Market Conduct Report

Anthem Health Plans, Inc.
Anthem Life Insurance Company

February 2, 2022

Connecticut Insurance Department

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I. INTRODUCTION

Anthem Health Plans, Inc. and Anthem Life Insurance Company, (hereinafter collectively referred to as the "Companies") have their home offices in Wallingford, Connecticut and Indianapolis, Indiana, respectively. By authority granted under §38a-15 of the Connecticut General Statutes, this examination was conducted by Market Conduct examiners of the State of Connecticut Insurance Department at the Department's offices in Hartford, Connecticut.

II. SCOPE OF EXAMINATION

From June 25, 2019 through March 5, 2020, the Market Conduct Division of the Connecticut Insurance Department examined the market conduct practices of the Companies using a sample period of January 1, 2016 through December 30, 2018. The examination was limited to Connecticut business.

The purpose of the examination was to evaluate the Companies' market conduct practices and treatment of policyholders in the State of Connecticut. The examination focused on the solicitation of new business, marketing and sales, agent licensing and appointment, underwriting and rating, policyholder service, complaint handling, network adequacy, provider credentialing, claim processing and company operations.

The Market Conduct examination was conducted pursuant to Connecticut Insurance Department policies and procedures, and the standards proposed in the NAIC Market Regulation Handbook.

III. COMPANY PROFILE

The Companies are wholly owned subsidiaries of Wellpoint, Inc. (the ultimate Parent Company). Anthem Health Plans, Inc. is domiciled in the State of Connecticut and commenced business on August 1, 1997. Anthem Life Insurance Company, Inc. is domiciled in the State of Indiana and commenced business on June 7, 1956. Anthem Health Plans, Inc. is licensed in Connecticut as a Health Care Center and Anthem Life Insurance Company is licensed in Connecticut to write accident and health insurance.

Direct premiums written as of December 31, 2018 were as follows:

Anthem Health Plans, Inc.

	Connecticut	
Accident & Health	1,282,010,471	

Anthem Life Insurance Company

	Connecticut	Total (All States)
Life	11,598,412	285,229,402
Accident & Health	9,635,268	85,875,529

IV. MARKET CONDUCT REPORTS

The examiners reviewed copies of all market conduct examination reports that had been issued to the Companies by other state insurance departments during the examination period. The reports were reviewed to ensure that corrective actions were taken regarding all recommendations made by the respective Insurance Departments.

V. AGENCY ORGANIZATION

The Companies market new business through the offices of independent agents as well as direct sales staff.

The Companies maintain ongoing training programs for their agents. The Companies supply new agents with a product portfolio, which provides detailed descriptions of products and coverages. Changes in coverage are mandated by statute or the Companies' policies and are communicated through written notices as they occur. In addition, the Companies host periodic training seminars for agents

VI. RECORDS SELECTED FOR REVIEW

The Companies supplied a listing of all individual and group health new business produced, terminations, declinations, complaints/appeals, and claims denied during the period under review. The examiners selected a random sample of files using a sampling methodology described in the NAIC Market Regulation Handbook. A sample of five hundred (500) new business contracts, terminations

and declinations and five hundred ninety-three (593) claims were selected for review.

The new health business files were reviewed to evaluate the solicitation and sales practices of producers and agents. In general, applications were examined for completeness, appropriate signatures and dates of application. The application process was reviewed to assure that medical underwriting was applied equitably and to verify that adverse selection had not occurred.

In addition, the producer licensing history and the application date for each policy in the samples were noted in order to identify any individuals or organizations that were not licensed or appointed at the time of sale. The licensing and appointment review is described in more detail in Section VII. Producer Licensing and Appointment.

VII. PRODUCER LICENSING AND APPOINTMENT

The lists of the new business written during the sample period, identifying the producer for each policy, were compared to the Department's licensing records to determine whether each producer was licensed in the State of Connecticut and whether each agent was appointed by the Companies.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Companies' records of licensed and appointed producers agree with Insurance Department's records.

Standard 2: Producers are properly licensed and appointed in the jurisdiction where the application was taken.

The following information was noted in conjunction with the review of these standards:

- The Companies maintain an automated producer database that interfaces with new group health business processing, policy maintenance and producer compensation.

- The Companies perform due diligence procedures on individuals prior to contracting with them.

- The Companies' appointment procedures are designed to comply with the Department's requirements, which mandate that an agent must be appointedwithin 15 days from the date that the Company receives the application.

Findings:

Comparisons were made between the Companies' records of licensed and appointed producers and the Insurance Department's records. A review of the Companies' records revealed one (1) individual who was not licensed and fifty-three (53) individuals acting as agents who were not appointed by the Companies within the timeframe required by statute. In addition, there were numerous instances where Anthem Life Insurance Company could not identify the original writing agents for new business sold during the examination period. The Department is concerned that the Companies failed to establish proper procedures are in place to ensure that no new business is accepted from individuals who were not properly licensed and appointed according to Connecticut requirements. It is noted that under Connecticut Insurance Department Docket numbers MC 15-61 and MC 15-62, executed on June 11, 2015, the Companies were cited for failure to establish proper policies and procedures to ensure compliance with statutory producer licensing and appointment requirements. The Department is concerned that the Companies failed to implement timely corrective action to ensure compliance with Connecticut requirements.

Standard 3: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

The Companies have procedures to provide notification of termination to the Department.

Findings:

The examiners reviewed the Companies' termination lists and verified that no producers were terminated for cause during the examination period.

Standard 4: The Companies' policies of producer appointments and terminations do not result in unfair discrimination against policyholders.

Findings:

The examiners noted no evidence of unfair discrimination against policyholders as a result of producer appointments and terminations.

Standard 5: Records of terminated producers adequately document reasons for terminations.

The examiners reviewed the Companies' terminated producer files to ensure that records are documented sufficiently.

Findings:

The examiners verified the listing of terminated agents and reviewed the reasons for termination for each agent.

In Summary:

It is recommended that each Company review its licensing and appointment system to ensure that no new business is accepted from, nor commissions paid to, individuals acting as agents of the Company whose license and appointment status has not been properly documented and recorded in the Respondent's business records, as required by statute. It is noted that under Connecticut Insurance Department Docket numbers MC 15-61 and MC 15-62, executed on June 11, 2015, the Companies were cited for failure to establish proper policies and procedures to ensure compliance with statutory producer licensing and appointment requirements. The Department is concerned that the Companies failed to establish that proper procedures are in place to ensure that sufficient documentation is available to demonstrate that no new business is accepted from individuals who were not properly licensed and appointed according to Connecticut requirement. In addition, the Department is concerned that the Companies failed to implement timely corrective action to ensure compliance with Connecticut requirements and the Department is also concerned that insufficient information was available for regulatory review.

VIII. UNDERWRITING AND RATING

The new group health business underwriting files were reviewed to determine the use and accuracy of rating methodology, accuracy of issuance, consistent (non-discriminatory) practices and use of proper forms. The Companies' policies, forms and rates were reviewed for proper filing with the Insurance Department and compliance with applicable statutes and regulations.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The rates charged for the policy coverages are in accordance with filed rates, if applicable, or the Companies' rating plans.

The following information was noted in conjunction with the review of this standard:

- Rates are systematically computed based on applicant information and rating classification assigned.
- The Companies have written underwriting policies and procedures.
- The Companies provided copies of Department approved rates for the new group health business submissions reviewed during the examination period.

Findings:

The examiners reviewed four (4) small group rating files and no exceptions were noted.

Standard 2: The Companies do not permit illegal rebating, commission cutting or inducements.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures to pay producers' commissions in accordance with Companies' approved written contracts.

Findings:

The examiners reviewed the Companies' policies and procedures and verified that controls are in place to monitor and prevent illegal rebating, commission cutting and inducements.

Standard 3: All forms, including contracts, riders, endorsement forms and certificates, are filed with the Insurance Department, if applicable.

The following information was noted in conjunction with the review of this standard:

- The Companies have compliance policies and procedures in place to review and track all forms, rates, contract riders and endorsements.

- The Companies have a process to log and document Department approved forms, rates, contract riders, endorsements and content of summary of benefits and coverage (SBC) in accordance with Connecticut requirements.

Findings:

The examiners reviewed the Companies' policy forms through a review of the new group health business files and no exceptions were noted.

Standard 4: The Companies' underwriting practices are not to be unfairly discriminatory. The Companies adhere to applicable statutes, rules and regulations and Companies' guidelines in selection of risks.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies and procedures prohibit unfair discrimination.

- Written underwriting guidelines are designed to reasonably assure consistency in rating of policies.

- The Companies have policies and procedures in place for the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials, dependent coverage for individuals to age 26, lifetime/annual limits on the dollar amounts of essential health benefits and PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.

- The Companies have established policies and procedures to ensure compliance with restrictions on establishing lifetime/annual limits on the dollar amounts of essential health benefits for any individual.

- The Companies have established policies and procedures regarding compliance with PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.

Findings:

The Companies' underwriting practices do not appear discriminatory.

Standard 5: File documentation adequately supports decisions made.

Findings:

See Section VIII. Underwriting and Rating, Additional Concerns.

Standard 6: Policies and endorsements are issued or renewed accurately, timely and completely.

The examiners reviewed the sample new group health business and renewal files to ensure that the Companies' underwriting policies and procedures were consistently applied for each sample file reviewed.

Findings:

The Companies' practices for the issuance of policies and endorsements had no exceptions noted.

Standard 7: Applications rejected and not issued are not found to be discriminatory.

The Companies' underwriting policies and procedures prohibit unfair discrimination.

Findings:

No exceptions were noted.

Standard 8: Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

The Companies have procedures in place for the issuance of cancellation and renewal notices.

Findings:

The examiners selected eighty (80) cancellation files for review. The examiners reviewed the sample files selected and no exceptions were noted.

Standard 9: Pertinent information on applications that form a part of the policies is complete and accurate.

Findings:

The examiners reviewed the Companies' sample new health business files, and no exceptions were noted.

Standard 10: Companies comply with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

The examiners reviewed the Companies' procedures for providing information pertaining to continuation of benefits, for processing applications and for notification to policyholders of the beginning and termination of benefit periods and premium notices.

Findings:

The examiners reviewed the Companies' underwriting procedures and sample new business files and no exceptions were noted.

Standard 11: The Companies comply with the provisions of HIPAA regarding limits on the use of pre-existing exclusions.

The Examiners reviewed the Companies' policies and procedures for provisions related to applicants/proposed insured under the age of 19 to verify that coverage is not denied based on a pre-existing condition.

Findings:

The Companies' pre-existing conditions were found to be in compliance with the requirements of HIPAA and Connecticut statutes and regulations, and no exceptions noted.

Standard 12: The Companies issue coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of 1 to 50.

The Examiners reviewed the Companies' policies and procedures regarding guaranteed availability and renewability of individual and small group health insurance coverage in accordance with statutes and regulations.

Findings:

The Companies' small group business appears to comply with Connecticut requirements.

Standard 13: The Companies refer eligible individuals entitled to portability under the provisions to HRA.

Findings:

The examiners verified that the Companies have procedures in place for individuals eligible for HRA. No exceptions were found for the small group new health business sample files reviewed.

Additional Concerns:

The Examiners noted four (4) instances in which group life declination files for Anthem Life Insurance Company were incomplete. The Company was unable to locate the files within the imaging system. In addition, there were numerous instances where the Company provided The Department is concerned that the Companies could not provide sufficient documentation for regulatory review.

In Summary:

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

IX. POLICYHOLDER SERVICE

New business, underwriting files and policy transactions were reviewed for accuracy and timeliness of handling.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Premium notices and billing notices are sent out with an adequate amount of advance notice.

The following information was noted in conjunction with the review of this standard:

- Verification that billing notices are generated automatically based on contract renewal dates and payment cycles.
- If premiums are not received, as required, an overdue premium notice is mailed, noting that non-payment will cause the policy to lapse.

Findings:

See Section IX. Policyholder Service, Additional Concerns.

Standard 2: Policy issuance and insured requested cancellations are timely.

The following information was noted in conjunction with the review of this standard:

- When the policyholder requests cancellation, the cancellation is processed and any premium due is provided to the policyholder.
- The Companies provide written notice to the policyholders when a policy cancels.

Findings:

See Section IX. Policyholder Service, Additional Concerns.

Standard 3: All communication directed to the Companies is answered in a timely and responsive manner by the appropriate department.

The following information was noted in conjunction with the review of this standard:

- The Companies have a customer call center to respond to policyholder and member concerns.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted. It is recommended that policyholder call center policies and procedures be reviewed to ensure that all member and provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

Standard 4: Reinstatement is applied consistently and in accordance with policy provisions.

The Companies have standardized reinstatement guidelines in place to ensure that requests are reviewed and either approved or denied by underwriting.

Findings:

The examiners reviewed the Companies' policies and procedures and sample underwriting files. No exceptions were noted.

Standard 5: Policy transactions are processed accurately and completely.

The Companies have policies and procedures in place for processing policyholder transactions including conversions, plan changes and enrollment updates.

Findings:

The examiners reviewed the Companies' policies and procedures and sampling of new business files. No exceptions were noted.

Standard 6: Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

The Companies have policies and procedures in place for tracking and issuing evidence of creditable coverage.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Additional Findings:

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, there were many instances where a member's policy cancelled for non- payment and the member did not receive a grace letter. The Company found that there was an issue on May 6, 2016 where no grace letters were being generated. The Company found that three hundred thirty (330) members were affected. The Company sent letters to these members in August 2016 offering reinstatement. It is recommended that the Company review its policies and procedures to ensure that all member or provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, two (2) complaints were filed by members who had duplicate attempts to draft premium payments from their bank or credit card in March 2018. On March 2, 2018, ACI Universal Payments noted that: The Anthem payment process was running longer than normal and suspected to be in a stalled condition. The Data Center Operations team stopped the batch payment process and reset it to run again. This action allowed the batch payment process to pick up payments that were already authorized and submit for a second authorization. This was an isolated incident that impacted 35,000 members. Additional controls to the Anthem batch payment process were implemented to identify improvements and increase processing efficiencies. It is recommended that the Company review its policies and procedures to ensure that all member or provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, Non-Department Complaints, and Member Appeals there were a number of instances where claims were not processed correctly. The Company acknowledges that these individual claims were manual processing errors, and not indicative of a systemic concern. It is recommended that the Company review its policies and procedures to ensure that claims are properly investigated at the time they were received.

In Summary:

It is recommended that the Company review its policies and procedures to ensure that all member or provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

X. MARKETING AND SALES

The Companies provided samples of all marketing and sales materials used in Connecticut during the period under examination. The marketing and sales materials were analyzed to identify any pieces that had a tendency to mislead or misrepresent any aspect of the Companies' products or benefits to policyholders. In addition, the marketing and sales materials were reviewed to verify compliance with statutes and regulations related to the disclosure of certain information regarding the Companies' identity, financial standing and organization.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the advertising and sales material process.
- All advertising and sales materials are reviewed in a consistent format through an online submission and tracking process.
- All advertising and producer generated material is subject to compliance review.
- Prior to final approval, all advertising and sales materials are reviewed to ensure that any necessary changes identified during the initial review were made.
- Approved submissions are endorsed for use for a specific period, which is incorporated into the approval number on the piece.

Findings:

The companies were found to be in compliance.

Standard 2: The Companies' internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Companies have developed training programs for their producers.

Findings:

The examiners reviewed the Companies' training programs and established policies and procedures. The Companies' internal producer training materials appear to be adequate and in compliance.

Standard 3: The Companies' communications to producers are in compliance with applicable statutes, rules and regulations.

The Companies maintain an extensive on-going training program. Written policies and procedures govern that all communications are reviewed and approved by the Companies' compliance units.

Findings:

The examiners verified that the Companies have communication procedures in place for all producers.

Standard 4: Outline of coverage is in compliance with applicable statutes, rules and regulations.

Findings:

The examiners reviewed the Companies' outlines of coverage and no exceptions were noted.

XI. COMPLAINTS

The examiners reviewed a sample of two hundred fifty-two (252) Department complaint files and three hundred forty-five (345) sample Non-Department Complaints, Grievances and Appeal files during the examination period. Included in our review were grievances and appeals involving mental health and substance abuse disorders.

See concerns identified through a review of complaints and appeals in Section XII. Claims.

Department Complaint Handling

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All complaints or grievances are recorded in the required format on the Companies' complaint registers.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the complaint handling process.
- All complaints are recorded in a consistent format in the complaint log.
- An automated tracking database is used to record and maintain complaint information.

Findings:

The examiners noted during a review of the Anthem Health Plans, Inc., Insurance Department Complaints Log, fifty-two (52) instances, where the Company's Log of Department Complaints did not match the Department's Complaint Log. The Company states that the complaints were not coded correctly and therefore not captured in the reporting. The Department is concerned that the Companies could not provide an accurate complaint log to the Department in compliance with Connecticut requirements.

Standard 2: The Companies have adequate complaint handling procedures in place and communicate such procedures to policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' Plan Descriptions have been reviewed and approved by the Department's Life and Health Division.
- The complaint handling procedures are included in the Plan Descriptions.

Findings:

The examiners verified that the Companies' Plan Descriptions include all complaint handling procedures as required by statute.

Standard 3: The Companies should take adequate steps to finalize and dispose of Department complaints in accordance with applicable statutes, rules and regulations and contract language.

Findings:

- The examiners noted during a review of the Anthem Health Plans Insurance Department Complaints,

Non-Department Complaints (Grievance/Appeal/Concerns)

The Companies have established the following complaint and appeal policies that are available to members and providers as outlined in the Plan Descriptions:

A. Inquiry/Complaint

A member or provider may contact the Companies' member relations to question problems or concerns.

B. Grievance

A complainant, who has not been satisfied at the inquiry/complaint level, may request a review of the previous decision. A complainant has one hundred eighty (180) days. Notification of the decision must occur within thirty (30) days of receipt of the grievance by the Companies.

C. Appeal

A complainant has sixty (60) days from receipt of notification of the Grievance decision to appeal. Appeals are acknowledged within three (3) business days of receipt. The member will be notified of the Committee's decision within twenty business (20) days.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 4: **The time frame within which the Companies respond to complaints, grievances and appeals is in accordance with applicable statutes, rules and regulations.**

Findings:

The examiners verified that the Companies responded to complaints, grievances and appeals in a timely manner.

Standard 5: **The health carriers document complaints, grievances and appeals and establish and maintain grievance/appeal procedures in compliance with statutes, rules and regulations.**

Findings:

See concerns identified through a review of complaints and appeals in Section XI, Standard 1 Complaints.

Standard 6: The health carriers file, with the Commissioner, a copy of their complaints, grievances and appeals, including all forms.

Findings:

The examiners verified that the plan descriptions filed with the Department appear to be in compliance.

Additional Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

In Summary:

It is recommended that the Companies review their complaint, grievance and appeal policies and procedures to ensure accurate reporting in compliance with Connecticut requirements.

XII. CLAIMS

The Companies provided a listing of all claims submitted during the period under examination. The review consisted of a sampling of five hundred ninety-three (593) denied claims. The files were reviewed to determine the accuracy and timeliness of claim and interest payments.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: **The initial contact by the Companies with the claimant is within the required time frame and claims are settled in a timely manner.**

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the claim handling process.
- All claim notifications are logged into the claim system.
- Claim management monitors claim accuracy and timeliness.

Findings:

Pursuant to §38a-816(15) of the Connecticut General Statutes, the Companies are required to pay clean claims within twenty (20) days for claims filed electronically and sixty (60) days for claims filed in paper format. The Department requested that the Companies provide a listing of all clean claims paid in excess of twenty (20) and sixty (60) days for the examination period. The examiners found eight hundred eighty-six (886)) claims that were not paid within twenty (20) and sixty (60) days, and failed to include interest.

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated and resolved pursuant to required claim settlement practices.

Standard 2: Claim files are adequately documented.

The following information was noted in conjunction with the review of this standard:

- copy of the HCFA form or electronic proof of loss
- applicable clinical/other investigative correspondence
- written communication, telephone or other communication
- proof of payment

Findings:

See concerns identified through a review of complaints and appeals in Section XII. Claims.

Standard 3: The Companies have appropriate policies in place for the archival and disposal of claim forms.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found.

Standard 4: The Companies' claim forms are appropriate for the type of product.

Findings:

The examiners noted that the claim forms were appropriate and in accordance with the Companies' policies and procedures.

Standard 5: Canceled benefit checks and drafts reflect appropriate claim handling practices.

The following information was noted in conjunction with the review of this standard:

- Claim procedures were verified to ensure that the check/draft claim process was handled accurately and was appropriate.

Findings:

The examiners verified that processes were in place and no exceptions were noted.

Standard 6: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

The following information was noted in conjunction with the review of this standard:

- All litigated claims were reviewed for the examination period.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found. Specific claim errors are identified below.

Standard 7: The group health plan complies with the requirements of Federal and State law for Mental Health Parity, (including PPACA and HIPAA).

The following information was noted in conjunction with the review of this standard:

- A review of the Companies' responses to the Mental Health Parity Annual Compliance Survey for the period under review.

- A review of the Companies' responses to Consumer Report Cards on Health Insurance Carriers in Connecticut for the period under review.

- A review of the Companies MCAS (Market Conduct Annual Statement) Health Data submission to I-Site for 2017 and 2018.

Findings:

The examiners reviewed the Companies' Mental Health Parity Annual Compliance Survey, which included the Companies' responses to the analysis and testing for any cost share features, penalties and benefit limitations and classifications (inpatient in and out-of-network, outpatient in and out-of-network, emergency and prescription drugs) that apply to mental health and substance abuse disorders vs. medical/surgical conditions. In addition, the examiners reviewed the Companies' responses in the Survey regarding non-quantitative treatment limitations (medical management, prior authorization and step therapy). Also, the examiners reviewed the Companies MCAS Health Data submissions. Finally, the examiners also reviewed the Companies' response to the Consumer Report Card on Health Insurance Carriers in Connecticut, for the period under review. No exceptions were noted.

Additional Concerns:

In addition, the examiners have identified the following concerns through a review of the complaints and appeals:

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, where the Company was charging double co-pays for ultrasounds. One co-pay to take the ultrasound, and The Company states that this only occurred if the ultrasound and the reading were at two different facilities and no other members were affected.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, one (1) instance there was an issue where the Company was denying Home Hospice Health Care for pre-authorization. This claim was denied in error as there is no pre-authorization required. The Company went back and paid forty (40) claims on totaling $81,567.19 in claim payments and $5,410.68 in interest

payments. The Company states that this was a claims processor error and the processors involved were educated. The examiners recommend that the Company review its policies and procedures to ensure that claims are properly investigated and paid.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, there was an issue where the Company was denying hearing aid codes V5160 and V5264 as benefits being exhausted. The Company found that these codes were being denied in error due to benefit set up. The Company went back and paid six (6) fully insured claims in the amount of $12,995.74 and fixed the benefit set up issue. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of the Anthem Health Plans, Inc. Insurance Department Complaints, there was an issue where the Company was denying claims for L8000 (Mastectomy Bras) limit one (1) unit per day. The Examiner had the Company go back and review if any other members were affected. The Company found two (2) other members were affected and made a total payment of $386.55 including interest and letters with Department language. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of the Anthem Health Plans, Inc. Insurance Department Complaints, there was an instance where the Company denied CPT code 93460 (right/left cardiac catheterization) for no pre-auth. The Company paid the claim as there is no pre-auth required. The Examiner went back and asked the Company if any other members and/or providers affected. The Company noted there was one (1) other claim that was denied in error and was paid on March 31, 2017 in the amount of $2,720.00 and included interest $62.64. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, there was an issue where the small grouprenewal date was March 31, 2016. In error, the Company was applying the 2016 prescription cost share as of January 1, 2016 instead of upon renewal. The Company states the system was not reading the renewal date. The Company re-processed thirty-six (36) claims that were impacted in the amount of $2,593.60. The systems were fixed April 15, 2016. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of the Anthem Health Plans, Inc. Insurance Department Complaints, there was an issue where the Company's established provider agreements with clinics classified all services as specialty office visits which applied a higher copay. The Company went back and paid two thousand (2,000) claims in the amount of $37,000 for the period of 1/1/14- 12/21/15. The Company also updated their system in 2016 to reflect a copay equal to the Primary Care office visits. Claims dated in 2016 were addressed via the adjustment on Anthem's system. In 2016, there were six hundred twenty-three (623) claims that were adjusted with $11,867.12 paid including $249.22 interest. The Company acknowledges that is applied the specialist copay and there was no administrative error or systemic issue involved. In addition, the Company acknowledges that there was not an appropriate level of communication between responsible areas regarding the application of the specialist copay. It is recommended that the Company review its policies and procedures to ensure the appropriate level of communication occurs when applying cost share benefits.

- The examiners noted, through a review of Anthem Health Plans, Inc. Provider Appeals, it was noted that the Company applied a 3D mammogram to the member's deductible versus paying as preventative. The Company overturned this due to the Company was to start paying 3D mammogram as preventative effective January 1, 2017 date of service. The Examiner has requested the Company to pull a claims sweep for both claims systems. The Company has identified that 3228 claims took cost shares during this period. The Examiner has requested the Company to make payments to member and/or provider and to include letter with Department language. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, a system issue was identified in which coinsurance was not applying to out-of-pocket accumulators. Information Technology coding was updated in October 2018, a claims sweep identified two hundred thirty-three (233) claims which were adjusted in the amount of $1,965.65 and interest paid $113.04. The Department is concerned that theCompanies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints there was an issue where the Company was applying visit limits to outpatient rehabilitation services of occupational, speech, and physical therapy with an Autism diagnosis. It was determined that the systems were not set up with the correct benefits for 2018 for all

on/off exchange members. This was corrected 8/20/18, six-hundred sixty-nine (669) were adjusted in the amount of $78,887.01 and interest paid totaling $3,191.13. The Department is concerned that the Companies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, an incorrect system edit was put in place in September 2018 which imposed a limit of 6 units to be billed. The edit was fixed on 9/29/19, an initial sweep was run from 1/1/18 through 8/13/19 which identified 32 impacted claims resulting in payment of $13,165.00 and interest totaling $73.40. Weekly sweeps were run and adjustments made to 17 claims totaling $2,760.61. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of Anthem Health Plans, Inc. member appeals, two (2) instances coverage for Orthotics was misquoted. The Grievance Analyst that reviewed one of the appeals did not adequately investigate or quote the proper exclusion. In the other instance, while the member and provider were advised that it was a non-covered benefit, the claim was submitted and paid in error. Anthem acknowledged inconsistencies in processing and accurately quotes benefits indicating that language specifically related to foot orthotics and inserts wasn't added to Explanation of Coverage documents until 2018. The Department is concerned that the Company did not properly investigate the claims at the time they were originally received.

- The examiners noted, through a review of Anthem Health Plans, Inc. member appeals and grievance files which were not adequately documented, the Company's' investigation was insufficient, the determination was incorrect or did not adequately address the basis of the appeal. The Department is also concerned that insufficient information was available for regulatory review.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, the Company had an issue with the transfer of authorizations from OrthoNet to the Company in 2010. Claims were being denied for no authorization but in fact there was an authorization. The Company developed a work around, the solution was a report that was worked on a weekly basis to process claims manually. In May 2016, the associate at the Company who worked the report left the company. The report was never reassigned. The Company states it was an oversight. This cause claims to be denied for no authorizations, when authorization had already been obtained. On March 14, 2017, the report was reassigned and is now being worked monthly. Upon receipt of the Department of Insurance Complaint, it was found that not all claims were shown on that initial claim \

sweep. The Examiner questioned this and a complete sweep on July 11, 2019,was done, which an additional 750 claims were found. Only 155 of those claims were fully insured claims. The Company paid additional $6,655.97 plus $12.60 interest. The Company's relationship with OrthoNet ended, so this is no longer an issue. The Department is concerned that the Company failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, the Company had an "internal error" caused by a system migration that caused missing refunds of premium on cancelled policies. The error was corrected and all 25 members that were impacted were refunded. The Department is concerned that the Company provided notification which tended to be insufficient for covered members.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, there were five (5) instances where the company denied an INN lab service due to "referral was needed", which was incorrect. The company went back and corrected those. The Examiner requested a claim sweep which resulted in additional 145 claims ($93,974), as of current, they are not paid, company is waiting for new EOB with new wording and will pay. The Department is concerned that the Companies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, the Company had an issue with their small group plans in which they were taking incorrect copays for emergency room visits in 2016. The Company was applying copayment of $200 and a deductible at the same time. As a result of the investigation a Stipulation and Consent Order (#MC16-58) was executed. The Department received the Corrective Action Report dated December 12, 2016, which stated that the Company addressed and corrected the issue July 30, 2016. It was determined that one group was inadvertently missed, another claim sweep and remediation was completed in July 2017. This resulted in 181 members affected. Total additional payment of $40,983.06 and interest paid totaling $4,242.15. The Department is concerned that the Companies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Non-Department Complaints, one (1) instance where a non-department complaint that the "Provider Finder Section" on the Company's website has incorrect information. Providers were listed as in network, but

actually, were not. Per the Company, Anthem's website has been corrected. The Company cannot confirm how long this error existed but instituted corrective action shortly after it was found in November 2016. The companystated that to prevent a recurrence, their implementation teams, along with provider finder information technology have taken additional steps to ensure this sort of issue does not occur again. The Department is concerned that theCompany provided notification which tended to be insufficient for covered members.

- The examiners noted, through a review of Anthem Health Plans, Inc. Insurance Department Complaints, an issue with inappropriate disclosure of Protected Health Information (PHI) occurred. Anthem performed an analysis and review of what type of information was disclosed and who it was disclosed to in order to determine if member notification was required under state and federal law. In this case, it was determined to be low probability of compromise (member who received PHI was also a provider). The Department was not notified. In the future, the Department recommends an incident such as this is reported to the Department. It is recommended that the Company review its policies and procedures to insure compliance security incidents.

- The examiners noted, through a review of the Anthem Health Plans, Inc., Insurance Department Complaints, Non-Department Complaints, and Member Appeals there were a number of instances where claims were not processed correctly. The Company acknowledges that these individual claims were manual processing errors, and not indicative of a systemic concern. It is recommended that the Company review its policies and procedures to ensure that claims are properly investigated at the time they were received.

- The Examiner noted through a review of Anthem Health Plans, Inc. Non-Department Member Complaints, one (1) instance where a complaint was denied due to "not a cover service", but should have been paid as out of network. The Company did reprocess the claim correctly and stated it was a processing error. The Examiners requested if any other members were affected by this processing error. Upon review, the Company stated this was a system error. The issue started on January 1, 2018 and was fixed in August of 2018. There were 6,368 additional claims that were found in the Nov.7, 2019 sweep. 3,310 claims were paid in November 2018 in the amount of $210,927.00, plus $9,899.41 in interest. The remaining 3,058 claims were adjusted but no payments were due since deductibles on those claims were not met yet. The Department recommends the Company review its appeal policies and procedures to ensure that claims are properly investigated and paid. The Department is concerned that the Companies failed to demonstrate that sufficient controls are in place to properly investigate and pay claims under Connecticut requirements.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that all claims, complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements.

XIII. NETWORK ADEQUACY

Standard 1: The health carrier demonstrates, using reasonable criteria that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

The following information was noted in conjunction with the review of this standard:

- ratios of providers, both primary care providers and specialty providers, to covered persons
- geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons
- waiting times for appointments, hours of operation, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care

The examiners reviewed the Connecticut Insurance Department Network Adequacy Survey, which included the Companies' responses to the ratio of providers, both primary care and specialty care to members. In addition, the examiners reviewed geographic accessibility of participating providers to the business or members personal residences and wait times for scheduling in-network appointments for the period under review.

Findings:

The Companies submitted the 2017 and 2018 Network Adequacy Survey. No exceptions were noted.

Standard 2: The health carrier files a quality assurance plan with the Commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material

change to an existing managed care plan. The carrier makes the quality assurance plans available to regulators.

The following information was noted in conjunction with the review of this standard:

- the health carrier's procedures for making referrals within and outside its network
- the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services
- the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning

Standard 3: The carrier has provided documentation to the Commissioner that it is currently NCQA and URAC accredited.

Standard 4: The health carrier files, with the Commissioner, all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Standard 5: The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week, within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the Managed Care Plan Network Adequacy Model Act.

Standard 6: The health carrier executes written agreements with each participating provider that are in compliance with statutes rules and regulations.

Standard 7: The health carrier's contracts with intermediaries are in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Intermediaries and participating providers, with whom they contract, shall comply with all applicable Requirements for Health Carriers and Participating Providers

as indicated in the Managed Care Plan Network Adequacy Model Act and accompanying regulations.

- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

- Each contract between a health carrier and participating provider or provider group shall contain a "hold harmless" provision specifying protection for covered persons from being billed by providers. The language of the "hold harmless" provision shall be substantially similar to the language of the Managed Care Plan Network Adequacy Model Act.

Standard 8: The health carrier provides notice to members advising them of Primary Care Physicians who have terminated with the plan as required by Connecticut Statute.

The following information was noted in conjunction with the review of this standard:

- The health carrier shall develop selection standards for primary care professionals and each health care professional specialty.

- The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries, and any provider networks with which it contracts.

Standard 9: The health carrier provides, at enrollment, a Provider Directory listing of all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XIV. PROVIDER CREDENTIALING

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carriers establish and maintain programs for credentialing and re-credentialing in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies have established written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carriers contract and shall apply those standards consistently.
- The Companies have assured that the carriers' medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.
- The Companies have established a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documentation.

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 2: The health carriers verify the credentials of a health care professional before entering into a contract with that health care professional.

The following information was noted to ensure providers are properly credentialed prior to appearing in the provider directory:

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 3: The health carriers require all participating providers to notify the health carriers' designated individual of changes in the status of any information that is required to be verified by the health carriers.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carriers provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XV. COMPANY OPERATIONS

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies have up-to-date, valid internal or external audit programs.

The following information was noted in conjunction with the review of this standard:

- The Companies have an internal audit department that has performed reviews of a variety of operational functions.

- Audit reports are distributed to all relevant operational and management personnel.
- External audits are performed on a regular basis.

Findings:

The Companies have performed a number of audits during the examination period. The examiners reviewed the audit reports provided and found no exceptions during the examination period.

Standard 2: **The Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.**

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures in place for all operational functions.
- System tests are performed on a regular basis.

Findings:

The examiners reviewed and verified that the Companies have programs in place to protect the integrity of computer information and appear to be in compliance.

Standard 3: **The companies have anti-fraud plans in place.**

The following information was noted in conjunction with the review of this standard:

- The Companies have written anti-fraud plans.
- The Companies have a Special Investigative Unit (SIU) dedicated to the prevention and handling of fraud.
- Potential fraud activity is tracked by the SIU and investigated. Activity is reported to the regulator, as necessary.

Findings:

The examiners reviewed the written anti-fraud plans and investigative policies and procedures. For the examination period, the Companies had no reportable incidents.

Standard 4: **The Companies have valid disaster recovery plans.**

Findings:

The examiners reviewed and verified that the Companies have valid disaster recovery programs in place and no incidences were reported during the examination period.

Standard 5: **Records are adequate, accessible, consistent and orderly and comply with record retention requirements.**

Findings:

The Companies appear in compliance.

Standard 6: **The Companies are licensed for the lines of business that are being written.**

The examiners reviewed the Certificates of Authority for the Companies and compared them to the lines of business that the Companies write in the State of Connecticut.

Findings:

The examiners verified that the Companies are duly authorized for the lines of business being written.

Standard 7: The Companies have procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies allow for sharing customer and personal information with affiliates, but do not share such information with non-affiliates.
- The Companies' policies require a consumer privacy notice to be provided to policyholders on an annual basis.
- The Companies have developed and implemented information technology security practices to safeguard the customer's personal and health information.

- The Companies' internal audit function conducts reviews of privacy policies and procedures.

Findings:

The examiners reviewed and verified that the Companies have valid programs in place. No incidences were reported during the examination period.

Standard 8: The Companies have a comprehensive written information security program for the protection of non-public customer information.

The examiners reviewed and verified that the Companies have a written security program in place for the protection of non-public customer information. In addition, the examiners verified that the Companies have proper cyber security policies and procedures in the areas of breach notification, administrative, physical and technical safeguards to protect consumer information and security incident response procedures.

Standard 9: The Companies cooperate on a timely basis with examiners performing the examinations.

Findings:

The Department received cooperation during the examination process.

XVI. SUMMARY OF RECOMMENDATIONS

Report
Section

VII. Producer Licensing and Appointment

The Department is concerned that the Companies failed to establish proper procedures are in place to ensure that no new business is accepted from individuals who were not properly licensed and appointed according to Connecticut requirements. In addition, the Department is also concerned that the Companies could not provide documentation for regulatory review.

VIII. Underwriting and Rating

It is recommended that the Companies review their underwriting policies and procedures to ensure that sufficient documentation is maintained for regulatory review.

IX. Policyholder Service

It is recommended that the Company review its policies and procedures to ensure that all member or provider concerns are properly investigated and resolved pursuant to required policyholder service practices.

XI. Complaints:

It is recommended that the Companies review their policies and procedures to ensure that all complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements.

XII. Claims:

It is recommended that the Companies review their policies and procedures to ensure that all claims, complaints, appeals and grievances are all properly investigated and resolved pursuant to required complaint and claim handling requirements.

XVII. ACKNOWLEDGMENT

Stephen DeAngelis, Meg Salamone, Karen Mayer and Shannon Gonska participated in the preparation of this report.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

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IN THE MATTER OF: DOCKET MC 21-67
ANTHEM HEALTH PLANS, INC.:

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STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Anthem Health Plans, Inc., and the State of Connecticut Insurance Department by and through Andrew N. Mais, Insurance Commissioner, to wit:

I

WHEREAS, pursuant to a Market Conduct examination, the Commissioner alleges the following with respect to Anthem Health Plans, Inc.:

1. Anthem Health Plans, Inc., hereinafter referred to as Respondent, is domiciled in the State of Connecticut and is licensed to transact the business of a health care center in the State of Connecticut under license number 60217 and is licensed to write accident and health insurance in Connecticut.

2. From June 25, 2019 through March 5, 2020, the Department conducted an examination of Respondent's market conduct practices in the State of Connecticut covering the period from January 1, 2016 through December 30, 2018.

3. During the period under examination, Respondent, in certain instances, failed to follow established practices and procedures to ensure compliance with statutory requirements, resulting in instances of:

   a. fifty (50) producers acting as agents of Respondent without required appointment

   b. failure to take corrective action regarding producer licensing and appointments as required under Docket MC 15-61, executed on June 11, 2015

   c. failure to pay claims without conducting a reasonable investigation

   d. failure to properly investigate claims for certain preventative services including 3D mammographies

e. failure to maintain sufficient controls to ensure that claims are properly investigated and sufficiently documented

f. failure to pay claims in a timely manner

g. failure to pay interest on claims not paid in a timely manner

h. failure to implement proper controls for the payment of claims for autism services

i. failure to maintain sufficient controls for the handling of member co-payments and co-insurances for emergency room claims

j. failure to implement proper controls for the payment of out of network claims

k. failure to implement proper controls for the loading and adjudication of deductibles and coinsurances

l. failure to maintain proper controls for the authorization and payment of certain vendor claims

m. failure to implement proper controls for the payment of claims related to in network lab services

n. failure to take corrective action for the prompt payment and investigation of claims required under Docket MC 15-61, executed on June 11, 2015

o. failure to maintain sufficient procedures relative to policyholder service

p. Respondent unable to provide documentation sufficient for regulatory review

4. The conduct as described above violates §§38a-702l, 38a-702m and 38a-816 of the Connecticut General Statutes, and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2, 38a-41 and 38a-817 of the Connecticut General Statutes.

II

1. WHEREAS, Respondent admits to the allegations contained in paragraphs three and four of Article I of this Stipulation; and

2. WHEREAS, Respondent agrees to undertake a complete review of its practices and procedures to enhance compliance with Connecticut statutes in the areas of concern, as described in the Market Conduct Report and this Stipulation; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a summary of actions taken to comply with the Recommendations in the Market Conduct Report within ninety (90) days of the date of this document; and

4. WHEREAS, Respondent agrees to pay a fine in the amount of $320,000 for the violations described herein; and

5. WHEREAS, Respondent, being desirous of terminating this proceeding without the necessity of a formal proceeding or further litigation, does consent to the making of this Consent Order and voluntarily waives:

   a. any right to a hearing; and

   b. any requirement that the Insurance Commissioner's decision contain a statement of findings of fact and conclusions of law; and

   c. any and all rights to object to or challenge before the Insurance Commissioner or in any judicial proceeding any aspect, provision or requirement of this Stipulation

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. That the Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. That Respondent is fined the sum of Three Hundred Twenty Thousand Dollars ($320,000) for the violations herein above described.

ANTHEM HEALTH PLANS, INC.

By: _____

(Representative of Insurance Company)

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 16 day of February 2022 for and on behalf of Anthem Health Plans, Inc., that he/she is the President of such company, and he/she has authority to execute and file such instrument.

By: _____

State of Connecticut

County of New Haven

Personally appeared on this 16 day of February 2022 Lou Gianquinto signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____
Notary Public/Commissioner of the Superior Court

DEBRA A. CHEFFER
NOTARY PUBLIC
MY COMMISSION EXPIRES 11/30/2024

Section Below To Be Completed by State of Connecticut Insurance Department

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March

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Dated at Hartford, Connecticut this _____ day of _____ 2022.

_____
Andrew N. Mais
Insurance Commissioner