REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

COVENTRY HEALTH AND LIFE INSURANCE COMPANY

AS OF DECEMBER 31, 2016

Conducted from June 23, 2017

Through

June 5, 2018

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 75-1296086
NAIC: 81973

COMMONWEALTH OF VIRGINIA

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I, Bryan Wachter, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Coventry Health and Life Insurance Company as of December 31, 2016, completed at the office of the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2019-00056 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 27th day of June 2019.

Bryan Wachter
Examiner in Charge

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I. SCOPE OF EXAMINATION

A Target Market Conduct Examination of Coventry Health and Life Insurance Company (hereinafter referred to as "CHLIC" or "the Company") was conducted under the authority of various sections of the Code of Virginia (hereinafter referred to as "the Code") and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC") including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-1809, 3407.15 C, and 38.2-5808 of the Code, as well as 14 VAC 5-90-170 A.

The period of time covered for the current examination was January 1, 2016, through December 31, 2016. The on-site examination was conducted at CHLIC's office in Harrisburg, Pennsylvania from September 11, 2017 to September 29, 2017, and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on June 5, 2018. The violations cited and the comments included in this Report are the opinions of the examiners.

The examiners may not have discovered every non-compliant activity in which the company was engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

The purpose of the examination was to determine whether CHLIC was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code. Compliance with the following regulations was considered in this examination process:

14 VAC 5-100-10 et seq.	Rules Governing the Submission for Approval of Life, Accident and Sickness, Annuity, Credit Life and Credit Accident Sickness Policy Forms;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review; and
14 VAC 5-400-10 et seq.	Rules Governing Unfair Claim Settlement Practices.

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Policy and Other Forms
- Agents
- Cancellations/Nonrenewals
- Complaints
- Claim Practices
- Internal Appeal and External Review

Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to CHLIC during the course of the examination.

II. COMPANY HISTORY

Coventry Health and Life Insurance Company was incorporated in the state of Texas on May 01, 1968, as a stock insurance company. Its ultimate parent was Coventry Corporation. On May 16, 1986, the Company was licensed in the Commonwealth of Virginia as American Service Life Insurance Company (American Service Life). In December of 1995, American Service Life changed its name to Coventry Health and Life Insurance Company (CHLIC). On November 17, 1997, Coventry Corporation formed Coventry Health Care, Inc., (CHC). In a business transaction on April 1, 1998, Coventry Corporation along with its CHLIC subsidiary became a subsidiary of CHC. On December 21, 1999, CHLIC redomesticated from Texas to Delaware. On June 22, 2000, Coventry Corporation was merged with and into CHC where CHC became the direct parent of CHLIC. On December 20, 2012, CHLIC redomesticated from Delaware to Missouri.

On January 1, 2014, CHC merged with and into Aetna Health Holdings, LLC, (AHH) a wholly-owned subsidiary of Aetna, Inc., whereas AHH is the surviving entity.

As of December 31, 2016, CHLIC's annual statement reported direct premiums written totaling $2,496,427,925; Virginia direct premiums written totaled $3,651,421. CHLIC notified the BOI that it would discontinue offering small group coverage as of July 1, 2015. In addition, CHLIC notified the BOI on January 29, 2016 that it would discontinue offering dental policies in all markets.

III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

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

COMPLAINT SYSTEM

The examiners reviewed the total population of 6 written complaints and appeals. The review revealed that CHLIC was in substantial compliance with its established procedures and the requirements of the Code.

IV. PROVIDER CONTRACTS

ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

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

Provider Contracts

The examiners reviewed a sample of 6 from an unknown population of provider contracts in-force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 of the Code. The review revealed 3 instances where CHLIC's contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 6	1	EF07J
§ 38.2-3407.15 B 7	1	EF06J
§ 38.2-3407.15 B 9	1	EF07GA

Provider Claims

Section 38.2-510 A 15 of the Code prohibits as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions, requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for

claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The examiners reviewed a sample of 50 claims from a population of 146 claims processed under the sample of 6 provider contracts selected for review.

Section 38.2-3407.15 B 1 of the Code states that a carrier shall pay any clean claim within 40 days of receipt of the claim. The review revealed 4 instances where CHLIC failed to pay a clean claim within 40 days, in violation of § 38.2-3407.15 B 1 of the Code. An example is discussed in Review Sheet EFCL12J. CHLIC agreed with the examiners' observations.

Section 38.2-3407.15 B 3 of the Code requires that any interest owing or accruing on a claim under § 38.2-3407.1 of the Code, shall be paid at the time the claim is paid or within 60 days thereafter. As discussed in Review Sheet EFCL19J, the review revealed 1 instance where CHLIC failed to pay interest as required by this section, in violation of §§ 38.2-3407.15 B 3 and 38.2-3407.1 B of the Code. CHLIC agreed with the examiners' observations.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis. The review revealed that CHLIC allowed less than the amount specified in the fee schedule for the health care service provided in 5 instances, in violation of § 38.2-3407.15 B 8 of the Code in each

instance. Examples are discussed in Review Sheet EFCL19J. CHLIC agreed with the examiners' observations.

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. CHLIC's failure to perform the provider contract provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3 and 38.2-3407.15 B 8 occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code.

CARRIER CONTRACTS WITH PHARMACY PROVIDERS; REQUIRED PROVISIONS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:1 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:1 B 1	1	EF01GA
§ 38.2-3407.15:1 B 2	1	EF01GA
§ 38.2-3407.15:1 B 3	1	EF01GA
§ 38.2-3407.15:1 B 4	1	EF01GA
§ 38.2-3407.15:1 B 5	1	EF01GA
§ 38.2-3407.15:1 B 6	1	EF01GA
§ 38.2-3407.15:1 B 7	1	EF01GA
§ 38.2-3407.15:1 B 8	1	EF01GA
§ 38.2-3407.15:1 B 9	1	EF01GA
§ 38.2-3407.15:1 C	1	EF01GA

CARRIER CONTRACTS; REQUIRED PROVISIONS REGARDING PRIOR AUTHORIZATION

Section 38.2-3407.15:2 B of the Code requires that any provider contract between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:2 B 1	3	EF04GA
§ 38.2-3407.15:2 B 2	3	EF04GA
§ 38.2-3407.15:2 B 3	3	EF04GA
§ 38.2-3407.15:2 B 4	3	EF04GA
§ 38.2-3407.15:2 B 5	3	EF04GA
§ 38.2-3407.15:2 B 6	3	EF04GA
§ 38.2-3407.15:2 B 7	3	EF04GA
§ 38.2-3407.15:2 B 8	3	EF04GA

CARRIER AND INTERMEDIARY CONTRACTS WITH PHARMACY PROVIDERS; DISCLOSURE AND UPDATING OF MAXIMUM ALLOWABLE COST OF DRUGS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:3 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:3 B 1	1	EF06GA
§ 38.2-3407.15:3 B 2	1	EF06GA
§ 38.2-3407.15:3 B 3	1	EF06GA
§ 38.2-3407.15:3 B 4	1	EF06GA
§ 38.2-3407.15:3 C1	1	EF06GA
§ 38.2-3407.15:3 C2	1	EF06GA
§ 38.2-3407.15:3 C3	1	EF06GA
§ 38.2-3407.15:3 C4	1	EF06GA
§ 38.2-3407.15:3 C5	1	EF06GA

V. POLICY AND OTHER FORMS

A review was conducted to determine if CHLIC complied with various statutory, regulatory, and administrative requirements governing the filing and approval of forms.

14 VAC 5-100-10 et seq. and § 38.2-316 of the Code sets forth the filing and approval requirements for forms that are to be issued or issued for delivery in Virginia.

Sections 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code set forth the filing and approval requirements for group and individual policies, certificates of insurance, amendments, riders and application/enrollment forms used in connection with any group accident and sickness insurance policy issued in Virginia.

ACCIDENT AND SICKNESS RATE FILING

Section 38.2-316 A of the Code sets forth the requirements for the filing of rates and rate changes. The review revealed that CHLIC was in substantial compliance with this section.

APPLICATION/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code set forth the requirements for the filing and approval of application and enrollment forms prior to use. The review revealed that CHLIC was in substantial compliance with this section.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its explanation of benefits forms for approval. The review revealed that CHLIC was in substantial compliance with this section.

VI. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 of the Code.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an insurer notify the agent within 5 calendar days, and the Commission within 30 calendar days, upon termination of the agent's appointment. A sample of 60 was selected from the total population of 1,494 agents whose appointments terminated during the examination time frame. The review revealed that CHLIC was in substantial compliance with this section.

VII. CANCELLATIONS/NONRENEWALS

The examination included a review of CHLIC's cancellation/nonrenewal practices and procedures to determine compliance with the policy provisions, the requirements of § 38.2-508 of the Code covering unfair discrimination, and the notification requirements of § 38.2-3542 C of the Code.

A sample of 7 was selected from a total population of 90 group accident and sickness policies that were cancelled, non-renewed, or terminated during the examination time frame.

The review revealed that CHLIC was in substantial compliance with its established procedures, the policy provisions, and the notification requirements of § 38.2-3542 C of the Code.

Additionally, there was no evidence of unfair discrimination in the sample files reviewed.

VIII. COMPLAINTS

CHLIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The total population of 6 written complaints and appeals received during the examination time frame were reviewed. The review revealed that CHLIC was in substantial compliance with this section.

IX. CLAIM PRACTICES

The examination included a review of CHLIC's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

GENERAL HANDLING STUDY

The review consisted of a sampling of medical, mental health, dental and pharmacy claims. Pharmacy claims were processed by Express Scripts, Inc. All others were processed internally by CHLIC.

PAID CLAIM REVIEW

Claims	Population	Sample
Paid Medical	9,687	80
Paid Mental Health	456	30
Paid Dental	19	5
Paid RX	9,330	65
Total	**19,492**	**180**

INTEREST

Section 38.2-3407.1 B of the Code sets forth the requirement that interest on claims proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of the claim payment. The review revealed 16 violations of this section. There were 4 instances where the amount of interest due was underpaid. An example is discussed in Review Sheet CL07, where CHLIC agreed that it underpaid the amount of statutory interest due. In 12 instances, no interest was paid. An example is discussed in CL03, where CHLIC agreed that it failed to pay the statutory interest due.

DENIED CLAIM REVIEW

Claims	Population	Sample
Denied Medical	2,965	35
Denied Mental Health	138	10
Denied Dental	41	10
Denied RX	497	10
Total	**3,641**	**65**

UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW

The total sample of 180 paid claims and 65 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-50 C requires that an appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer.

14 VAC 5-400-60 B requires that if the investigation of a claim has not been completed, every insurer shall, within 45 days from the date of the notification of the claim and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

14 VAC 5-400-70 B requires an insurer to include a reasonable explanation of the basis for the denial of a claim in the written denial.

14 VAC 5-400-70 D requires an insurer to offer a claimant an amount that is fair and reasonable.

The review was conducted using the date the letter or check was mailed as the settlement date.

14 VAC 5-400-50 A - in 1 instance, a claim was not acknowledged within 10 working days upon receipt of notification. 14 VAC 5-400-60 A - in 14 instances, a claimant was not advised of the acceptance or denial of a claim within 15 working days after proof of loss was received. 14 VAC 5-400-60 B – in 7 instances, when the investigation of a claim was not completed, a letter setting forth the reasons additional time is needed for investigation was not sent to the claimant within 45 days from the date of the notification of the claim and every 45 days thereafter. An example of each is discussed in Review Sheet CL16. The original claim was received on June 9, 2015 and denied on July 9, 2015. The medical records were received on January 21, 2016, and the claim was not reprocessed until April 25, 2016.

CHLIC partially disagreed with the examiners' observations stating that:

> Although the claim does not appear to be paid timely, the Company respectfully asserts that timely notice was given to the provider pursuant to 14 VAC 5-400-50. A and C and 14 VAC 5-400-60. A. Both the original claim and the medical records were submitted electronically to the Company via a claims clearinghouse. When the provider transmitted the original claim as well as the medical records, transmission reports are sent back to the provider indicating if the claim/records are received by the Company. These reports are typically sent to the provider daily – well within the required time frames set out be 14 VAC 5-400-50 A and C and 14 VAC 5-400-60 A. In addition, the Company appropriately provided notice to the provider since the provider is a participating provider. The Company respectfully agrees that the claim was not paid timely.

The examiners do not concur. CHLIC failed to provide documentation that it acknowledged receipt of the claim within 10 days, failed to advise the first party claimant

of acceptance or denial of the claim within 15 days of receipt of proof of loss and failed to provide notification every 45 days of the status of the claim.

14 VAC 5-400-50 C - in 3 instances, a reply was not made within 10 working days on pertinent communications from a claimant which reasonably suggest that a response is expected. An example is discussed in Review Sheet CL04, where CHLIC took 53 calendar days to respond to appeal information received regarding a claim. CHLIC disagreed with the examiners' observations but it did not directly address this issue in its response.

14 VAC 5-400-70 B - in 1 instance, a claim was denied without a written reasonable explanation of the basis for such denial. An example is discussed in Review Sheet CL15, where the claim was unreasonably denied, as the authorization number was on file. CHLIC disagreed with the examiners' observations stating, in part, that: "...the Company appropriately provided notice to the provider since the provider is a participating provider." The examiners do not concur. CHLIC failed to provide a reasonable explanation of the basis for denial to the insured.

14 VAC 5-400-70 D – in 8 instances, CHLIC failed to offer a claimant an amount that was fair and reasonable. An example is discussed in Review Sheet CL01. CHLIC agreed with the examiners' observations.

The violations of 14 VAC 5-400-60 A occurred with such frequency as to indicate a general business practice, placing CHLIC in violation of this section.

OUT-OF-POCKET MAXIMUM

The examiners reviewed a sample of 25 from a total population of 416 insureds who had met their out-of-pocket maximum during the examination time frame. The review revealed that CHLIC was in substantial compliance with the policy provisions.

THREATENED LITIGATION

CHLIC informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

X. INTERNAL APPEAL AND EXTERNAL REVIEW

Chapter 35.1 of Title 38.2 of the Code and 14 VAC 5-216-10 et seq. set forth the requirements for the establishment of a health carrier's internal appeal process and a process for appeals to be made to the Bureau of Insurance to obtain an external review of final adverse determinations.

On July 14, 2011, the Bureau of Insurance issued Administrative Letter 2011-05, the purpose of which was to provide a summary of the new internal appeals and external review process under Virginia law, and to provide guidance for the submission of complaint system filings revised to comply with these new requirements.

The examiners reviewed the total population of 6 written complaints and appeals received during the time frame for compliance with CHLIC's established procedures and the requirements of the Code. The review revealed that CHLIC was in substantial compliance with its established procedures and the requirements of the Code.

XI. CORRECTIVE ACTION PLAN

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

1. Establish and maintain procedures to ensure that every "provider contract" as defined in § 38.2-3407.15 A of the Code contains the specific provisions required by §§ 38.2-3407.15 B, 38.2-3407.15:1 B, 38.2-3407.15:1 C, 38.2-3407.15:2 B, 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code;
2. Strengthen its established procedures to ensure that all clean claims are paid within 40 days as required by § 38.2-3407.15 B 1 of the Code;
3. Strengthen and maintain procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.15 B 3 and § 38.2-3407.1 B of the Code;
4. Strengthen its established procedures to ensure that claims are paid in accordance with the provider fee schedule as required by § 38.2-3407.15 B 8 of the Code;
5. Reopen and reprocess the claim discussed in Review Sheet EFCL19J to pay at the correct contracted rate along with any statutory interest owed on the underpaid portion. In addition, review and consider for re-adjudication all claims for provider BOI # 2 for procedure codes 99213, 99214 and 90460, that underpaid according to the Medicare fee schedule; for the years of 2016, 2017, 2018 and the current year and make additional payments including interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send checks for the additional payments and interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market

Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was underpaid." After which, furnish the examiners with documentation that the additional payments and interest have been paid within 180 days of this report being finalized;

6. Review all medical and mental health claims paid in 2016, 2017, 2018 and the current year. Determine those instances where interest is owed as required by § 38.2-3407.1 B of the Code and make payments to the insureds/providers to whom interest is due. All checks for reimbursement should be accompanied by a letter of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that interest was due on the payment of this claim. Please accept this check for an additional payment.";
7. Review its established procedures to ensure an appropriate reply is made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected, as required by 14 VAC 5-400-50 C;
8. Strengthen and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;
9. Strengthen and maintain procedures to ensure that every insurer offers to a first party claimant, or to a first party claimant's authorized representative, an amount which is fair and reasonable as shown by the investigation of the claim,

provided the amount so offered is within policy limits and in accordance with policy provisions, as required by 14 VAC 5-400-70 D;

10. Reopen and reprocess claims discussed in Review Sheets CL01, CL02, CL03, CL07, CL08, CL09, CL10 and CL11 to pay amounts required under the terms of the policy, as required by 14 VAC 5-400-70 D.

11. Within 90 days of this report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XII. ACKNOWLEDGMENT

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

Janay Brown, MCM, Gregory Lee, FLMI, CIE, MCM and Laura Klanian, HIA, PHIAS, AMCM of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie R Fairbanks

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

PROVIDER CONTRACTS
Ethics and Fairness – Provider Contracts
§ 38.2 3407.15 B 6, 1 violation, EF07J
§ 38.2 3407.15 B 7, 1 violation, EF06J
§ 38.2 3407.15 B 9, 1 violation, EF07GA
Ethics and Fairness – Provider Claims
§ 38.2-3407.15 B 1, 4 violations, EFCL12J, EFCL25J, EFCL27J, EFCL26J
§ 38.2-3407.15 B 3, 1 violation, EFCL19J
§ 38.2-3407.15 B 8, 5 violations, EFCL19J, EFCL21J, EFCL22J, EFCL23J, EFCL24J
Carrier Contracts with pharmacy providers; required provisions; limit on termination or nonrenewal
§ 38.2 3407.15:1 B 1, 1 violation, EF01GA
§ 38.2 3407.15:1 B 2, 1 violation, EF01GA
§ 38.2 3407.15:1 B 3, 1 violation, EF01GA
§ 38.2 3407.15:1 B 4, 1 violation, EF01GA
§ 38.2 3407.15:1 B 5, 1 violation, EF01GA
§ 38.2 3407.15:1 B 6, 1 violation, EF01GA
§ 38.2 3407.15:1 B 7, 1 violation, EF01GA
§ 38.2 3407.15:1 B 8, 1 violation, EF01GA
§ 38.2 3407.15:1 B 9, 1 violation, EF01GA
§ 38.2 3407.15: 1 C, 1 violation, EF01GA
Carrier contracts; required provisions regarding prior authorization
§ 38.2-3407.15:2 B 1, 3 violations, EF03GA, EF04GA, EF05GA
§ 38.2-3407.15:2 B 2, 3 violations, EF03GA, EF04GA, EF05GA
§ 38.2-3407.15:2 B 3, 3 violations, EF03GA, EF04GA, EF05GA

§ **38.2-3407.15:2 B 4, 3 violations,** EF03GA, EF04GA, EF05GA
§ **38.2-3407.15:2 B 5, 3 violations,** EF03GA, EF04GA, EF05GA
§ **38.2-3407.15:2 B 6, 3 violations,** EF03GA, EF04GA, EF05GA
§ **38.2-3407.15:2 B 7, 3 violations,** EF03GA, EF04GA, EF05GA
§ **38.2-3407.15:2 B 8, 3 violations,** EF03GA, EF04GA, EF05GA
Carrier and intermediary contracts with pharmacy providers; disclosure and updating of maximum allowable cost of drugs; limit on termination or nonrenewal
§ 38.2 3407.15:3 B 1, 1 violation, EF06GA
§ 38.2 3407.15:3 B 2, 1 violation, EF06GA
§ 38.2 3407.15:3 B 3, 1 violation, EF06GA
§ 38.2 3407.15:3 B 4, 1 violation, EF06GA
§ 38.2 3407.15:3 C 1, 1 violation, EF06GA
§ 38.2 3407.15:3 C 2, 1 violation, EF06GA
§ 38.2 3407.15:3 C 3, 1 violation, EF06GA
§ 38.2 3407.15:3 C 4, 1 violation, EF06GA
§ 38.2 3407.15:3 C 5, 1 violation, EF06GA
CLAIM PRACTICES
14 VAC 5-400-50 A, 1 instance, CL16
14 VAC 5-400-50 C, 3 instances, CL04, CL05, CL06
14 VAC 5-400-60 A, 14 violations, CL01, CL02, CL03, CL07, CL08, CL09, CL10, CL13, CL14, CL16, CL17, CL18, CL30, CL31
14 VAC 5-400-60 B, 7 instances, CL13, CL14, CL16, CL17, CL18, CL20, CL21
14 VAC 5-400-70 B, 1 instance, CL15
14 VAC 5-400-70 D, 8 instances, CL01, CL02, CL03, CL07, CL08, CL09, CL10, CL11
§ 38.2-3407.1 B, 16 violations, CL03, CL07, CL08, CL09, CL15, CL20, CL21, CL22, CL23, CL24, CL25, CL26, CL27, CL28, CL29, CL30

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
www.scc.virginia.gov/boi

February 4, 2019

SENT VIA EMAIL

Lynn C. Quinn
Sr. Compliance Lead
Coventry Health and Life Insurance Company
3033 Honeymead Road
Downingtown, PA 19335

RE: Market Conduct Examination Report
Exposure Draft

Dear Ms. Quinn:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Coventry Health and Life Insurance Company (CHLIC) for the period of January 1, 2016, through December 31, 2016. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of CHLIC, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. CHLIC response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
(804) 371-9385

aetna®

Lynn C. Quinn, MCM
Sr. Compliance Lead
151 Farmington Avenue, REGA
Hartford, CT 06156

Phone: 215-775-5629
Email: quinnl2@aetna.com

March 6, 2019

Sent Via e-mail - Julie.Fairbanks@scc.virginia.gov

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157

RE: Coventry Health and Life Insurance Company, NAIC 81973
Market Conduct Examination Draft Report

Dear Ms. Fairbanks:

This is in response to the Coventry Health and Life Insurance Company (the "Company") Draft Market Conduct Examination Report.

The Company confirms there is no remaining Coventry membership in the Commonwealth of Virginia as of June 30, 2017.

Section IV. Provider Contracts

In the "**Provider Contracts**" section found on page 5 of the draft report, the Company respectfully disagrees that the provider contract associated with review sheet EF07GA did not contain the contract provisions required by Virginia Code § 38.2 3407.15 B 9. Please see Attachment A. This provision can be found in the first paragraph on page 3 of the "Provider Manual VA Regulatory Section.pdf"

The Company acknowledges the time and effort of the examiners and staff at the Bureau of Insurance in revising the draft report and appreciates your consideration of the above information when issuing a final draft report.

If you have any questions regarding this information or need further information, please do not hesitate to contact me. I can be reached directly at 215-775-5629 or via email at quinnl2@aetna.com. Thank you very much.

Very truly yours,

Lynn C. Quinn

Lynn C. Quinn, MCM

Enclosures

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

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1300 E. MAIN STREET
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TELEPHONE: (804) 371-9741
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April 25, 2019

SENT VIA EMAIL ONLY

Lynn Quinn
Sr. Compliance Lead
Coventry Health and Life Insurance Company
3033 Honeymead Road
Downingtown, PA 19335

RE: Coventry Health and Life Insurance Company
Response to the Draft Examination Report

Dear Ms. Quinn:

The examiners have received and reviewed Coventry Health and Life Insurance Company's (hereinafter referred to as "CHLIC") response to the Draft Report dated March 6, 2019. This letter will primarily address those areas of the response where CHLIC disagreed with the findings of the Report.

Section IV. Provider Contracts

Although the provision required by § 38.2-3407.15 B 9 is included in the addendum to the Provider Manual, the definition of "Provider Manual" in the contract between Express Scripts Inc. (ESI) and the pharmacy contains language that states, "The Provider Manual may be revised from time to time by ESI in its sole discretion; notice of any changes in the Provider Manual shall be given to the Provider within 30 days of the effective date of the change." This conflicts with the requirements of § 38.2-3407.15 B 9, which requires CHLIC to provide notice of amendments at least 60 calendar days before the effective date; therefore, CHLIC's provider contract is in violation of this provision.

The examiners also note that the contract (referred to as the "Agreement") contains language in the definition of "Provider Manual" that states, "Should any term or condition contained in the Provider Manual conflict with this Agreement, the terms of this Agreement shall control."

The Provider Manual contains a regulatory addendum with language that states, "In the event there is a conflict between the terms and conditions set forth in this Addendum and the terms and conditions set forth in the Provider Agreement (including the Provider Manual), the terms and conditions set forth in this Addendum shall control."

Since the regulatory addendum is in the Provider Manual, there is conflicting language as to which document would control. Both documents (the Agreement and the regulatory addendum in the Provider Manual) indicate that they would control over the other. The examiners would caution CHLIC that this conflicting language regarding controlling terms is confusing and could potentially weaken the required provisions included in the regulatory addendum in the provider manual. The Report appears correct as written.

The examiners discovered an error on page 19 and the word "decisions" in the first paragraph has been replaced with "determinations" to be consistent with the applicable statutes and regulations. A copy of the entire Report with the revised page noted is attached, and the revised page contains the only substantive revision we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that CHLIC violated the Unfair Trade Practices Act, specifically § 38.2-510 A 15 and 14 VAC 5-400-60 A of Rules Governing Unfair Claim Settlement Practices.

It also appears that CHLIC violated §§ 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15:1 B 1, 38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3, 38.2-3407.15:1 B 4, 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, 38.2-3407.15:1 B 9, 38.2-3407.15:1 C, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 1, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 3, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 2, 38.2-3407.15:3 C 3, 38.2-3407.15:3 C 4, 38.2-3407.15:3 C 5 and 38.2-3407.1 B of the Code.

Violations of the above sections of the Code can subject CHLIC to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

aetna™

509 Progress Drive
Suite 117
Linthicum, MD 21090

15 May 2019

Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

RE: Alleged violation of Code of Virginia §§ 38.2-510 A 15, 38.2-3407.15 B 1, 38.2-3407.15 B 3, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15:1 B 1, 38.2-3407.15:1 B 2, 38.2-3407.15:1 B 3, 38.2-3407.15:1 B 4, 38.2-3407.15:1 B 5, 38.2-3407.15:1 B 6, 38.2-3407.15:1 B 7, 38.2-3407.15:1 B 8, 38.2-3407.15:1 B 9, 38.2-3407.15:1 C, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-3407.15:3 B 1, 38.2-3407.15:3 B 2, 38.2-3407.15:3 B 3, 38.2-3407.15:3 B 4, 38.2-3407.15:3 C 1, 38.2-3407.15:3 C 2, 38.2-3407.15:3 C 3, 38.2-3407.15:3 C 4, 38.2-3407.15:3 C 5 and 38.2-3407.1 B as well as 14 VAC 5-400-60 A, Rules Governing Unfair Claim Settlement Practices.

Case No. INS-2019-00056

Dear Ms. Blauvelt:

This will acknowledge receipt of the Bureau of Insurance's letter dated May 10, 2019, concerning the above-referenced matter.

Coventry Health and Life Insurance Company wishes to make a settlement offer for the alleged violations cited above. Further, we agree to:

1. Enclose with this letter a certified check, cashier's check or money order payable to the Treasurer of Virginia in the amount of $18,000.

2. Comply with the corrective action plan set forth in the Target Market Conduct Examination report of December 31, 2016.

3. Acknowledge Coventry Health and Life Insurance Company's right to a hearing before the State Corporation Commission in this matter and waive that right if the State Corporation Commission accepts this offer of settlement.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Sincerely,

Coventry Health and Life Insurance Company

Michael Bucci

(Signed)

Michael Bucci

(Type or Print Name)

Market President

(Title)

15 May 2019

(Date)

Enclosure

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

190620290

AT RICHMOND, JUNE 21, 2019

SCC-CLERK'S OFFICE
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2019 JUN 21 P 1:14

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2019-00056

COVENTRY HEALTH AND
LIFE INSURANCE COMPANY,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that Coventry Health and Life Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated § 38.2-510 A (15) of the Code of Virginia ("Code") by failing to comply with claim settlement practices; § 38.2-3407.1 B of the Code by failing to comply with the requirements for the payment of interest; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (3), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (8), and 38.2-3407.15 B (9) of the Code by failing to comply with ethics and fairness requirements in carrier business practices; §§ 38.2-3407.15:1 B (1), 38.2-3407.15:1 B (2), 38.2-3407.15:1 B (3), 38.2-3407.15:1 B (4), 38.2-3407.15:1 B (5), 38.2-3407.15:1 B (6), 38.2-3407.15:1 B (7), 38.2-3407.15:1 B (8), 38.2-3407.15:1 B (9), and 38.2-3407.15:1 C of the Code by failing to comply with contract requirements between the Defendant and pharmacy providers; §§ 38.2-3407.15:2 B (1), 38.2-3407.15:2 B (2), 38.2-3407.15:2 B (3), 38.2-3407.15:2 B (4), 38.2-3407.15:2 B (5), 38.2-3407.15:2 B (6), 38.2-3407.15:2 B (7), and 38.2-3407.15:2 B (8) of the Code by failing to comply with contract requirements between the Defendant and a participating health care provider, or its contracting agent, regarding prior authorization;

§§ 38.2-3407.15:3 B (1), 38.2-3407.15:3 B (2), 38.2-3407.15:3 B (3), 38.2-3407.15:3 B (4), 38.2-3407.15:3 C (1), 38.2-3407.15:3 C (2), 38.2-3407.15:3 C (3), 38.2-3407.15:3 C (4), and 38.2-3407.15:3 C (5) of the Code by failing to comply with contract and intermediary contract requirements between the Defendant and pharmacy providers regarding disclosure and updating of maximum allowable cost of drugs; and 14 VAC 5-400-60 A of the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, by failing to provide claimants timely notification of acceptance or denial of claims.

The Commission is authorized by §§ 38.2-218, 38.2-219, and 38.2-1040 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan outlined in the Bureau's Target Market Conduct Examination Report of December 31, 2016, has tendered to the Treasurer of Virginia the sum of Eighteen Thousand Dollars ($18,000), and has waived the right to a hearing.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Lynn Quinn, Senior Compliance Lead, Coventry Health and Life Insurance Company, 3033 Honeymead Road, Downingtown, Pennsylvania 19335; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.