COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

National Health Insurance Company

4455 LBJ Freeway
Suite 500
Dallas, TX 75244

As of: June 20, 2024
Issued: August 7, 2024

Division of Health Market Conduct
Office of Market Regulation

pennsylvania
INSURANCE DEPARTMENT

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Joseph Handline, MCM (Name of Examiner), Chief of Health Market Conduct (Title of Examiner) from

N/A (Name of Vendor/Department) certify that I was the Examiner-In-Charge of the Report of

Examination of National Health Insurance Company (Name of Examined Company) made as of 5/1/2024 (Date).

The last date of examination file review was 1/15/2021 (Date) and the written Report

of Examination was reviewed and accepted by Joseph Handline (Chief of Health Market Conduct)

on 6/20/2024 (Date).

I have reviewed the completed written Report of Examination and certify that the facts and figures recited therein are true and accurate, according to the records, documents and other evidence obtained during the course of the examination.

Joseph Handline
(Examiner-in Charge)

N/A
(Name of Vendor/Department)

N/A
(Address of Vendor/Department)

Joseph Handline
(Examiner in Charge Signature)

06/20/2024
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

O R D E R

AND NOW, this __3rd___ day of _July___, 2023, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate David J. Buono, Jr., Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.

Michael Humphreys
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
National Health Insurance Company 4455 LBJ Freeway Suite 500 Dallas, TX 75244	:	40 P.S. §§ 310.71(a); 310.71(f); 324.3; 991.2166(a); 991.2166(b); 1171.5 (a)(1)(i); 1171.5(a)(2); 1171.5(a)(10)(i), (a)(10)(iii), (a)(10)(v), (a)(10)(vi), (a)(10)(x)
	:	18 Pa. C.S. § 4117(k)(1)
Respondent	:	31 Pa. Code §§ 37.61(a); 51.21(a); 51.21(b), 146.3; 146.4(a); 146.4(b); 146.5(a); 146.5(d); 146.6; 146.7, (a)(1), (c)(1); 154.18(a), (c)
		45 C.F.R § 144.103
		Docket No. MC24-07-023

CONSENT ORDER

And now, this ____7th_____ day of _____August_____, 2024, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa. C.S. §§ 101 et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter and agrees that this Consent Order shall have the full force and effect of an order duly

entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is National Health Insurance Company, 4455 LBJ Freeway Suite 500, Dallas, TX 75244.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2017 to June 30, 2019.

(c) On June 20, 2024, the Insurance Department issued a Market Conduct Examination Report to Respondent ("Examination Report").

(d) Respondent provided to the Insurance Department a response to the Examination Report on July 19, 2024.

(e) All findings and conclusions in the Examination Report, which is attached hereto, are hereby incorporated into this Consent Order.

CONCLUSIONS OF LAW

4. In accordance with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Violations of 40 P.S. §§ 310.71(a) and 310.71(f), as contained in the Examination Report, are punishable by the following under 40 P.S. §§ 310.91:

(1) License revocation.

(2) Imposition of a penalty of not more than five thousand dollars ($5,000.00) for each violation.

(3) An order to cease and desist.

(4) Any other conditions as the commissioner deems appropriate.

(c) Violations of 40 P.S. § 324.3, as contained in the Examination Report are punishable under 40 P.S. § 324.13:

(1) Failure to hold a license shall subject the administrator to a civil penalty of not less than $1,000 nor more than $5,000 for each instance of unlicensed activity.

(d) Violations of 40 P.S. §§ 991.2166(a) and 991.2166(b), as contained in the Examination Report, are punishable by the following under 40 P.S. § 991.2182:

(1) Imposition of a penalty of not more than five thousand dollars ($5,000.00) for each violation.

(2) An action for an injunction to prohibit any activity that violates the act.

(3) An order temporarily prohibiting respondent from enrolling new members.

(4) A requirement to develop and adhere to a plan of correction.

(e) Violations of 40 P.S. §§ 1171.5 (a)(1)(i), 1171.5(a)(2), 1171.5(a)(10)(i), 1171.5 (a)(10)(iii), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), 1171.5(a)(10)(x), as contained in the Examination Report, are punishable by the following under 40 P.S. § 1171.9:

(1) An order to cease and desist.

(2) License suspension or revocation.

(f) In addition to any penalties imposed by the Commissioner for violations of 40 P.S. §§ 1171.5 (a)(1)(i), 1171.5(a)(2), 1171.5(a)(10)(i), 1171.5 (a)(10)(iii), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), 1171.5(a)(10)(x), as contained in the Examination Report, the Commissioner may, under 40 P.S. §§ 1171.10, 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

(1) An injunction.

(2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars ($50,000) in any six-month period.

(3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six-month period.

(g) Violations of 31 Pa. Code §§ 146.3, 146.4(a), 146.4(b), 146.5(a), 146.5(d), 146.6, 146.7, 146.7(a)(1), 146.7(c)(1), as contained in the Examination Report, are punishable by the following under 40 P.S. §1171.9:

(1) An order to cease and desist.

(2) License suspension or revocation.

(h) In addition to any penalties imposed by the Commissioner for violations of 31 Pa. Code §§ 146.3, 146.4(a), 146.4(b), 146.5(a), 146.5(d), 146.6, 146.7, 146.7(a)(1), 146.7(c)(1), as contained in the Examination Report, the Commissioner may, under 40 P.S. §§1171.10 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

(1) An injunction.

(2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars ($50,000) in any six-month period.

(3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars ($10,000) in any six-month period.

(i) Violations of 31 Pa. Code §§ 154.18(a) and 154.18(c), as contained in the Examination Report, are punishable by the following under 40 P.S. § 991.2182:

(1) Imposition of a penalty of not more than five thousand dollars ($5,000.00) for each violation.

(2) An action for an injunction to prohibit any activity that violates the act.

(3) An order temporarily prohibiting respondent from enrolling new members.

(4) A requirement to develop and adhere to a plan of correction.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact, which incorporate the findings and conclusions contained in the Examination Report, and Conclusions of Law, insofar as the activities violate the laws of the Commonwealth of Pennsylvania.

(b) Respondent shall share the Examination Report and this Order with each of its directors and submit affidavits executed by each of its directors, stating under oath that they have received a copy of the Examination Report and this Order. Such affidavits shall be submitted within 30 days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the Examination Report.

(d) Respondent shall report on a quarterly basis, beginning ninety (90) days after the date of this Order, all restitution paid as a result of the reprocessing of those claims as identified in the Examination Report. All restitution reporting shall be completed within 12 months from the date of this Order.

(e) Respondent shall pay Two hundred Fifty thousand dollars ($250,000.00) to the Commonwealth of Pennsylvania in settlement of the violations contained in the Examination Report.

(f) Payment of this matter shall be made at https://www.bpp.ob.pa.gov/Customer. Instructions on how to do this are provided in the attached cover letter to this order. Payment must be made no later than thirty (30) days after the date of this Order.

(g) To determine Respondent's compliance with the full and timely implementation of all recommendations ("Recommendations") in the Examination Report, the Department may conduct a re-examination of Respondent. The Department may inquire with the Respondents about its implementation of the Recommendations no earlier than twelve (12) months from the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein, the Insurance Department may pursue any and all legal

remedies available, including but not limited to the following: the Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Insurance Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order that Respondent has not remedied after being afforded a reasonable opportunity to do so, the Insurance Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein, including those contained in the Examination Report incorporated herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: National Health Insurance Company,
Respondent

Charles Harris President

President / Vice President

Karen Millard, Secretary

Secretary / Treasurer

David J Buono

COMMONWEALTH OF
PENNSYLVANIA
David J. Buono, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on National Health Insurance Company, hereafter referred to as "Company," in the offices of the Pennsylvania Insurance Department (the Department) and off-site locations.

Pennsylvania Market Conduct Examination Reports (Examination Report) generally note the items that have been reviewed and whether there is a violation of law or regulation. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in an Examination Report may result in imposition of penalties. An Examination Report also includes management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance. Findings identified in all summaries issued to the Company throughout the Examination process are included in this Examination Report; however, in some instances, the content of multiple summaries may be combined into a single report section. This only applies to sections in which no violations were found.

The Department notes that much of the experience period (January 1, 2017 through June 30, 2019) occurred prior to the publication of the Department's updated guidance regarding the filing requirements related to out-of-state associations and short-term limited duration insurance (STLDI).[1] Any conclusions reached in this Examination Report concerning the compliance of associations with the requirements of Pennsylvania law were based on the limited information obtained by Examiners.

It is also noted that certain areas subject to Examination are and will continue to be the focus of ongoing compliance emphasis by the Department; for example, concerns with marketing practices with respect to STLDI health plans. The Department appreciates and anticipates the continued cooperation of the Company in providing coverage consistent with the laws and regulations

[1] *See* Department Notice 2018-08 (48 Pa. B. 7284) (published November 17, 2018); *see also* Department Notice 2018-10 (48 Pa. B. 7282) (published November 17, 2018) ("Further, with respect to AHPs, the Department by this notice reminds insurers of their obligations to file documentation regarding an association or other group of employers to which they market or issue insurance, whether that association or group is located in this Commonwealth or out-of-state, if the coverage is intended to cover employers or individuals in this Commonwealth.").

governing these areas. It should be noted that the Company stopped marketing STLDI health plans in 2019, and the latest policy effective date was March 7, 2019.

Throughout the course of the Examination, Company officials were provided status memoranda or summaries, which reference specific policy or claim numbers with citations to each section of law violated. Additional information was requested to clarify apparent violations. Multiple conference calls, status meetings, and an exit conference were conducted with Company officials to discuss the various types of violations identified during the Examination and to review written summaries provided on the violations found.

The courtesy and cooperation extended by the officers and employees of the Company during the course of the Examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Examination Report.

Katie Dzurec, JD, MPA, MCM
Acting Director, Bureau of Health Market Actions
Pennsylvania Insurance Department

Nicole R. McClain, MCM
Examiner-In-Charge
PA Insurance Department

Tom McIntyre, CIE, CPCU, FLMI, AMCM, CICSR,
CCP, AIRC, APA, ARA, ACS, CWCP
Contract Examiner-In-Charge

Lindsi Swartz, MBA, MCM
Contract Examiner

Debra J. McNeil, MCM
Contract Examiner

Marc Springer, CIE, CPCU, MCM
Contract Examiner

Jo-Anne Arrowood
Contract Examiner

Joseph Handline, MCM
Market Conduct Chief
PA Insurance Department

Penny Callihan, MCM
Market Conduct Chief
PA Insurance Department

Ryan Sellers, MCM, APIR
Market Conduct Examiner II
PA Insurance Department

Frank Callihan, MCM
Market Conduct Examiner II
PA Insurance Department

Joseph Barrett, MCM, APIR
Market Conduct Examiner II
PA Insurance Department

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§ 323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2017, through June 30, 2019, unless otherwise noted. The purpose of the Examination was to ensure compliance with Pennsylvania insurance laws and regulations, as well as applicable federal laws and regulations not superseded by state law.

The Examination focused on the Company's policies, procedures, and processes in the following areas: Operations and Management, Complaints, Marketing and Sales, Producer Licensing, Policyholder Services, Underwriting, and Claims.

Examiners requested that the Company identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for Examination.

For control purposes, some of the review segments identified in this Examination Report may be broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Examination Report, are included and grouped within the respective categories of the Examination Report. All reviews conducted throughout the Examination included consideration of Company responses to examiner requests pursuant to 40 P.S. §§ 323.3 and 323.4. While included in all reviews completed during the Examination, the Examination Report only notes when examiners found a violation of these sections in a particular area.

III. COMPANY HISTORY

National Health Insurance Company (NHIC) is a legal reserve life company organized in 1965 and is domiciled in the state of Texas. NHIC maintains certificates of authority in 49 states and the District of Columbia. On November 1, 2012, NHIC was purchased by Integon Indemnity Corporation from Great Midwest Insurance Company, a wholly-owned subsidiary of Houston International Insurance Group, Texas. The acquisition was approved by Texas Commissioner's Order No. 12-0853, dated October 31, 2012. Integon Indemnity Corporation is a wholly-owned subsidiary of National General Management Corporation (NGMC). NGMC is wholly owned by National General Holdings Corporation (NGHC). NGHC is publicly traded on the NASDAQ. The NGHC insurance group made the strategic decision to enter the accident and health market and acquired NHIC as the platform to commence writing life, accident, and health products.

A.M. Best Co. has assigned a financial strength rating of A- (Excellent) and an issuer credit rating of "A-" to National Health Insurance Company (NHIC) (Dallas, TX). The outlook assigned to both ratings is stable. This rating was affirmed September 5, 2019.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to internal audit and compliance procedures. The audits and procedures were reviewed to assure best practices and compliance with applicable laws and regulations. Documents requested dealt with monitoring business functions, record retention policies and procedures, company management and governance, privacy protections and notices, and standards for handling non-public personal information. Unless noted, all documents identified in each universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 991.2166 and 45 C.F.R. § 144.103.

A. Third-Party Agreements

Examiners requested copies of contracts that were in effect during the experience period with any third-party entity, including managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs), and vendors conducting activities on behalf of the Company during the experience period. In addition, examiners requested a list of all entities that were involved in the sale or servicing of STLDI products. The Company identified a universe of 22 documents and supplied one additional document in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with state and federal laws and regulations. The following violation was noted:

1 Violation - 40 P.S. § 324.3

On and after the effective date of this act, no person shall act as or hold himself out to be an administrator in this Commonwealth, other than an adjuster in this Commonwealth for the kinds of business for which he is acting as an administrator, unless he shall hold a license as an administrator issued by the department. The Company utilized an unlicensed third-party administrator.

B. Contracted-Entity Activity Monitoring

Examiners requested documentation demonstrating that the Company adequately monitored the activities of any entity that contractually assumed a business function or acted on behalf of the Company. The Company identified a universe of seven documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. The following Concern was noted:

Concern: Examiners found internal audit recommendations for the third party-administrator, Meritain, referencing controls associated with claims' turn-around for clean claims and customer service metrics for claims, including claims timeliness, pre-existing conditions investigations, and misrepresentation investigations. The Company did not provide evidence that it implemented those recommendations or acted upon the performance metrics. In addition, claims review in the examination supported these monitoring failures because its TPA failed to: 1) pay claims within 45 days of receipt; 2) pay claims timely and pay interest of $2 or more when applicable; 3) accurately represent the Emergency Room (ER) deductible as a deductible rather than a copay; 4) complete claim investigations within 30 days and issue status letters at 30 days and every 45 days thereafter; 5) issue Explanations of Benefits (EOBs) with enough information for members to be able to understand the coverage in question; and 6) notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. Notably, the Company has increased monitoring of TPAs and implemented process improvements to address the noted issues.

C. Written Overview of Operations

Examiners requested a written overview of the Company's operations including management structure, type of carrier, states where the Company is licensed, and the major lines of business the Company had written for the experience period, including information if a regional office handled any portion of the Pennsylvania business. The request included current organizational charts outlining the structure of Pennsylvania operations with respect to management, marketing, customer service, complaints, underwriting, and claims. The request also included any specialty operations conducted separately. The Company identified a universe of 14 documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure

compliance with applicable state and federal laws and regulations noted above, as well as 18 Pa. C.S. § 4117(k)(1); 40 P.S. §§ 310.71 et. seq., 756.2 et. seq., 1171.5; 31 Pa. Code §§ 37.61, 51.21, 51.22, Ch. 146 and Ch. 154. No violations were noted in the written records regarding operations and management; however, the following violations and a concern were noted with respect to Company operations and management based on responses and actions taken during the course of the Examination:

1 General Violation - 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions.

AND

31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

AND

31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company failed to define Out-of-Pocket Maximum (OOPM) in the applications, Schedules of Benefits (SOBs), and Certificates of Coverage (COCs). Additionally, the Company failed to include and track all out-of-pocket expenses incurred by members in the OOPM accumulations. This issue is identified as a general violation in the Company Operations section of the report because it was noted across several claim sections.

1 General Violation - 40 P.S. § 1171.5(a)(10)(iii)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

AND

40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to implement reasonable standards for the prompt investigation of rescinded policies once all medical records were received. Timeframes from dates of receipt of all medical records to dates that letters of intent to rescind were issued to members ranged from 77 to 249 days in the sample rescissions reviewed. This issue is identified as a general violation in the Company Operations section of the report because it was noted as an issue that impacted all rescissions. Notably, the Company has indicated it is working toward creation of more robust policies and procedures regarding the time of review standard.

Concern: For emergency room (ER) claims, the Company requested additional information for an extensive number of diagnosis codes and procedure codes, which created a delay for the processing of ER claims. The Company failed to complete ER claims investigations within 30 days and failed to pay the claims within 45 calendar days.

D. Response to Requests

Examiners requested documentation demonstrating that the Company understood that it was required to respond to requests from examiners in a timely manner. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness and accuracy of responses for items requested by the Department during the Examination. One general data integrity violation, described later in this Examination Report, was noted for the Company's general failure to provide timely access to all information requested by the Department during the course of the Examination. No other violations were noted.

E. External Audits and Examinations

Examiners requested a list of all fines, penalties, and recommendations from any state for the years 2015-2019. Examiners also requested copies of all market conduct Examination reports conducted during the last five years by any state. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

V. CONSUMER COMPLAINTS

Examiners requested documentation relating to consumer complaints, including policies and procedures for complaint handling, record keeping, dispositions, and timelines. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 991.2166 and 1171.5; and 31 Pa. Code Ch. 146 and 154.

A. Consumer Complaints and Logs

Examiners requested documentation that all complaints were recorded in the required format on the Company's complaint register for the experience period. The Company identified a universe of four documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

B. Complaint Handling Procedures

Examiners requested that the Company provide policies and procedures related to complaint and grievance handling and for communicating such procedures to policyholders. The Company identified a universe of eight documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

C. Complaint Resolution

Examiners requested documentation demonstrating that the Company took adequate steps to finalize complaints in accordance with applicable state laws and regulations and contract language. The Company identified a universe of nine documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

D. Complaint Response Time

Examiners requested documentation demonstrating that the timeframe for the Company to respond to complaints is in accordance with applicable state laws and regulations. The Company identified a universe of 10 documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. List of Complaints

Examiners requested a list of all consumer and social media complaints filed with the Company during the experience period. The list included complaints received from the Department, as well as complaints made directly to the Company on behalf of Pennsylvania consumers. The Company identified a universe of two documents, containing 83 NHIC complaints and 451 Meritain complaints for a total of 534 complaints. A random sample of 20 NHIC complaints and 45 Meritain complaints were requested. Examiners reviewed five NHIC complaints and 26 Meritain complaints. In accordance with the requirements of the Examination, the files were reviewed to ensure compliance with applicable state laws and regulations. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's

liability under the policy has become reasonably clear. The Company failed to pay the noted clean claim within 45 days of receipt.

2 Violations – 40 P.S. § 1171.5(a)(10)(i)

The following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

40 P.S. § 1171.5(a)(10)(vi)

The following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the noted claims when liability was clear.

F. Root Cause Analysis

Examiners requested the Company's policies, procedures, and guidelines for complaint handling and monitoring of complaints for root cause analysis and improvements to policies and procedures in effect during the experience period. The Company identified a universe of eight documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

G. Expedited Review of Grievances

Examiners requested documentation demonstrating that the Company had procedures for, and conducted, expedited reviews of grievances involving adverse determinations, in compliance with applicable state laws and regulations. The Company identified a universe of five documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

VI. MARKETING AND SALES

Examiners requested documentation relating to marketing and sales, including policies and procedures regarding systems, record-keeping, and verification. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 756.2 and 1171.5; 31 Pa. Code Ch. 51, and § 146.4; and 45 C.F.R. § 144.103.

A. Policy Forms – Schedules of Benefits and Disclosures

Examiners requested a list and copies of all policy forms, amendments, riders, applications, SOBs, disclosures, and other forms for limited benefit and STLDI products/plans marketed and issued in Pennsylvania during the experience period. The Company identified a universe of 180 documents and provided five additional documents in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. The following violations were noted:

30,550 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

31 Pa. Code § 146.4 (a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented or when the benefits, coverages or other provisions are pertinent to a claim. The

Company failed to define and fully disclose maximum out-of-pocket provisions, including applicability of coinsurance and the ER deductible.

B. Application Process

Examiners requested documentation demonstrating the application process for its STLDI plans during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

C. URL for Plan Documents

Examiners requested Uniform Resource Locators (URLs) where consumers could obtain plan documents and information during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

D. Accessing Plan Documents

Examiners requested a description of the process the Company had in place for individuals to request and obtain hard copies of plan documents and information during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Company Websites and Social Media Platforms

Examiners requested a list of all Company websites and social media sites used by the Company to market its limited benefit and STLDI products/plans during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

F. Advertising Materials

Examiners requested copies of all sales, marketing and advertising materials, brochures, flyers, radio recordings, postcards, billboard photographs, and e-newsletters produced by the Company to market the Company's limited benefit and STLDI products/plans during the experience period. The Company identified a universe of 170 documents and provided three additional documents in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. The following violations were noted:

9 Violations – 40 P.S. § 1171.5(a)(2)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

AND

31 Pa. Code § 51.21(a)

The format and content of an advertisement of an insurance contract shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

AND

31 Pa. Code § 51.21(b)

Advertisements shall be untruthful and not misleading in fact or in implication. The Company failed to provide clear information in their marketing materials; the materials contained inconsistent statements regarding the minimum age for primary applicants.

G. Producer Created Marketing Materials

Examiners requested copies of all sales, marketing and advertising materials, brochures, flyers, radio recordings, postcards, billboard photographs, and e-newsletters created by producers to market or advertise the Company's limited benefit and/or STLDI plans during the experience period. The Company identified a universe of 24 documents and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. The following violations were noted:

11 Violations – 40 P.S. § 1171.5(a)(2)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading.

AND

31 Pa. Code § 51.21(a)

The format and content of an advertisement of an insurance contract shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

AND

31 Pa. Code § 51.21(b)

Advertisements shall be truthful and not misleading in fact or in implication. AWA association marketing materials limiting coverage effective dates to the 1st or 15th day of the month did not coincide with the Company's quoting platform and application process, which do not identify any limitations on coverage effective dates.

H. Procedures for Approving Producers Marketing Materials

Examiners requested documentation demonstrating that the Company approved Company- and Producer-created marketing, advertising materials, brochures, flyers, radio recordings, postcards, billboard photographs, gala and e-newsletters during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

VII. PRODUCER LICENSING

Examiners requested documentation relating to producer licensing, including policies and procedures regarding systems, record-keeping, and verification. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 310.1 et seq. and 1171.5; and 31 Pa. Code § 37.61 and Ch. 39a.

A. Active and Terminated Producers

Examiners requested documentation demonstrating that the Company maintained required records of licensed and appointed producers and continuously monitored the producer list in comparison to the Insurance Department's records during the experience period. Examiners also requested a list of all producers appointed with the Company in Pennsylvania or authorized to conduct business in Pennsylvania at any time during the experience period. The Company provided a list of 4,616 individual producers, comprised of 2,412 active appointments, one pending appointment, and 2,203 terminated appointments. Examiners compared the Company's Producer List to the Department's Sircon Producer Lists. Additionally, Examiners verified all agents were licensed and appointed to the Company by comparing agent license numbers provided in other Examination sections to the Department's Producer Lists. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. The following violations were noted:

10 Violations – 40 P.S. § 310.71(a)

An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed.

AND

31 Pa. Code § 37.61(a)

A certificate does not permit a person to act as an agent. To complete the certificate process to act as an agent, a person shall secure a written appointment from each sponsoring entity. Appointment activity by an entity for existing certificate holders shall be reported to the Department on a monthly basis. The report shall be in a format approved by the Department. The report shall be filed within 30 days of the end of the month being reported. The Company failed to ensure that all producers were licensed and/or appointed.

1 Violation – 40 P.S. § 310.71(f)

An insurer shall, upon request, certify to the department the names of all licensees appointed by the insurer. The Company failed to maintain an accurate list of producer appointments for the experience period.

B. Appointment and Oversight of Producers

Examiners requested copies of internal documents describing requirements for appointment, termination, training and oversight of producers during the experience period. The Company identified a universe of eight documents and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

C. Management of Producer Oversight

Examiners requested a list of all Company employees involved with the appointment, termination, training, and oversight of producers for the Company during the experience period. The Company identified a universe of two documents and provided two additional documents in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

D. Producer Contracts

Examiners requested a copy of producer contracts used during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the

Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Licensing and Appointment Verification

Examiners requested a description of how the Company issues licensing and appointments and verifies that all business accepted from producers was written by individuals who were duly licensed and appointed to represent the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

F. Producer Training Materials

Examiners requested copies of all training manuals and other training materials produced by the Company for the training of its producers during the experience period. The Company identified a universe of 16 documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. The following violations were noted:

9 Violations – 40 P.S. § 1171.5(a)(2)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading. The Company failed to provide clear information in their producer training materials; the materials contained inconsistent statements regarding the minimum age for primary applicants.

G. Commission Schedules

Examiners requested the Company's commission schedules used during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the

Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. Sales Call Recording and Retention

Examiners requested information regarding voice recordings of sales calls, including whether such recordings are available and how long they are retained. The Company identified a universe of two documents and a universe of 1,234 unique recordings from two agencies. The examiners requested a random sample of 20 recordings from the universe of recordings. Of the 20 recordings received, two contained audio formats which were not supported by the examiners' software. In accordance with the requirements of the Examination, the documents and recordings were reviewed to ensure compliance with applicable state laws and regulations. The following concern was noted:

Concern: The Company was not able to produce a listing of recordings for all producers who market its products or identify which producers have recordings available. While the Company had a retention policy which outlines requirements if calls are recorded and how long they should be maintained, the Company did not have a written policy for the handling and identification of recorded calls for all producers and vendors during the experience period. However, in response to the Department's recommendation related to this concern, the Company immediately created a policy and procedure that identifies which sales partners must record calls, how recordings will be obtained, and how long records must be maintained by applicable sales partners.

VIII. POLICYHOLDER SERVICES

Examiners requested documentation relating to policyholder services. Specifically, the documents were reviewed to ensure policyholder service guidelines were in place and being followed in a uniform and consistent manner, and that no policyholder service practices or procedures were in place that could be discriminatory in nature, or specifically prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 477a, 753, 761, and 1171.5.

A. Collection Billing Practices

Examiners requested policies and procedures for premium collection and billing practices describing requirements for issuance of notices with required advance notice during the experience period. The Company identified a universe of two documents and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

B. Timely Policy Issuance and Insured-Requested Cancellation

Examiners requested documentation describing requirements for timely policy issuance and insured-requested cancellations during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. The following concern was noted:

Concern: In some instances, the Company failed to allow for insured-requested cancellation of coverage on the date requested. In addition, the Company failed to issue pro-rata refunds in some instances due to system constraints. In those cases, a full month refund was offered, or the Company offered to cancel as of the current-paid to date and not take any additional premium.

Notably, the Company has developed policies and procedures to allow for insured-requested cancellation of coverage on any date requested and to issue pro-rata refunds when required.

C. Correspondence Received by the Company

Examiners requested policies and procedures or other documentation describing requirements for timely and responsive answers by the appropriate department to all correspondence directed to the Company during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

D. Assumption Reinsurance Agreements

Examiners requested documentation demonstrating that whenever the Company transferred the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement during the experience period, the Company had gained prior approval, and the Company had sent the required notices to affected policyholders. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Policies with Service-Related Transactions

Examiners requested an Excel list of service-related transactions such as beneficiary information, policyholder requests, and free-look provisions that occurred during the experience period. The Company identified a universe of two documents and 171,312 transactions and provided four additional documents in response to an examiner-issued information request. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

F. Premium and Billing Notices

Examiners requested samples of final approved premium notices and final approved billing notices during the experience period. The Company identified a universe of five documents. In

accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

G. Cancelled Policies

Examiners requested a list of all STLDI policy cancellations during the experience period. The Company identified a universe of two documents and 4,604 cancellation files. A sample of 36 cancellation files was requested and 10 were selected for review. During review, it was determined that three policies went to term and were not cancellations. In accordance with the requirements of the Examination, these files were replaced, and 10 files were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

H. Policy Premium Refunds

Examiners requested a list of all STLDI policy refunds during the experience period. The Company identified a universe of two documents and 57 refund files. A sample of 36 refund files was requested and 10 were selected for review. During review, it was determined that two files did not include a refund and one was a dental plan, which is outside the scope of this Examination. In accordance with the requirements of the Examination, these files were replaced, and 10 files were reviewed to ensure compliance with applicable state and federal laws and regulations. The following concern was noted:

Concern: In some instances, the Company failed to issue pro-rata premium refunds due to system constraints. In those cases, a full month refund was offered, or the Company offered to cancel as of the current paid to date and not take any additional premium. Notably, the Company has developed policies and procedures to allow for insured-requested cancellation of coverage on any date requested and to issue pro-rata refunds when required.

IX. UNDERWRITING

Examiners requested documentation relating to underwriting. Specifically, the documents were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner, and that no underwriting practices or procedures were in place that could be considered discriminatory in nature or prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. When the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 756.2(f)(3), 1171.5, and 3801.301 et seq.; and 45 C.F.R. § 144.103.

A. Mandated Disclosures

Examiners requested documentation demonstrating how the Company assured that all mandated disclosures were issued in accordance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. The following violations were noted:

29,483 Violations – 45 C.F.R. § 144.103

STLDI means health insurance coverage provided pursuant to a contract with an issuer that, with respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading "Notice 1," with any additional information required by applicable state law:

Notice 1:

> This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding

coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month. The Company failed to prominently display the required notice language in the contracts and in any application materials.

B. Policy Form Review

Examiners requested documentation demonstrating that all forms, including policies, contracts, riders, amendments, endorsements forms, and certificates were filed during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. The following concern was noted:

Concern: 40 P.S. §§ 756.2(f)(3) and 40 P.S. § 3801.301 et seq.

A Company may only issue a group accident and sickness insurance policy to an out-of-state association that the Company can demonstrate complies with the applicable statutory requirements, namely, that the association must be organized or domiciled in a state other than this Commonwealth, have a constitution and bylaws, be organized by other than an insurer, be maintained in good faith for purposes other than those of obtaining insurance, have been in active existence for at least two years, operate from offices other than the insurer's and be controlled by principals other than the insurer's. The Company failed to timely file with the Department documentation demonstrating that the Lifestyle Innovations for Empowerment (L.I.F.E.) Association, Affiliated Workers Association (AWA), and Unified Caring Association (UCA) satisfied the requirements set forth in 40 P.S. § 756.2(f)(3) prior to offering health insurance products through these associations to Pennsylvania consumers. Regardless of the substantive merits of the association, the form filing requirements contained in the Accident and Health Filing

Reform Act (40 P.S. § 3801.301 et seq.) apply to documentation supporting compliance with the elements of 40 P.S. § 756.2(f)(3). The provisions in 40 P.S. § 3801.301 et seq. are not within the exemption granted when compliance with 40 P.S. § 756.2(f)(3) is demonstrated. Recognizing that the beginning of the experience period for this exam occurred prior to updated association filing guidance issued by the Department, which was published in the Pennsylvania Bulletin on November 16, 2018, the Department will treat the Company's failure to timely file the association documentation as a concern and note that the Department, during this Examination, raised concerns regarding the merits of the associations noted above.

C. Issue and Renewal

Examiners requested documentation demonstrating that policies, contracts, riders, amendments, and endorsements were issued or renewed accurately, timely, and completely during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to determine compliance with applicable state laws and regulations. The following violations were noted:

69 Violations – 40 P.S. § 1171.5(a)(2)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, issuing, publishing or circulating in any manner an advertisement, announcement or statement containing any representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business which is untrue, deceptive or misleading. AWA association marketing materials limiting coverage effective dates to the 1st or 15th day of the month did not coincide with the Company's quoting platform and application process which do not identify any limitations on coverage effective dates.

D. Policy Rejections and Declinations

Examiners requested documentation demonstrating that rejections and declinations were not unfairly discriminatory during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Cancellation and Non-Renewals

Examiners requested documentation that cancellation/nonrenewal, discontinuance and declination notices used during the experience period complied with policy and contract provisions, and state laws and regulations. The Company identified a universe of nine documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. No violations were noted.

F. Rescissions

Examiners requested a list of all policies rescinded during the experience period. The Company identified a universe of one document and 112 rescinded policies. Examiners requested all 112 rescinded policies and selected six files for review. In accordance with the requirements of the Examination, the files were reviewed to ensure compliance with applicable state laws and regulations. The following violations were noted:

6 Violations – 40 P.S. § 1171.5(a)(10)(iii)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

AND

40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company's process for coverage rescission investigations resulted in the failure to affirm or deny coverage within a reasonable time after the receipt of medical records. However, the Company has made

several improvements in the process to create a more streamlined process, leading to faster turnaround time since the examination period.

X. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures, including policies and procedures for claims handling, record keeping, dispositions, and timelines. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 18 Pa. C.S. § 4117(k)(1); 40 P.S. §§ 991.2166 and 1171.5; and 31 Pa. Code Ch. 146 and Ch. 154.

A. Claimant Contact

Examiners requested documentation demonstrating that initial contact with the claimants occurred within the required timeframe applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state laws and regulations. No violations were noted in the policy and procedure documents. However, violations were identified through the review of claim samples. The following violations were noted:

1 General Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to

affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. In many instances, the Company failed to complete investigations within 30 days. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections.

C. Timely Claims Resolution

Examiners requested documentation demonstrating that claims were resolved in a timely manner during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. No violations were noted in the policy and procedure documents. However, violations were identified through the review of claim samples. The following violations were noted:

1 General Violation – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the Company's liability under the policy has become reasonably clear. In many instances, the Company failed to pay clean claims within 45 days of receipt. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections. Notably, the Company has been working to improve timeliness and to ensure adherence with policies and procedures related to claims handling.

1 General Violation – 40 P.S. § 991.2166(b) & 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. In many instances, interest of $2 or more remains unpaid for claims that were paid untimely. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections.

D. Claims Correspondence Handling

Examiners requested a description of how claims correspondence was handled during the experience period, from the date received through closure. The Company identified a universe of six documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. No

violations were noted in the policy and procedure documents. However, violations were identified through the review of claim samples. The following violations were noted:

1 General Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. In many instances, the Company failed to notify the first-party claimant of acceptance or denial within 15 working days after receipt of the proofs of loss. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections.

1 Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. When the Company failed to complete investigations within 30 days, status letters were not mailed out at 30 days and every 45 days thereafter. When status letters were sent by the Company, the letters did not indicate the reasons additional time was needed for the investigation, nor did they indicate when decisions on the claims may be expected. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections. The Department notes that in July 2020, the Company implemented additional touchpoints with the member through the process to inform them that claims are still pending for additional information. These communications go out at 20, 40, and 60 days to inform the customer that their claim is continuing to pend awaiting additional information.

1 General Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage in question. The EOBs did not contain the OOP maximum accumulator or the family deductible accumulator snapshots. This

issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claim sections. The Department notes that the Company has been working to improve the EOBs that are sent to members and providers.

1 General Violation – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide necessary claim forms within 10 working days. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections.

E. Claims Forms

Examiners requested documentation demonstrating that the Company's claim forms were appropriate for the type of product for which they were used during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to determine compliance with applicable state and federal laws and regulations. The following violations were noted:

8 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The Company failed to provide the required fraud warning notice on claim forms. The Department notes that the Company updated the claim forms to include the required verbatim language effective October 1, 2021.

F. Claim Reserves

Examiners requested documentation demonstrating files were reserved in accordance with the Company's established procedures. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

G. Denied and Closed-without-Payment Claims

Examiners requested documentation demonstrating that denied and closed-without-payment claims were handled in accordance with policy provisions and applicable state law. The Company identified a universe of six documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. No violations were noted.

H. Claims Closing Practices

Examiners requested documentation demonstrating that claim-handling practices did 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. The Company identified a universe of 14 documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

I. Claims Handling Practices

Examiners requested documentation demonstrating that claim files were handled in accordance with policy provisions and applicable state law. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the documents were reviewed to determine compliance with applicable state and federal laws and regulations. No violations were noted in the policy and procedure documents. However, violations were identified through the review of claim samples. The following violations were noted:

1 General Violation - 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions. The CSI system did not accurately reflect the coverages listed in the applications, SOBs, and COCs. Therefore, claims did not always process according to the coverage provisions listed in the applications, SOBs and COCs. Further, corresponding EOBs incorrectly reflected member responsibility. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claim sections.

1 General Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

The following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to define OOPM in the application, SOBs, and COCs. Additionally, the Company failed to include and track all out-of-pocket expenses incurred by members in the OOPM accumulations. This issue is identified as a general violation in the Claims Procedures section of the report because it was noted across several claims sections.

XI. MEDICAL CLAIMS REVIEW

Examiners requested a list of all medical claims paid, denied/closed-with-out-payment, and partially paid/partially denied during the experience period. The Company identified a universe of 50,528 medical claims. A random sample of claim files was requested, received, and reviewed for the following types of claims:

A. Medical Paid Claims
    a. 2017
    b. 2018
    c. 2019
B. Medical Denied or Closed-Without-Payment
    a. 2017
    b. 2018
    c. 2019
C. Medical Partially Paid or Partially Denied Claims
    a. 2017
    b. 2018
    c. 2019

In accordance with the requirements of the Examination, all claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including applicable standards found in 18 Pa. C.S. § 4117(k)(1); 40 P.S. § 991.2166 and 1171.5; and 31 Pa. Code Ch. 146, and 154.

The following general concern was noted in multiple sections:

Concern: For ER claims, the Company requested additional information for an extensive number of diagnosis codes and procedure codes, which created a delay for the processing of ER claims. The Company failed to complete ER claims investigations within 30 days and failed to pay the claims within 45 calendar days.

A. Medical Paid Claims

Examiners requested lists of all medical claims paid during the experience period, separated by year. In accordance with the requirements of the Examination, claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. Examiners found violations in all three sections.

2017 Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 7,972 paid medical claims. In accordance with the requirements of the Examination, a random sample of 109 claim files were reviewed. The following violations were noted:

2 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

15 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

4 Violations – 40 P.S. § 991.2166(b) & 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the noted clean claims timely and interest of $2 or more remains unpaid.

2017 Medical Paid Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions that are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

336 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. While actual cost sharing applied in the noted claims was appropriately applied to deductible in accordance with member SOBs, the CSI claim system and member EOBs reflected the ER deductible cost sharing as a copay rather than as a deductible. Further, member SOBs did not clearly indicate that the separate ER deductible did not apply to the OOPM, and the ER deductible was not in fact applied to the OOPM. Notably, the Company agreed to immediately evaluate all claims adjudicated pursuant to the $250 ER deductible for impact on member OOPM accumulators, and in the event members exceeded the OOPM, reprocess claims accordingly and refund the ER Deductible applied after satisfaction of the OOPM.

21 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following acts if committed or performed with such frequency as to indicate

a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

6 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2017 Medical Paid Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

76 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to Examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claims files for the noted claims.

2018 Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 11,697 paid medical claims. In accordance with the requirements of the

Examination, a random sample of 91 claim files were reviewed. In accordance with the requirements of the Examination, the files were reviewed. The following violations were noted:

3 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

7 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

2 Violations – 40 P.S. § 991.2166(b) & 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning

the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the noted clean claims timely and interest of $2 or more remains unpaid.

2018 Medical Paid Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

The following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

365 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. While actual cost sharing applied in the noted claims was appropriately applied to deductible in accordance with member SOBs, the CSI claim system and member EOBs reflected the ER deductible cost sharing as a copay rather than as a deductible. Further, member SOBs did not clearly indicate that the separate ER deductible did not apply to the OOPM, and the ER deductible was not in fact applied to the OOPM. Notably, the Company agreed to immediately evaluate all claims adjudicated pursuant to the $250 ER deductible for impact on member OOPM accumulators, and in the event members exceeded the OOPM, reprocess claims accordingly and refund the ER deductible applied after satisfaction of the OOPM.

10 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

8 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2018 Medical Paid Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

34 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to Examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

2 Violations – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

2019 Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 5,697 paid medical claims. A random sample of 109 claim files was requested and 39 were reviewed. In accordance with the requirements of the Examination, the files were reviewed. The following violations were noted:

6 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company

or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

1 Violation – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claim within 45 days of receipt.

2019 Medical Paid Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

206 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. While actual cost sharing applied in the noted claims was appropriately applied to the deductible in accordance with member SOBs, the CSI claim system and member EOBs reflected the ER Deductible cost sharing as a copay rather than as a deductible. Further, member SOBs did not

clearly indicate that the separate ER deductible did not apply to the OOPM, and the ER deductible was not in fact applied to the OOPM. Notably, the Company agreed to immediately evaluate all claims adjudicated pursuant to the $250 ER deductible for impact on member OOPM accumulators, and in the event members exceeded the OOPM, reprocess claims accordingly and refund the ER deductible applied after satisfaction of the OOPM.

3 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

2 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2019 Medical Paid Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to Examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the noted claim.

B. Medical Denied or Closed-without-Payment Claims

Examiners requested lists of all medical claims denied or closed-without-payment during the experience period, separated by year. In accordance with the requirements of the Examination, claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. Examiners found violations in all three sections.

2017 Medical Denied or Closed-without-Payment Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 6,151 denied medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

3 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

6 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the claims within 45 days of receipt.

1 Violation – 40 P.S. § 991.2166(b) & 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the noted clean claim timely and interest of $2 or more remains unpaid.

2017 Medical Denied or Closed-without-Payment Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

3 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's

liability under the policy has become reasonably clear. The claims did not process according to the coverage listed in the applications, SOBs, and COCs, and member EOBs incorrectly reflected member responsibility.

6 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

6 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2017 Medical Denied or Closed-without-Payment Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair Methods of Competition "and "Unfair or Deceptive Acts or Practices" in the business of insurance means the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

5 Violations -

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to provide references to specific policy provisions, conditions, or exclusions on member EOBs for the noted denied claims.

17 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to Examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

2 Violations – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

2018 Medical Denied or Closed-without-Payment Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 6,851 denied medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

2 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company

or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

6 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

2 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The claims did not process according to the coverage listed in the applications, SOBs, and COCs, and member EOBs incorrectly reflected member responsibility.

2018 Medical Denied or Closed-without-Payment Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

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40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to define OOPM in the SOBs and COCs for the noted claims. The Company failed to include accurate OOPM threshold amounts in SOBs.

5 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall,

30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

5 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2018 Medical Denied or Closed-without-Payment Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough

information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

8 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

2 Violations – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

4 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of the claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter

setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The status letter sent by the Company did not indicate the reasons additional time was needed for an investigation nor did it indicate when a decision on the claim is expected.

2019 Medical Denied or Closed-without-Payment Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 3,926 denied medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

4 Violations – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance Company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on claim forms.

4 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting

in good faith to effectuate prompt, fair and equitable settlements of claims in which the Company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

2019 Medical Denied or Closed-without-Payment Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to define OOPM in the SOBs and COCs for the noted claims. The Company failed to include accurate OOPM threshold amounts in SOBs.

3 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and/or status letters were not mailed out at 30 days and every 45 days thereafter.

2019 Medical Denied or Closed-without-Payment Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage

under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

1 Violation -

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to provide references to specific policy provisions, conditions, or exclusions on member EOBs for the noted denied claims.

4 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to Examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

C. Medical Partially Paid/Partially Denied Claims

Examiners requested lists of all medical claims partially paid/partially denied during the experience period, separated by year. In accordance with the requirements of the Examination, claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. Examiners found violations in all three sections.

2017 Medical Partially Paid/Partially Denied Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 5,089 partially paid medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

1 Violation – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on the claim form.

4 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

2017 Medical Partially Paid/Partially Denied Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

10 Violations – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The claims did not process according to the coverage listed in the applications, SOBs, and COCs, and member EOBs incorrectly reflected member responsibility.

8 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised

of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

4 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

2017 Medical Partially Paid/Partially Denied Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage

under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to provide references to specific policy provisions, conditions, or exclusions on member EOBs for the noted denied claims.

16 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

1 Violation – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

2018 Medical Partially Paid/Partially Denied Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 2,234 partially paid medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

1 Violation – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on the claim form.

2 Violations – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claims within 45 days of receipt.

2018 Medical Partially Paid/Partially Denied Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

1 Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

The following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The member EOB does not accurately reflect the member's cost sharing responsibility.

3 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter

setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

4 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2018 Medical Partially Paid/Partially Denied Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair Methods of Competition "and "Unfair or Deceptive Acts or Practices" in the business of insurance means the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made;

specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

1 Violation – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the receipt of the claim within 10 working days.

3 Violations – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

2019 Medical Partially Paid/Partially Denied Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 911 partially paid medical claims. In accordance with the requirements of the Examination, a random sample of 25 claim files were reviewed. The following violations were noted:

1 Violation – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to

criminal and civil penalties**.** The Company failed to provide the required fraud warning notice on the claim form.

1 Violation – 40 P.S. § 991.2166(a) & 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider for services provided within 45 days of receipt of the claim from the health care provider.

AND

40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company failed to pay the noted clean claim within 45 days of receipt.

2019 Medical Partially Paid/Partially Denied Claims Universe Violation – 40 P.S. § 1171.5(a)(1)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a

business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

31 Pa. Code §§ 146.4(a)&(b)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented and may not fail to fully disclose to first-party claimants benefits, coverages or other provisions are pertinent to a claim. The Company failed to include accurate OOPM threshold amounts in SOBs.

6 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation within 30 days and status letters were not mailed out at 30 days and every 45 days thereafter.

5 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to notify first-party claimants of acceptance or denial of claims within 15 working days after receipt of the proofs of loss.

2019 Medical Partially Paid/Partially Denied Claims Universe Violation - 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a

business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company failed to issue EOBs with enough information for insureds to be able to understand the coverage under which payments were made; specifically, the EOBs did not include OOPM accumulator snapshots and family deductible accumulator snapshots.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the noted claim.

1 Violation – 31 Pa. Code § 146.5(d)

Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a). The Company failed to provide the necessary claim forms within 10 working days.

XII. DATA INTEGRITY

As part of the Examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements, and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with Section 904(b) of the Insurance Department Act of 1921 (40 P.S. § 323.1 et seq.). Several data integrity issues were found during the Examination. The data integrity issues from each review are identified below:

B.1 – Company Operations and Management – Third Party Agreements

Situation: During the review of contracts with TPAs, incomplete information was noted.

Finding: The Company failed to provide two contracts in their submission of TPA contracts.

F.7 and F.8 – Lists of Policy Cancellations and Policy Premium Refunds

Situation: During the review of the Company's lists of policy cancellations and policy premium refunds, inaccurate information was noted.

Finding: The Company provided cancellation and refund information for non-STLDI medical products, but the Company explained it provided that information inadvertently.

Section G. – Underwriting

Situation: During the review of the Company's response to Information Request #2, inaccurate information was noted.

Finding: The Company's response to Information Request #2 incorrectly labeled all applications as LIFE Association products; however, the underwriting population provided included applications from Patriot and PHS. The underwriting population was revised to reflect the correct association.

I.1 – I.9 – Claims Data Requests

Situation: During the review of claim universe data and claim sample files, inaccurate information was noted.

Finding: Claim universe data did not reflect accurate clean claim dates.

I.8 and I.9 – 2018 and 2019 Partially Paid Claims

Situation: During the review of claim sample files, inaccurate information was noted.

Finding: The Company provided some claims that were paid or denied rather than partially paid.

XIII. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number, nature, or severity of violations noted in this Examination Report.

1. The Company must review and revise any and all claim forms to ensure that all claim forms contain the required fraud warning notice pursuant to 18 Pa. C.S. § 4117(k)(1).
2. The Company must develop and implement internal control procedures to ensure compliance with the producer appointment and termination requirements of 40 P.S. §§ 310.1 et seq.
3. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §§ 323.3 and 323.4 so that the violation noted in this Examination Report does not occur in the future. These procedures must also ensure compliance with 31 Pa. Code § 146.3 relating to the maintenance of complete claim files and documentation.
4. The Company must review and revise internal control procedures to ensure compliance with 40 P.S. § 324.3, which requires TPAs to be licensed by the Commonwealth.
5. To the extent the Company intends to offer coverage through associations, the Company must comply with 40 P.S. §§ 756.2 and 3801.301 et seq., and file all required information with the Department demonstrating that an association to which it has issued or proposes to issue a policy covering Pennsylvania residents satisfies the requirements of the statute.
6. The Company must implement procedures to ensure compliance with the Unfair Insurance Practices Act, including the following noted issues:
    a. 40 P.S. §§ 1171.5(a)(1)(i) and 1171.5(a)(10)(i): the Company must accurately represent the benefits, advantages, conditions, or terms of insurance policies, as well as pertinent facts or policy or contract provisions relating to coverages at issue, in member documents, including SOBs and EOBs;
    b. 40 P.S. § 1171.5(a)(2): the Company must ensure accurate representation of coverage eligibility and benefit coverage in all advertising and marketing materials, including such representation in materials used by associations offering coverage to their members;

c. 40 P.S. § 1171.5(a)(10)(iii): the Company must adopt and implement reasonable standards for the prompt investigation of claims, including ER claims and claims that result in policy rescission investigations;

d. 40 P.S. § 1171.5(a)(10)(v): the Company must affirm or deny coverage within 30 days after proof of loss for the claims is received;

e. 40 P.S. § 1171.5(a)(10)(vi): the Company must ensure prompt, fair and equitable settlements are being provided to the claimants; for any claims improperly denied, the Company must ensure the identified clean claims are paid, and proof of such payment must be provided to the Department;

f. 40 P.S. § 1171.5(a)(10)(x): the Company must provide an explanation of benefits that properly represents the activity of the claim;

g. 40 P.S. § 1171.5(a)(10)(xiv): the Company must provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for the denial of a claim or for the offer of a compromise settlement.

7. The Company must review and revise internal control procedures to ensure compliance with 31 Pa. Code §§ 51.21(a) and 51.21(b), so that the violations relating to inaccurate, incomplete, or misleading information related to coverage eligibility, coverage effective dates, and benefit coverage in advertising and marketing materials do not occur in the future. The Company must ensure such compliance includes producer training materials, as well as materials used by associations to market the coverage to their members.

8. The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code Ch. 146, so that the concerns and violations relating to complete files, claims acknowledgements, status letters, acceptance or denials, and denial reasons, as noted in this Examination Report, do not occur in the future. For example:

   a. With respect to 31 Pa. Code § 146.4(a), the Company must fully disclose benefits, coverages, or other provisions of insurance policies under which a claim is presented;

   b. With respect to 31 Pa. Code § 146.4(b), the Company must fully disclose benefits, coverages, or other provisions of insurance policies when the benefits, coverages or other provisions are pertinent to a claim;

c. With respect to 31 Pa. Code § 146.5(a), the Company must acknowledge the receipt of notice of a claim within 10 working days;

d. With respect to 31 Pa. Code § 146.6, the Company must ensure claimants receive a reasonable and timely written explanation for delay if claims investigations cannot be completed within 30 days of notification of the claim;

e. With respect to 31 Pa. Code § 146.7(a)(1), the Company must ensure claimants are advised of the acceptance or denial of a claim within 15 working days after receipt, and for denials based on a specific policy provision, condition, or exclusion, reference to the policy provision, condition or exclusion must be included in the denial.

f. With respect to 31 Pa. Code § 146.7(c)(1), if the Company needs more time to determine whether a first-party claim should be accepted or denied, the Company must notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. The Company must ensure claimants are provided timely status letters in such cases.

9. The Company must evaluate claims and member cost-sharing responsibilities and reprocess the maximum out-of-pocket accumulator calculations for noted claims that may have been impacted, to determine if restitution is due. The Company must provide the Department with documentation to demonstrate that any restitution due to Pennsylvania consumers has been paid accordingly.

10. The Company must review all claims denied from January 1, 2017 to present based on exclusion #19 – Treatment of Mental Health Conditions, Substance Use Disorder incurred, to identify inappropriate denials based on coverage under the policies; reprocess claims that were inappropriately denied; and provide proof of restitution for these claims to the Department. This issue is addressed as part of the violations cited under 40 P.S. § 1171.5(a)(1)(i), 40 P.S. § 1171.5(a)(10)(i), and 40 P.S. § 1171.5(a)(10)(vi), in the 2018 Medical Denied or Closed-without-Payment Claims.

11. The Company must ensure that all clean claims are paid within 45 days of receipt as per 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a). Any and all clean claims that have not been paid as noted in this Examination Report must be paid, and proof of such payment must be provided to the Department. The Department expects that the Company will review

its policies and procedures to ensure that they address tracking claim timeliness from claim receipt date to actual payment date (check date or electronic payment transfer).

12. The Company must ensure all requirements are met related to interest payments as per 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c). Applicable interest amounts for unpaid claims noted in the Examination Report must be paid, and proof of such payment must be provided to the Insurance Department.
13. The Company must ensure that disclosures required pursuant to 45 C.F.R. § 144.103 are prominently displayed in policy contracts and application materials in accordance with the regulatory requirements.
14. The Department expects that the Company will review and revise internal controls to permit members to cancel policies on the date requested, and to issue premium refunds on a pro-rata basis.
15. The Department expects that the Company will implement recommendations from internal audits and place additional controls and monitoring for its TPAs' adjudications of claims to ensure accurate and timely processing of claims, as well as clear and timely communications with members regarding claims processing.
16. The Department expects that the Company will modify its SOBs to provide sufficient detail to allow consumers to fully understand their benefit coverage and cost sharing responsibilities, particularly with regard to cost sharing and OOPM accumulators.
17. The Department expects that the Company will create a written policy to establish a log for customer calls, which notes the specific nature of the call, notification to the appropriate Company department, and the outcome or action taken concerning the call.

XIV. COMPANY RESPONSE

The Company appreciates the opportunity to review the Department's findings and recommendations of this Examination Report. The Company notes the report includes recommendations of corrective measures to the STLDI health plans for which NHIC stopped marketing in March 2019. The Company response to each of the 17 recommendations included in the final report are below.

1. *The Company has reviewed and revised claim forms to ensure that such claim forms contain the required fraud warning notice pursuant to 18 Pa. C.S. § 4117(k)(1). The required updates were completed on October 1, 2021.*

2. *The Company confirms that internal control procedures have been implemented since the period under examination to ensure compliance with the producer appointment and termination requirements of 40 P.S. §§310.1 et seq.*

3. *The Company confirms there are internal controls in place to ensure that all records and documents are maintained in accordance with 40 P.S. §§ 323.3 and 323.4 and 31 Pa. Code § 146.3 relating to the maintenance of complete claim files and documentation.*

4. *The Company confirms there are internal control procedures in place to ensure compliance with 40 P.S. § 324.3, which requires TPAs to be licensed by the Commonwealth. The Company notes the TPA relationship at issue was terminated during the examination period.*

5. *The Company acknowledges, to the extent the Company intends to offer coverage through associations in the future, the Company must comply with 40 P.S. §§ 756.2 and 3801.301 et seq., and file all required information with the Department demonstrating that an association to which it has issued or proposes to issue a policy covering Pennsylvania residents satisfies the requirements of the statute.*

6. *The Company acknowledges the recommendations of the Department and has implemented processes and procedures to ensure compliance with the Unfair Insurance Practices Act and regulations contained therein.*

7. *The Company acknowledges the recommendations of the Department and notes with respect to concerns relating to marketing practices for the STLDI health plans, NHIC stopped marketing such plans in 2019. To the extent the Company intends to offer coverage through associations in the future, the Company will comply with 31 Pa. Code §§ 51.21(a) and 51.21(b).*

8. *The Company acknowledges the recommendations of the Department, and further asserts there are policy and procedures in place to ensure compliance with the claims handling requirements of 31 Pa. Code Ch. 146.*

9. *The Company confirms the claims for member cost-sharing responsibilities has been completed and restitution paid to members in April 2024. The Company has enclosed the required documentation with this response to demonstrate the restitution paid to Pennsylvania consumers.*

10. *The Company acknowledges this recommendation and asserts that the Company reprocessed claims that were inappropriately denied, and corrective measures were implemented in November 2017. The*

Company respectfully submits such remediation is complete as demonstrated in the examination.

11. *The Company acknowledges this recommendation and confirms the Company reprocessed claims identified as exceeding the requirements pursuant to 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a) during the examination.*

12. *The Company acknowledges this recommendation and further acknowledges there are processes and procedures in place to ensure compliance with 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c). With respect to the reprocessing of claims, the Company asserts any claims identified as exceeding the requirements pursuant to 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a) were reprocessed as demonstrated during the examination.*

13. *The Company acknowledges the recommendations of the Department and notes with respect to the STLDI health plans, NHIC stopped marketing such plans in 2019. To the extent the Company intends to offer STLDI coverage in the future, the Company will comply with 45 C.F.R. § 144.103.*

14. *The Company acknowledges the recommendations of the Department, and further acknowledges there are policy and procedures in place which permits members to cancel policies on the date requested, and to issue premium refunds on a pro-rata basis.*

15. *The Company acknowledges the recommendations of the Department, and further acknowledges there are policy and procedures in place to ensure monitoring of its TPA's compliance with the claims handling requirements of 31 Pa. Code Ch. 146.*

16. *The Company notes with respect to the STLDI health plans, NHIC stopped marketing such plans in Pennsylvania in 2019. The Company confirms the most recently filed STLDI SOBs (in states other than Pennsylvania) have been modified and provide sufficient detail to allow consumers to fully understand their benefit coverage and cost sharing responsibilities.*

17. *The Company acknowledges the recommendations of the Department and acknowledges there are policy and procedures in place with respect to logging customer calls.*