

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 fifteen (15) terminated small groups and the four (4) individual plans terminated. The results of testing are as follows:

Table E 2 Policyholder Service Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Small Group Cancellations	15	15	0	15	0	100%
Individual Cancellations	4	4	0	4	0	100%
Total	19	19	0	19	0	100%

Observations: Testing of the employer small group and individual terminated plans determined the Company was terminating coverage accurately and 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 regulated entity 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 sixty-eight (68) newly issued small groups. There were no individual plans issued. 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	68	68	0	68	0	100%
Newly Issued Individual Plans	0	0	0	0	0	0%
Total	68	68	0	68	0	100%

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

Recommendations: None

Standard E 7 *NAIC Market Regulation Handbook - Chapter 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. § 33-6C-5

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 fifteen (15) terminated small groups and the four (4) individual plans terminated. 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	15	15	0	15	0	100%
Individual Plans Terminated	4	4	0	4	0	100%
Total	19	19	0	19	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, so rarely is there a return of unearned premium. 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 & 33-15-4

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

Results: **Pass**

Testing for this standard was performed based on the sixty-eight (68) newly issued small groups, the fifteen (15) terminated small groups and the four (4) individual plans terminated. There were no individual plans issued. Testing of the files indicated none of the policyholders or employer groups were reinstated during the period under examination. The results of testing are as follows:

Table E 8 Policyholder Service Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Individual Terminated	4	4	4	0	0	N/A
Small Groups Terminated	15	15	15	0	0	N/A
Newly Issued Small Groups	68	68	68	0	0	N/A
Total	87	87	87	0	0	N/A

Observations: There were no cases where a terminated file was reinstated. However, the Company guidelines for reinstatement were reviewed and it was determined the guidelines allowed for compliance with West Virginia statutes and rules. Therefore, no further testing was deemed necessary. 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

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 § 33-16D-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 with and approved by the WVOIC. 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: **Fail**

Testing for this standard was performed based on the population of sixty-eight (68) newly issued small groups and six (6) newly issued large groups. The Company was not in the individual market, except for its conversion plans. 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 Small Groups	68	68	0	0	68	0%
Newly Issued Large Groups	6	6	0	0	6	0%
Newly Issued Individual Plans	0	0	0	0	0	N/A
Total	74	74	0	0	74	0%

Observations: The Company failed to file the base rates utilized during the period under examination for all issued small and large groups. Testing determined the sixty-eight (68) small groups and six (6) large groups sampled were rated in violation of W. Va. Code § 33-16B-1. In addition, all the groups issued and renewed during the period under examination were issued or renewed with rates that were not filed with the WVOIC in violation of W. Va. Code § 33-16B-1. The Company agreed it failed to file the rates used during the period under examination.

Recommendations: The Company filed its current rates during the period under examination. The Company should ensure that all rates are filed with the WVOIC prior to issuing or renewing policies with those rates.

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*

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, certificates of coverage ("COCs"), enrollment guides, group 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:

- THP failed to provide benefits for childbirth and routine nursery care in conversion policies in violation of W. Va. Code § 33-16A-8, for an insured who is pregnant at inception of coverage. The Company's response stated, "THP agrees, and will remedy immediately. We've also done a claims check and found no denied services for pregnancy." The Company commented, "COI language was previously approved by the State."

- THP failed to comply with W. Va. Code § 33-16A-8, by imposing a preexisting conditions limitation under the Basic and Standard conversion policies for conditions that occurred within the first two years of coverage under the group policy. The Company's response stated, "THP agrees that the paragraph in question may appear to provide for the imposition of a preexisting even though that was not our intent. THP will delete this paragraph from the COIs. The Company commented, "COI language was previously approved by the State."

- THP's group and conversion policies failed to comply with W. Va. Code §§ 33-6-6 and 33-15-4, by providing that a written "instrument" may be used to void coverage or deny a claim. A policy could not be voided, and no claim could be denied based on an applicant's statements unless those statements were made on the application for the coverage or policy and a copy of the application was attached to or otherwise made a part of the policy when issued. The Company's response stated, "THP agrees and will

remedy." The Company commented, "COI language was previously approved by the State."

- The Company's group and basic and standard conversion policies failed to reimburse mammography claims on the "same as" basis required under W. Va. Code §§ 33-15-4c and 33-16-3g. Therefore, the Company was requested to determine if insureds coverage was limited in compliance with its group and conversion policy wording and if the insureds should be reimbursed for claim payments for mammography during the period under examination. The Company's response concerning the conversion policies stated, "THP agrees and will remedy immediately. THP also did a claims check and we have not received any claims for mammography for these two plans." However, its initial response did not indicate it agreed for the group mammography claims. The Company's second response stated, "Per our Claims Director, under THP Group, Basic & Standard plans, payments were based on other medical/surgical benefits within the particular plan; therefore, claims were processed correctly. THP will revise documents." The Company commented, "COI language was previously approved by the State."

- THP failed to comply with W. Va. Code § 33-15-21, by limiting emergency transport to local, ground ambulance services in a manner not allowed. The Company's response stated, "THP agrees the language is poorly written. THP has never denied any air ambulance services simply because we have not had any requests for this service under these policies. THP will revise the language." The Company commented, "COI language was previously approved by the State."

- The Company failed to comply with W. Va. Code § 33-15-2d and HIPAA, by denying guaranteed renewability of individual contracts. The individual policies (conversion plans) had an ongoing eligibility provision that allowed the Company to terminate a policy for reasons that were not allowed. The Company's first response stated that it disagreed. Its second response stated, "THP & HPUOV will revise policies/procedures and documents." As a result of the examination, the Company agreed to correct and update its practices and policies for compliance with WV statutes and rules, and HIPAA.

- THP failed to offer a conversion policy, which provided benefits in compliance with the requirements of W. Va. Code §§ 33-16A-10 and 33-15-4a. The Code requires the offer of a conversion policy with a Lifetime Maximum Benefit of at least $250,000 if the group policy from which the insured converted, provided a Lifetime Maximum Benefit of more than $250,000. As an alternative to the $250,000 Lifetime Maximum, the Company was allowed to provide a $250,000 maximum benefit for each unrelated sickness or injury. In addition, the Company failed to offer mental health benefits as mandated. The Company's response stated it agreed. The Company commented, "COI language was previously approved by the State."

- The Company's conversion policies failed to cover preexisting conditions covered under the group policy, in violation of W. Va. Code § 33-16A-8. The conversion policies failed to provide coverage of any preexisting condition not excluded under the group policy from which conversion was made. The Company's response stated it agreed and it would

revise the conversion policies. The Company commented, "COI language was previously approved by the State."

- THP failed to provide for termination of group policies only at renewal, as required under W. Va. Code §§ 33-16-31 and 33-16D-7. In the case of a group of two that falls to one covered employee, termination may only be affected at the first renewal following the new Plan Year (see testing performed at F 8, a small group was invalidly terminated for this reason). The Company response stated it agreed and was making the necessary corrections.

- The Company failed to comply with W. Va. Code §§ 33-16-31 and 33-16D-7, by providing in some certificates of coverage (policies) 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 in part, "Agree with...POS COI from January 2006 thru September 2-, *(sic)* 2007 does not disclose the '180' but the POS COI for September 30, 2007 thru December 31, 2008 does." "Agree the PPO COI from January 2006 thru September 29, 2007 does not disclose the '180' but the PPO COI from September 30, 2007 thru December 31, 2008 does." The Company commented, "COI language was previously approved by the State."

- THP failed to comply with W. Va. Code §§ 33-16-3f, 33-16-3h 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 is not signed by the employer. The Company stated it agreed and would remedy. Company indicated a misunderstanding concerning THP and the State. THP re- implemented waiver requirement. Further THP commented that the COI language had been previously approved by the State.

- The Company failed to correctly define the look-back period for "preexisting conditions," in violation of W. Va. Code §§ 33-16-1a and W. Va. Code 33-16-3k, and HIPAA. The Company should ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date. The Company initially disagreed, and later indicated it agreed and would revise policy (COI) language to mirror that in West Virginia statutes.

- THP'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 age limits more restrictive than permitted by West Virginia law. The Company disagreed by stating, "THP & HPUOV are compliant to the fact the *(sic)* we provide coverage for dependents to the age 25 as insurance law mandates; unless the DOL mandates employers to cover to age 25, THP & HPUOV fail to see how we as a carrier can enforce insurance law on an employer that we both agree is regulate *(sic)* 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. Providing any employer group with dependent age restrictions of less than 25 years of age 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. Company responses stated in part, "THP/HPUOV will revise language to address 'qualifying child.' Neither THP nor 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 child 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 501/502." The Company commented, "COI/EOC language was previously approved by the State."

- THP group policies failed to comply with W. Va. Code §§ 33-16-3k and 33-16-1a(k), and HIPAA, by limiting medical care for some accidental injuries. The Company restricted hospital and physician services to services that have been initiated and rendered within six months of the accident. In addition, the Company should ensure that no claim relating to accidental dental injuries is denied based on the restrictions in its policies. The Company disagreed initially, but later stated in part, "...for THP the "rendered within six months" language could be construed as a permanent preexisting condition. THP & HPUOV will revise policies/procedures and documents."

- 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, "COI/EOC language was previously approved by the State."

- The Company failed to comply with W. Va. Code St. R. § 114-39-5.1(g), by denying coverage in group policies for all donor-related expenses for organ transplants. The Company's response stated, "HPUOV/THP agrees we are not covering the benefit incorrectly." The Company commented that the previous language was approved by the State.

- THP failed to comply with W. Va. Code § 33-16-3a, by omitting from the group policies, the benefits mandated to be provided for some serious mental illnesses, namely substance-related disorders and anorexia and bulimia and imposing contract year maximum "encounters" for serious mental illnesses, which are not permitted to be imposed for serious mental illness if those maximums do not apply to other medical and surgical benefits. The Company's response stated, "THP agrees that the definitions were missing and will remedy, but the cited disorders are and have been covered services. After review by our in-house counsel, THP agrees that substance abuse needs to be covered as all other medical and surgical benefits." The Company commented, "COI language was previously approved by the State."

- ***Recommendations:*** The Company should revise its conversion forms and policies and procedures to comply with W. Va. Code § 33-16A-8 and NMHPA, and ensure that claims for childbirth and routine nursery care are paid if the pregnancy existed at the time of conversion.

The Company should eliminate conversion language relating to the imposition of a preexisting conditions limitation and should revise its policies and procedures to ensure that no such limitation is imposed.

The Company should comply with W. Va. Code §§ 33-6-6 and 33-15-4, by revising its group and conversion policies, and its policies and procedures to ensure that no policy is voided and no claim is denied based on an applicant's statements unless those statements are made on the application for coverage and a copy of the application has been attached to or otherwise made a part of the policy when issued.

The Company should comply with W. Va. Code §§ 33-15-4c and 33-16-3g, by revising its forms, policies and procedures to ensure that mammograms are paid subject to the same deductibles, coinsurance and other limitations that apply to other covered services. The Company should review its claim payments for mammography during the period under examination, and should reimburse any insureds whose claims have been limited by the contract wording.

The Company should revise every form and individual policy that requires proof of the policyholder's "ongoing eligibility," and any provision that provides for termination of an individual policy, and revise its practices and procedures to ensure that its policies are guaranteed renewable, in compliance with state and federal laws.

The Company should comply with W. Va. Code §§ 33-16A-10 and 33-15-4a, by offering a conversion policy providing the benefits required under those Codes.

The Company should revise its conversion policies to state that any preexisting condition not excluded under the group policy from which conversion was made, will be covered under the conversion policy.

The Company should revise its policy forms, policies and procedures to ensure that employer groups are terminated only at renewal in the event participation fails to meet the Company's participation requirements. In the case of a group of two that falls to one covered employee, termination may only be affected at the first renewal following the new plan year.

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.

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.

The Company should revise its PPO and POS policies to reflect the requirements of W. Va. Code § 33-16-1a, and should review its policies and procedures to ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date in compliance with W. Va. Code § 33-16-3k.

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 based on the policy's limiting age. Any other option available to the employer may exceed that age, but not reduce it.

The Company should revise its policies to ensure that qualifications for dependent child eligibility complies with W. Va. Code § 33-16-1a. In addition, the Company should revise its policies and procedures to ensure that no qualifying dependent child is denied coverage, or terminated from coverage due to the policy language.

The Company should comply with W. Va. Code § 33-16-3k by revising its practices and procedures and its policies to remove any restriction requiring hospital and physician services to have been initiated and rendered within six months of the accident.

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 WVOIC'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 should revise its policy forms, policies and procedures to ensure that air ambulance service is always covered in a true emergency.

Because of the market conduct examination, the Company agreed to correct its underwriting guidelines, conversion and group contracts, COCs, enrollment guide, application, and practices and procedures for compliance with West Virginia statutes and rules, and HIPAA. The WVOIC should follow-up with the Company to determine if it has made the corrections as indicated above.

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 §§ 33-11-4, 33-12-23 ,33-16D-4 & W.Va. St. R. § 114-54-9.1(a)*

***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.

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 §§ 33-2-9,33-16D-4&7,33-16D-4(b)&33-15-2d*

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 properly pay commissions 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'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 employer 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. In addition, guaranteed issue of small employers was also restricted by THP's underwriting guidelines that allowed for declination when a certain percentage of out of area subscribers was enrolling and when the group had management only employees enrolling. THP'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 retained a practice and provision on 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.

- ***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.

THP 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 of "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.

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 §§ 33-6-8, 33-29-5 & 33-15-2*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. An insurer is not to issue policies, forms or endorsements that have not been filed and approved by the WVOIC.

Results: **Pass with Recommendations**

Observations: Testing was completed to determine if the Company's forms and endorsements had been filed with the WVOIC, and where required, whether 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.

However, THP failed to identify individual policies and riders with a form number in the lower left hand corner of each form and to provide page numbers in the Table of Contents, in violation of W. Va. Code §§ 33-29-5 and 33-15-2. The Company's response stated in part, "THP agrees the form numbers were not on the documents when sent to print; however, form numbers were included with the state filings. THP will add the form numbers to all applicable documents.... We will correct by hard coding the page numbers before sending to print." Therefore, as a result of the examination the Company agreed to correct its policy forms.

Recommendations: The Company should comply with W. Va. Code §§ 33-29-5 and 33-15-2, by revising its contracts, riders and policies and procedures to ensure that a form number appears on each form and to ensure that the Table of Contents contains page numbers.

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, 33-16-D4& W. Va. Code St. R. §§ 114-15-4.3(b),114-54-9.1(a)*

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**

The Company provided a population of sixty-four (64) small employer groups declined files and all were sampled for testing. However, one (1) file was not a declination and therefore, there were sixty-three (63) files tested. THP stated there were no individual plans declined during the period under examination, because they were not marketing in the individual market. The results of testing are as follows:

Table F 7 Underwriting and Rating Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Individual declined apps.	0	0	0	0	0	N/A
Small Group declined apps.	64	63	1	9	54	14%
Total	64	63	1	9	54	14%

Observations:

- The Company's declined small group applications stated, "THP 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.

- 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 THP 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 (1) of the five (5) files above, THP 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 THP 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 based on 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 their eligible employees (two [2] 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) group files or failed to retain documents for the one (1) file. As a result of the market conduct examination, the Company agreed to correct its practices and procedures associated with declining employer groups due to the number of out-of-area employees.

Recommendations: The Company should maintain declination files in compliance with W. Va. Code St. R. § 114-15-4.3b, which would provide evidence for the validity of the Company's small group declinations.

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

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, 33-16D-8 & § 114-54-6, 114-15-4*

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 four (4) individual policies terminated and the population of fifteen (15) terminated small groups. 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	15	15	0	13	2	87%
Terminated Individual Policies	4	4	0	4	0	100%
Total	19	19	0	17	2	89%

Observations: Testing of the Company's small group terminated plans revealed one (1) small employer was terminated because the group dropped to one (1) covered employee. The Company's underwriting guidelines 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 coinciding with 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 was one (1) other file failed, because the Company failed to provide supporting documentation for a valid termination of the small employer group in violation of 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 THP will retain all pertinent documents in the future."

Recommendations: It is recommended THP provide evidence it corrected its guidelines to only allow termination at the plan year renewal when an employer group falls to one (1) covered employee.

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, 33-6-7 & 33-16-3l

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 employer groups or individual plans 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 §§ 33-16D-5, 33-16-1a & 33-16-3k & 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 with recommendations**

Observations:

- The Company generally complied with the preexisting condition(s) limitations provided under W. Va. Code § St. R. 114-54-3 and HIPAA. However, there were two (2) issues associated with preexisting conditions noted in testing performed at Standard F 2, as noted below.

- The Company failed to correctly define the look-back period for "preexisting conditions," in violation of W. Va. Code § 33-16-1a, W. Va. Code § 33-16-3k and HIPAA. The Company should ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date. See F2.

- THP group policies failed to comply with W. Va. Code §§ 33-16-3k and 33-16-1a(k), by limiting medical care for some accidental injuries. The Company restricted hospital and physician services to those initiated and rendered within six (6) months of the accident. In addition, the Company should ensure that no claim relating to accidental dental injuries is denied based on the restrictions in its policies. The Company commented, "COI language was previously approved by the State."

- ***Recommendations:*** The Company should ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date, and it should ensure that no claim related to accidental dental injuries is denied on the basis of the restrictions in its policies for compliance with W. Va. Code §§ 33-16-1a and 33-16-3k, and HIPAA.

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 & 33-16D-5*

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement under W. Va. Code § 33-16D-5 and HIPAA. An insurer is not allowed to deny coverage or discriminate based on health status for any member of any large or small group. In addition, a federally eligible individual must be offered coverage in the market without preexisting conditions.

Results: **Pass**

Observations: The Company does not offer coverage in the individual market in West Virginia. However, it does make a conversion plan available to its group members that lose coverage, in compliance with W. Va. Code § 33-16A-1 et seq. There were no indications during testing of

any files or records that the Company discriminated based on health status against any member or potential member in the group market. Therefore, there were no exceptions noted during testing of this standard.

Recommendations: None

Standard F 12	*NAIC Market Regulation Handbook – Chapter XX, § F, Standard 7.*
The regulated entity issues coverage that complies with the guaranteed-issue requirements of HIPAA and related state laws for groups of 2 to 50.	*W. Va. Code § 33-16D-4 & W. Va. Code St. R. § 114-54-9*

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. § 114-54-9 and HIPAA mandate that all eligible small employers be guaranteed issue of a small group health plan.

Results: **Fail**

The Company provided a population of sixty-four (64) small employer groups declined files and all were sampled for testing. However, one (1) file was not a declination and therefore, there were sixty-three (63) files tested. THP stated there were no individual plans declined during the period under examination. 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	63	1	9	54	14%
Total	64	63	1	9	54	14%

Observations:

- The Company failed to retain records for forty-four 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 employers 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 (2) or more eligible employees based on 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 (2) 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 retain records in compliance with W. Va. Code §§ 33-16D-4 & 7, and HIPAA.

The Company should pay commissions and bonuses fairly to its producers for max-rated small groups.

The Company should not decline small groups on the basis that the employer could not or would not supply a quarterly wage report or an insurer's most recent invoice. A listing of employees should be accepted, and a recent invoice is never a valid reason for declination.

The Company should not decline management-only small groups if they are eligible small employers.

The Company should not decline an eligible small employer based on the percentage of out-of-area members in the employer's group.

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 §§ 33-6-6, 6-7 &33-2-9 & W. Va. Code St. R. § 114-15-4.3

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 sixty-four (64) newly issued small groups. There were no individual plans issued during the period under examination. 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 Small Groups	68	68	0	68	0	100%
Total	68	68	0	68	0	100%

Observations: Testing of the small employer group issued applications determined they were complete and accurate, identified the producer, and requested information in a clear manner. However, the Company allowed for voidance of coverage for a misstatement in an application through its conversion and group plan language. Misstatements are not a valid reason for voidance. (See testing performed at Standard J 7)

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 in the event of layoff 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 §§ 33-15-2b, 33-11-4 & 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 THP's responses to informational items requested by the examiner, discussions with THP 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.

Standard G 3	*NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 3.*
Claims are resolved in a timely manner.	*W. Va. Code § 33-45-2a & W. Va. Code St. R. § 114-14-6.7*

Comments: Review methodology for this standard is generic, sample, and electronic. This standard has a direct statutory requirement. 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 with recommendation**

Testing for this standard was performed based on a random sample of sixty (60) paid in-network claims from a population of 40,126 and sixty (60) paid out-of-network claims from a population of 12,082. In addition, testing was performed on a random sample of sixty (60) closed without payment in-network claims from a population of 7,338 and sixty (60) closed without payment out-of-network claims from a population of 706. 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	40,126	60	0	60	0	100%
Out-of-Network Paid Claims	12,082	60	0	56	4	93%
In-Network CWOP Claims	7,338	60	0	60	0	100%
Out-of-Network CWOP Claims	706	60	0	59	1	98%
Total	60,252	240	0	235	5	98%

Observations:

- The Company failed to pay claims timely for four (4) out-of-network paid claims in violation of W. Va. Code St. R. § 114-14-6.7 and W. Va. Code § 33-45-2(a) (see testing performed at G 6).

- The Company failed to pay one (1) out-of-network closed without payment claim timely in violation of W. Va. Code St. R. § 114-14-6.7 and W. Va. Code § 33-45-2(a) (see testing performed at G 6).

Recommendations: The Company should ensure that claims are paid timely and accurately.

Standard G 4 *NAIC Market Regulation Handbook - Chapter XVI, § G, Standard 4.*
The regulated entity 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: THP'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 § 33-45-2

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

Results: **Pass**

Testing for this standard was performed based on a random sample of sixty (60) paid in-network claims from a population of 40,126 and sixty (60) paid out-of-network claims from a population of 12,082. In addition, testing was performed on a random sample of sixty (60) closed without payment in-network claims from a population of 7,338 and sixty (60) closed without payment out-of-network claims from a population of 706. 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	40,126	60	0	60	0	100%
Out-of-Network Paid Claims	12,082	60	0	60	0	100%
In-Network CWOP Claims	7,338	60	0	60	0	100%
Out-of-Network CWOP Claims	706	60	0	60	0	100%
Total	60,252	240	0	240	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 §§ 33-11A-4(9) & 33-45-2(a) & W. Va. Code St. R. §§ 114-14-6.1&6.7

Comments: Review methodology for this standard is generic and sample. This standard has a direct statutory requirement. An insurer must provide claim handling in compliance with its

provider contracts as governed under W. Va. Code § 33-11A-4, and in compliance with W. Va. Code § 33-45-2.

Results: **Pass with Recommendations**

Testing for this standard was performed based on a random sample of sixty (60) paid in-network claims from a population of 40,126 and sixty (60) paid out-of-network claims from a population of 12,082. 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	40,126	60	0	59	1	98%
Out-of-Network Paid claims	12,082	60	0	53	7	88%
Total	52,208	120	0	112	8	93%

Observations:

- For one (1) in-network paid claim the original EOB indicated an amount greater than the out of pocket maximum was applied toward the family's in-network out of pocket maximum, and an amount greater than the in-network maximum was applied toward the member's in-network out of pocket maximum, which was not in compliance with W. Va. Code St. R. §§ 114-14-6.1 & 6.7, and W. Va. Code §§ 33-45-2(a) and 33-11-4 (9). The Company's response stated it agreed an error had occurred because a manual entry was mistakenly applied to this claim. As a result of the examination, the Company provided a corrected EOB with the refund for the insured.

- For four (4) out-of-network paid claims, THP failed to pay claims timely. The Company paid interest for one (1) of the claims in compliance with W. Va. Code § 33-45-2(a) (4). The Company's response stated in part, "Interest was owed on all claims referenced. . . . Delay in payments in all cases was due to utilization of a secondary network in order to obtain a discount for providers non-contracted with Health Plan." Therefore, the Company failed to pay the claims timely in violation of W. Va. Code St. R. §§ 114-14-6.1 & 6.7, and W. Va. Code § 33-45-2(a), and failed initially to pay interest on the other three (3) claims in violation of W. Va. Code § 33-45-2(a) (4).

- For one (1) out-of-network paid claim, the Company failed to pay the correct amount on behalf of the certificate holder in violation of W. Va. Code St. R. §§ 114-14-6.1 & 6.7, and W. Va. Code §§ 33-45-2(a) and 33-11-4 (9). The Company's response stated in part, "Evidence of system correction is attached. EOB was not programmed to pick up limits on the default group.... IS has corrected this so default group limits will apply on EOB if no specific group limits are programmed." As a result of the examination, the Company paid the correct amount and has updated its system for group default limits.

- For two (2) out-of-network paid claims, the Company failed to pay the correct amount on behalf of the certificate holder in violation of W. Va. Code St. R. §§ 114-14-6.1 & 6.7, and W. Va. Code §§ 33-45-2(a) and 33-11-4 (9), because the claim was not applied to the

out-of-network limit properly. The Company's response stated in part, "Per IS there is no way...to generate member limits specific to claim from claim image on system. It will calculate everything accumulated to date of request. Must use information from members' folder to obtain accurate benefit limits generated at time of claim processing." Therefore, both files were failed.

Recommendations: The Company should pay claims timely and accurately, and pay interest when applicable in compliance with W. Va. Code § 33-45-2(a).

The Company should update its claims systems to ensure that policyholders are not paying amounts greater than in and out-of-network, out of pocket maximum amounts.

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

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

Results: **Pass**

Testing for this standard was performed based on a random sample of sixty (60) paid in-network claims from a population of 40,126 and sixty (60) paid out-of-network claims from a population of 12,082. In addition, testing was performed on a random sample of sixty (60) closed without payment in-network claims from a population of 7,338 and sixty (60) closed without payment out-of-network claims from a population of 706. 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	40,126	60	0	60	0	100%
Out-of-Network Paid Claims	12,082	60	0	60	0	100%
In-Network CWOP Claims	7,338	60	0	60	0	100%
Out-of-Network CWOP Claims	706	60	0	60	0	100%
Total	60,252	240	0	240	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. 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 regulated entity's established procedures.

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 THP 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 §§ 33-45-2, 33-11-4(9) & W. Va. Code St. R. § 114-14-6.7

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

Results: **Pass**

Testing for this standard was performed based on a random sample of sixty (60) closed without payment in-network claims from a population of 7,338 and sixty (60) closed without payment out-of-network claims from a population of 706. 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	7,338	60	0	60	0	100%
Out-of-Network CWOP Claims	706	60	0	59	1	98%
Total	8,044	120	0	119	1	99%

Observations: For one (1) out-of-network closed without payment claim the Company failed to pay a claim that it was contractually obligated to pay, in violation of W. Va. Code § 33-11-4 (9), and denial of the claim was not timely in violation of W. Va. Code St. R. § 114-14-6.7 and W. Va. Code § 33-45-2(a). The Company's response stated in part, "Claim was sent for repricing....Claim was denied in error and has been reprocessed for payment to include interest." As a result of the examination, the Company paid the claim.

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 § 33-45-2

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

Results: **Pass**

Testing for this standard was performed based on a random sample of sixty (60) paid in-network claims from a population of 40,126 and sixty (60) paid out-of-network claims from a population of 12,082. 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	40;126	60	60	60	0	100%
Out-of-Network Paid Claims	12,082	60	60	60	0	100%
Total	52,208	120	120	120	0	100%

Observations: The Company's monthly payment of claims was 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 § 33-11-4

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: THP 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 regulated entity 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, THP'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.

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 § 33-11-4a

Comments: Review methodology for this standard is generic and is not file specific. The standard does not have a direct statutory requirement. The concern tested is that any grievance "initiated by enrollees concerning any matter relating to any provisions of the Company's insurance policies, including, but not limited to, complaints regarding the scope of coverage for health care services; denials, cancellations or nonrenewals of insureds' coverage; observance of an insured'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 § 33-11-4*

Comments: Review methodology for this standard is generic and is not file specific. The standard does not have a direct statutory requirement. Examiners reviewed Company grievance procedures, files, and reports, in order to determine if the Company met statutory documentation requirements.

Results: **Pass**

Observations: The Company had documented grievance procedures, and a database that stored essential grievance documentation.

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.	

Comments: Review methodology for this standard is generic and is not file specific. The standard does not have a direct statutory requirement.

Results: **Pass**

Observations: Testing determined the Company responded to, and resolved all grievances within its 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.	

Comments: The review methodology for this standard is sample. The standard does not have a direct statutory requirement.

Results: **Pass**

Testing for this standard was performed on the sampled population of forty-five (45) first level grievance/appeal files. However, twenty-four (24) of the files were for grievance/appeal that occurred prior to the period under examination (N/A), and therefore were not applicable for testing purposes. The results of testing are as follows:

Table H 4 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level I	45	45	24	21	0	100%
Total	45	45	24	21	0	100%

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

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.

Comments: The review methodology for this standard is sample. The standard does not have a direct statutory requirement.

Results: **Pass**

Testing for this standard was performed on the sampled population of seven (7) Second Level grievance/appeal files. The results of testing the Level II appeals are as follows:

Table H 5 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Appeals: Level II	7	7	0	7	0	100%
Total	7	7	0	7	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.

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

Results: **Pass**

Of the twenty-one (21) tested First Level grievance/appeal files, and the seven (7) Second Level grievance/appeal files, none were expedited grievances/appeals. The results of testing are as follows:

Table H 7 Grievance Procedures						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Grievance Procedures	28	28	28	0	0	N/A
Total	28	28	28	0	0	N/A

Observations: There were no expedited grievance/appeal files. Therefore, there were no exceptions for this standard.

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 PPO maintains service networks that are sufficient to assure that all services are accessible without unreasonable delay. The standards require the PPO to assure 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 regulated entity 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.

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

Results: **Pass**

Observations: THP had a network in place that achieved provider to enrollee standards for PCPs, OBGs, PEDs, and other Specialists to ensure access to provides without unreasonable delays. 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 health carrier has filed an access plan for each managed care plan that the health carrier offers in the state, and files updates whenever it makes a material change. The health carrier 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 § 33-16D-4

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 a PPO 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. THP provided THP's annual evaluations for determining the adequacy of provider access, including specialists. There were no material changes in terms of network adequacy during the period under examination. 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 regulated entity 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 §§ 33-15-21 & 33-24-7e*

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: THP provided access for emergency care for members both in and outside of its network. 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 § 33-45-2*

Comments: The review methodology for this standard is generic. This standard has a direct regulatory requirement. Credentialing is the process by which a PPO authorizes, contracts with, or employs practitioners who are licensed to provide services to its members.

Results: **Pass**

Observations: THP 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 § 33-45-2. THP 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 THP 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*

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 (1) page out of the 2008 provider directory. That page contained a listing of forty-eight (48) providers, and all were tested. The entire population of in-network providers was not counted, because it was deemed unnecessary for testing of this standard. The results of testing are as follows:

Table J 2 Provider Credentialing Sample Results

Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	0	48	0	48	0	100%
Total	0	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 § 33-45-2*

Comments: The review methodology for this standard is sample. This standard has a direct regulatory requirement. Concerns tested with this standard included a PPO or POS carrier obtaining and reviewing 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 PPO's policy;
f. Complete professional liability claims history;
g. Any other information deemed necessary by the PPO in determining whether to contract with a prospective provider.

Results: **Pass**

Testing for this standard was performed based on an arbitrary sample of one (1) page out of the 2008 provider directory. That page contained a listing of forty-eight (48) providers, and all were tested. The results of testing are as follows:

Table J 3 Provider Credentialing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	0	48	0	48	0	100%
Total	0	48	0	48	0	100%

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

Recommendations: None

Standard J 5 *NAIC Market Regulation Handbook – Chapter XX, § J, Standard 5.*
The health carrier obtains, at least every three (3) years, primary verification of the information required by applicable state provisions equivalent to the Health Care Professional Credentialing Verification Act and accompanying regulations.

Comments: The review methodology for this standard is sample. This standard does not have a direct statutory requirement. In terms of re-credentialing, a PPO or POS shall develop a process for the periodic verification of credentials that shall be implemented at least every three (3) years. A PPO or POS shall obtain and review verification of the requirements from the sources listed in Standard J 3 above.

Results: **Pass**

Testing for this standard was performed based on an arbitrary sample of one (1) page out of the 2008 provider directory. There were forty-eight (48) providers on the page and all were tested. The results of testing are as follows:

Table J 5 Provider Credentialing Sample Results						
Type	Population	Sample	N/A	Pass	Fail	% Pass
Provider Credentialing	0	48	0	48	0	100%
Total	0	48	0	48	0	100%

Observation: Testing determined that all providers in the sample were subject to the re-credentialing process by one (1) 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.

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 PPO or POS carrier's requirement for the provider to provide the PPO or the POS carrier with notice of any change in the physician's information that is required to be verified for credentialing and re-credentialing.

Results: **Pass**

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

Recommendations: None

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

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 PPO 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: THP'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 applicable state provisions equivalent to the Health Care Professional Credentialing Verification Act and accompanying regulations are met.	

Comments: The review methodology for this standard is generic. This standard does not have a direct regulatory requirement. This standard is focused on the level of the oversight provided by the PPO when it contracts with an external entity that assumes the provider credentialing function for the PPO. 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 ("UM") portion of the examination is designed to assure 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 THP'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.

Comments: Review methodology for this standard is generic. This standard does not have a direct statutory requirement. It is generally not file specific. THP's UM program was reviewed for adherence to its established guidelines.

Result: **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 preauthorization 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 THP'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 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.

Comments: Review methodology for this standard is generic. This standard does not have a direct regulatory requirement. It is generally not file specific.

Results: **Pass**

Observations: THP provided a description of its utilization management program to the WVOIC. There were no exceptions noted during testing of this standard.

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.	

Comments: Review methodology for this standard is generic. This standard does not have a statutory requirement. It is generally not file specific. The Company should communicate its UM program to the extent of providing enrollees with information concerning its grievance procedures, including phone numbers to points of contact.

Result: **Pass**

Observations: THP provides a description of its grievance procedures in its enrollment guides and its COC. There were no exceptions noted during testing of this standard.

Recommendation: None

Standard L 4	*NAIC Market Regulation Handbook – Chapter XX, § l, Standard 4.*
The health carrier conducts provider related utilization management activities in a timely manner and in compliance with statutes, rules, and regulations.	

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

Results: **Pass**

Testing of Level II appeals provided two (2) concurrent review and two (2) retrospective review determinations. Testing of Level I appeals provided eleven (11) concurrent review and four (4) retrospective review determinations. Therefore, those nineteen (19) files were tested, and because no errors were noted during this testing an additional sample of concurrent or retrospective review files were 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	19	19	0	19	0	100%
Total	19	19	0	19	0	100%

Observations: Testing determined that THP 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.	

Comments: Review methodology for this standard is sample. It is generally file specific. This standard does not have a direct statutory requirement. This standard is primarily concerned that the Company adheres to periods for decisions outlined in its Utilization Review procedures. THP had established time frames for Utilization Review decisions based upon the type of review in its UM guidelines.

Results: **Pass**

Testing of Level II appeals provided two (2) concurrent review and two (2) retrospective review determinations. Testing of Level I appeals provided eleven (11) concurrent review and four (4) retrospective review determinations. Therefore, those nineteen (19) files were tested, and because no errors were noted during this testing an additional sample of concurrent or retrospective review files were 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	19	19	0	19	0	100%
Total	19	19	0	19	0	100%

Observations: Testing determined that THP acted in compliance with its internal UM policy standards for each case sampled for concurrent review and retrospective review. 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 § 33-45-2

Comments: Review methodology for this standard is sample. It is generally file specific. This standard has a direct statutory requirement.

Results: **Pass**

Testing of Level II appeals provided two (2) concurrent review and two (2) retrospective review determinations. Testing of Level I appeals provided eleven (11) concurrent review and four (4) retrospective review determinations. Therefore, those nineteen (19) files were tested, and

because no errors were noted during this testing an additional sample of concurrent or retrospective review files were 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	19	19	0	19	0	100%
Total	19	19	0	19	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 § 33-45-2

Comments: Review methodology for this standard is sample. It is generally file specific. This standard does not have statutory requirements.

Results: **Pass**

Testing of Level II appeals provided two (2) concurrent review and two (2) retrospective review determinations. Testing of Level I appeals provided eleven (11) concurrent review and four (4) retrospective review determinations. Therefore, those nineteen (19) files were tested, and because no errors were noted during this testing an additional sample of concurrent or retrospective review files were 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	19	19	0	19	0	100%
Total	19	19	0	19	0	100%

Observations: Testing of the sampled files determined that three (3) of the files had a request for reconsideration by the provider after an adverse decision. Testing determined there were no exceptions noted during testing of those files.

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 §§ 33-24-7e & 33-2-10

Comments: Review methodology for this standard is generic. This standard has a direct statutory requirement. W. Va. Code § 33-24-7e states in part, "(a)(1) Every insurer shall provide for emergency services..."

Results: **Pass**

Observations: Testing determined the Company's UM guidelines for emergency services provided for emergency services in compliance with W. Va. Code § 33-24-7e. 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." However, the Company's conversion policy failed to provide air emergency transport benefits in compliance with W. Va. Code § 33-15-21 (see testing performed at Standard F 2). The policy stated that local ground transportation was covered, and excluded other transport 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.	

***Comments*:** Review methodology for this standard is generic. This standard does not have a direct statutory requirement. It is generally not file specific.

Result: **Pass**

***Observations*:** THP'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 Committee (URAC). The Company's and provider responsibilities are outlined in the "Practitioners Procedure Manual," which indicated that through utilization management, THP 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 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. It should not decline eligible small employer groups when the employer could or would not supply a quarterly wage report. In addition, the Company pay commissions fairly for all small groups.

Recommendation F 1
The Company should ensure that all rates are filed with the WVOIC prior to issuing or renewing policies with those rates. The Company filed its current rates during the period under examination.

Recommendation F 2
The Company should revise its conversion forms and policies and procedures to comply with W. Va. Code § 33-16A-8 and NMHPA, and ensure that claims for childbirth and routine nursery care are paid if the pregnancy existed at the time of conversion.

Recommendation F 2
The Company should eliminate conversion language relating to the imposition of a preexisting conditions limitation and should revise its policies and procedures to ensure that no such limitation is imposed.

Recommendation F 2
The Company should comply with W. Va. Code §§ 33-6-6 and 33-15-4 by revising its group and conversion policies, and its policies and procedures to ensure that no policy is voided and no claim is denied based on an applicant's statements unless those statements are made on the application for coverage and a copy of the application has been attached to or otherwise made a part of the policy when issued.

Recommendation F 2
The Company should comply with W. Va. Code §§ 33-15-4c and 33-16-3g by revising its forms, policies and procedures to ensure that mammograms are paid subject to the same deductibles, coinsurance and other limitations that apply to other covered services. The Company should review its claims payments for mammography during the period under examination, and should reimburse any insureds whose claims have been limited by the contract wording.

Recommendation F 2
The Company should revise every form and individual policy that requires proof of the policyholder's "ongoing eligibility," and any provision that provides for termination of an individual policy, and revise its practices and procedures to ensure that its policies are guaranteed renewable, in compliance with state and federal laws.

Recommendation F 2
The Company should comply with W. Va. Code §§ 33-16A-10 and 33-15-4a, by offering a conversion policy providing the benefits required under those Codes.

Recommendation F 2
The Company should revise its conversion policies to state that any preexisting condition not excluded under the group policy from which conversion was made will be covered under the conversion policy.

Recommendation F 2
The Company should revise its policy forms, policies and procedures to ensure that employer groups are terminated only at renewal in the event participation fails to meet the Company's participation requirements. In the case of a group of two (2) that falls to one (1) covered employee, termination may only be effected at the first renewal following the new plan year.

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.

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 2
The Company should revise its PPO and POS policies to reflect the requirements of W. Va. Code § 33-16-1a, and should review its policies and procedures to ensure that the look-back period for preexisting conditions ends on the enrollment date and that the preexisting conditions limitation period starts on the enrollment date in compliance with W. Va. Code § 33-16-3k.

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 based on 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 revise its policies to ensure that qualifications for dependent child eligibility complies with W. Va. Code § 33-16-1a. In addition, the Company should revise its policies and procedures to ensure that no qualifying dependent child is denied coverage, or terminated from coverage due to the policy language.

Recommendation F 2
The Company should comply with W. Va. Code § 33-16-3k, by revising its practices and procedures and its policies to remove any restriction requiring hospital and physician services to have been initiated and rendered within six (6) months of the accident.

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 should revise its policy forms, policies and procedures to ensure that air ambulance service is always covered in a true emergency.

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 (1) enrollee at the end of the group plan year in compliance with guaranteed renewability provisions in West Virginia law and HIPAA.

Recommendation F 4
THP should retain all declination records to support it is not restricting guaranteed availability in the small group market in violation of 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 5
The Company should comply with W. Va. Code §§ 33-29-5 and 33-15-2 by revising its contracts, riders and policies and procedures to ensure that a form number appears on each form and to ensure that each policy's Table of Contents contains page numbers.

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 of being an eligible employer small group for compliance with St. R. § 114-54-9.1(a) and W. Va. Code § 33-16D-4.

Recommendation F 8
It is recommended THP provide evidence it corrected its guidelines to only allow termination at the plan year renewal when an employer group falls to one (1) covered employee.

Recommendation F 10
The Company should comply with W. Va. Code § 33-16-3k by revising its practices and procedures and its policies to remove any restriction requiring hospital and physician services to have been initiated and rendered within six (6) months of the accident.

Recommendation F 12
The Company should retain records in compliance with W. Va. Code §§ 33-16D-4.

Recommendation F 12
The Company should pay commissions and bonuses fairly to its producers for max-rated small groups.

Recommendation F 12
The Company should not decline small groups on the basis that the employer could not or would not supply a quarterly wage report or an insurer's most recent invoice.

Recommendation F 12
The Company should not decline management only small groups if they are eligible small employers.

Recommendation F 12
The Company should not decline an eligible small employer based on the percentage of out-of-area members in the employer's group.

Recommendation G 3
The Company should ensure that claims are paid timely and accurately.

Recommendation G 6
The Company should pay claims timely and accurately, and pay interest when applicable in compliance with W. Va. Code § 33-45-2(a).

Recommendation G 6
The Company should update its claims systems to ensure that policyholders are not paying amounts greater than in- and out-of-network, out-of-pocket maximum amounts.

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, 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 THP Insurance Company.

2. I have reviewed the examination work papers and examination report, and the examination of THP 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 Heenan

Notary Public

My commission expires 9/29/2015

SUSAN JANE HEENAN
NOTARY PUBLIC OF NEW JERSEY
My Commission Expires 9/29/2015

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Morgantown, WV 26505

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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 60016
EXAMINATION NUMBER WV014-M18

Dear Ms. Cline:

THP Insurance Company is in receipt of the aforementioned report and agrees to the findings.

Sincerely,

Larai A. Doughty
Manager, Marketing Services

ld

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

certificate of mailing

SCANNED

RECEIVED
APR 20 2011
MARKET CONDUCT
WVOIC