

**MARKET CONDUCT EXAMINATION**

**of**

**KAISER FOUNDATION HEALTH PLAN OF THE  
NORTHWEST  
KAISER PERMANENTE HEALTH  
ALTERNATIVES**

**500 NE MULTNOMAH ST., STE 100  
PORTLAND, OR 97232**

**January 1, 2006 – December 31, 2006**



Order No. 08-0078  
Kaiser Foundation Health Plan  
of the Northwest  
Kaiser Permanente Health Alternatives  
Exhibit A

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The Honorable Mike Kreidler  
Washington State Insurance Commissioner  
302 14<sup>th</sup> Avenue SW  
P.O. Box 40258  
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed on the following Companies:

Kaiser Foundation Health Plan of the Northwest	NAIC #95540
Kaiser Permanente Health Alternatives	NAIC #77378

In this report, the above entities are collectively referred to as the Companies. In addition, Kaiser Foundation Health Plan of the Northwest is also referred to as "KFHPNW". Kaiser Permanente Health Alternatives is referred to as "KPHA".

This report of examination is respectfully submitted.

## CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Sandy Ray, CIE, CPCU and Jeanette M. Plitt, AIE, CLU of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Kaiser Foundation Health Plan of the Northwest and Kaiser Permanente Health Alternatives during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.



Sally Anne Eastman AIE, AIC  
Chief Market Conduct Examiner  
Office of the Insurance Commissioner  
State of Washington

## FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

### Scope

#### Time Frame

The examination covered the Companies' operations from January 1, 2006 through December 31, 2006. This was the first market conduct examination of Kaiser Foundation Health Plan of the Northwest and Kaiser Permanent Health Alternatives. This examination was performed in the Companies' office in Portland Oregon; in the offices of the third party administrator located in Portland and Beaverton, Oregon; and, at the Washington Insurance Commissioner's office in Seattle, WA.

#### Matters Examined

The examination included a review of the following areas:

Company Operations and Management  
Agent Activity  
Complaints  
Underwriting

Claims  
Rate and Form Filing  
Provider Activity

### Sampling Standards

#### Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance

These are the guidelines prescribed by the National Association of Insurance Commissioners in the Market Conduct Examiners Handbook and the Market Regulation Handbook.

## **Regulatory Standards**

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio which determines whether or not a standard is met. If the error ratio found in the sample is less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and policy form and rate filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures or specific processes to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

## COMPANY OPERATIONS AND MANAGEMENT

### Company History

Kaiser Permanente (KP) is a nonprofit, group-practice health plan that was founded in 1945 and is headquartered in Oakland, California. Kaiser Permanente encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Groups.

The Kaiser Foundation Health Plan's affiliates doing business in Washington include Kaiser Foundation Health Plan of the Northwest (KFHPNW) and Kaiser Permanente Health Alternatives (KPHA). KFHPNW was admitted into Washington on October 1, 1947 and KPHA was admitted on December 5, 1990. Both KFHPNW and KPHA are domiciled in Oregon and licensed in Washington as Health Care Service Contractors. KFHPNW was previously licensed as a Health Maintenance Organization (HMO) but amended its' Certificate of Registration to a HCSC effective January 1, 2006.

Kaiser Foundation Health Plan of the Northwest and Kaiser Permanente Health Alternatives contract with affiliates Kaiser Foundation Hospitals, Northwest Permanente, P.C. and Permanente Dental Associates to provide or arrange hospital, dental and medical services for members.

*Subsequent Event: Effective December 12, 2007 Kaiser Permanente Health Alternatives merged with Kaiser Foundation Health Plan of the Northwest with KFHPNW being the surviving entity.*

### Company Operations and Management

Kaiser Foundation Health Plan of the Northwest is managed by a Board of Directors (BOD) made up of 14 members. The following individuals were KFHPNW Directors during the exam period:

Board Member	Original Appointment Date	Term Expiration Date
Christine K. Cassel, MD, MACP	06/01/2003	03/01/2008
Thomas W. Chapman, EdD	03/08/1994	03/01/2009
Daniel P. Garcia	07/16/1992	03/01/2008
William R. Graber	10/01/2004	03/01/2010
J. Eugene Grigsby, III, PhD	04/01/2004	03/01/2009

Board Member	Original Appointment Date	Term Expiration Date
George C. Halvorson	05/01/2002	Ex Officio
Judith A. Johansen	04/01/2006	03/01/2008
Kim J. Kaiser	04/01/2004	03/01/2010
Philip A. Marineau	04/01/2004	03/01/2009
Jenny Ming	12/15/2006	03/01/2010
Edward Y.W. Pei	04/01/2006	03/01/2008
J. Neal Purcell	07/01/2003	03/01/2009
Cynthia A. Telles, PhD	04/24/2003	03/01/2008
Sandra P. Thompkins	06/01/2005	03/01/2010

The following individuals were Directors of Kaiser Permanente Health Alternatives during the exam period:

Board Member	Original Appointment Date	Term Expiration Date
Mary Durham	03/09/2005	12/31/2006
Cynthia A. Finter	03/09/2005	08/15/2006
Kim J. Kaiser	03/09/2006	12/31/2006
Leslie A. Margolin	03/09/2005	01/27/2006
Robert L. Ridgley	03/09/2005	12/31/2006
Bernard J. Tyson	03/09/2006	12/31/2006

### Territory of Operations

During the exam period the Companies offered health plans in Clark and Cowlitz Counties as well as:

- Zip codes 98591, 98593 and 98596 in Lewis County
- Zip codes 98639 and 98647 in Skamania County
- Zip codes 98612 and 98647 in Wahkiakum County

### Findings

The following Company Operations and Management Standards passed without comment:

<b>1</b>	<b>The Company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington.</b>	<b>RCW 48.44.015(1)</b>
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2	<b>The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State.</b>	<b>RCW 48.44.013</b>
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The following General Examination Standard passed with comment:

3	<b>When the Company registers with the OIC, it is required to state its territory of operations.</b>	<b>RCW 48.44.040</b>
4	<b>The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington.</b>	<b>RCW 48.46.027(1)</b>

**Company Operations and Management Standard 3:** During review of the underwriting files the examiners found one (1) group (OIC I01) located in Jefferson County. This group was located in Clark County when it was first underwritten but moved out of the stated territory of operations; the out-of-area address for the group went unidentified during renewal processing. This issue is also addressed in the underwriting section of the exam.

**Company Operations and Management Standard 4:** Throughout the examination it was found that each Company referred to itself as a Health Maintenance Organization (HMO) instead of a Health Care Service Contractor (HCSC). The Companies' internal bulletins, procedures and guidelines refer to plans as HMO products. RCW 48.46.027(1) states that "a person may not in this state, by mail or otherwise, act as or hold himself or herself out to be a health maintenance organization as defined in RCW 48.46.020 without first being registered with the commissioner".

### GENERAL EXAMINATION FINDINGS

The Companies' records and operations were reviewed to determine if the Companies do business in accordance with the requirements of this state.

#### Findings

The following General Examination Standards passed without comment:

1.	<b>The Company does business in good faith, and practices honesty and equity in all transactions.</b>	<b>RCW 48.01.030</b>
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2	<b>The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.</b>	<b>RCW 48.44.145(2)</b>
3	<b>The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.</b>	<b>WAC 284-30-572(2)</b>

## COMPLAINTS

### Complaint Policies and Procedures

The Companies provided the examiners with the following documents for review:

- Customer Complaint Resolution Policy
- Policy for Reviewing Grievances and Appeals
- Claims, Complaints, Grievances and Appeals Flyer – Medical
- Claims, Complaints, Grievances and Appeals Flyer – Dental

Member complaints concerning administrative, quality of care or service issues, either written or oral are forwarded to the manager of the department responsible for the subject of the complaint. The manager is responsible for researching the complaint and responding to the member. Grievances and appeals are reviewed by the appropriate clinical or health plan manager, Member Relations or the appeal committee.

All complaints, grievances and appeals are entered into the Companies' Customer Information Documentation and Reporting System (CIDARS). The member perspective and information submitted, results of research, physician review information, actions taken, decision made, oral and written notices and all other information related to review and resolution of a grievance or appeal is also documented in CIDARS.

### Findings

The examiners reviewed OIC CA 69 which involved denial of acupuncture treatment for a member with rheumatoid arthritis. In the complaint, the member states that this treatment is the only one that provides relief from the arthritis pain. The Company denied treatment because acupuncture is not a covered benefit for treatment of a chronic illness. Over the course of treatment, the patient was seen in the Kaiser Pain Clinic. The Pain Clinic asked for and received approval to provide 12 treatments over the course of 2 – 3 months provided the member signed a statement that they understood that this was an exception, that they

understood that this is not normally a covered benefit and that benefits would terminate if the member violated the confidentiality of the exception or if they in any other way violated the agreement. The member was given 7 days to sign or the offer was off the table. The member was not comfortable with the way the agreement was written, elected not to sign and brought the proposed agreement to the OIC as part of a complaint against Kaiser.

The examiners asked the Company how often they make exceptions such as this. The Companies stated that two (2) referrals through the Pain Management Clinic for medically necessary treatment for chronic pain were made for members of Washington plans in 2006. Both members did not meet the established standard utilization review criteria but their cases were evaluated by Pain Management Clinic and were found to meet the Clinic's medical criteria for a referral. The Companies maintain that the established medical necessity criteria and the criteria under the Pain Management Clinic policy are applied consistently for all members and therefore the agreements offered are not discriminatory. The examiners maintain that all members should be subject to one set of criteria as established within the Companies' policy and that criteria should be applied uniformly for all members.

### **File Review**

The Companies reported a total of 1,281 complaints broken down as follows:

- 589 Complaints
- 464 Pre-Service Requests (Provider request submitted on behalf of members for treatment services that must be approved through utilization review, such as bariatric surgery).
- 212 First Appeals
- 16 Second Appeals

A random sample of 50 files was selected for review. To verify that the Companies are using the prudent lay-person definition of an emergency and not generating member complaints relating to ER claim denials the examiners also selected the 16 files identified as involving ER claims. The Companies' database does not include an identifier for complaints received by the OIC so the examiners also selected the five (5) complaints received by the OIC during the examination period. A total of 71 files were reviewed.

The Customer Complaint System (CCS) in use during the exam period links only to current member information within the Companies' main database. When pulling the complete list of complaints, grievances and appeals the Companies included files for members that currently belong to a Washington group but were Oregon group members during the exam period. As a result of the system limitation, two (2) of the selected files involved complaints from members belonging to Oregon groups. One (1) file involved a Medicare member. The Companies were unable to determine why the Medicare indicator was not included in CCS. Three (3) files

were randomly selected to replace the complaints involving members and products outside the scope of this exam. The Companies informed the examiners that they had no way of knowing how many of the initially reported 1,281 complaints involved Oregon members.

*Subsequent event: The Customer Complaint System was replaced by the Customer Information Documentation and Reporting System (CIDARS) in 2007.*

The following Complaints Standards passed without comment:

#	Complaints Standards	Reference
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC.	RCW 48.43.055
2	The Company maintains a fully operational, comprehensive grievance process.	RCW 48.43.530, WAC 284-43-615
3	The Company provides enrollees access to independent review services to resolve disputes.	RCW 48.43.535
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.	WAC 284-30-650, Technical Advisory T 98-4
5	The Company complies with procedures for health care service review decisions.	WAC 284-43-620

## CLAIMS

The Companies utilize a number of different systems, as well as third party administrators (TPAs), in the adjudication of claims and encounters. The Companies have the following systems in place:

- Tapestry – This system processes encounters and is maintained by Patient Business Services.
- Diamond – This system tracks claims for medical services not provided by the Companies facilities or physicians. The claims adjudicated in this system include referred services, ER services, hospital services, alternative care services as well as claims for durable medical equipment.
- Team – This system is used to process encounters for dental services and is maintained by Permanente Dental Associates.

The Companies also utilize the services of the following administrators:

- Complimentary Health Care Plan (CHP) – Alternative care claims are adjudicated by CHP. The TPA utilizes its own network of providers. CHP adjudicates its claims on its own system called Luminx.

- MedImpact – Out of network and point of service pharmacy claims are handled by this TPA.
- Employers Mutual Inc. (EMI) – The Companies contract with American Medical Response (AMR) to provide ambulance services. AMR in turn subcontracts with the administrator, EMI to adjudicate the ambulance service claims.
- William C. Earhart Company Inc. – This TPA adjudicates claims for dental services provided by providers not contracted by the Companies.

The Companies audit the claims of EMI on a monthly basis. The Companies reviewed 120 claims during 2006 and found a 93% accuracy rate. No scheduled audits or reviews of the remaining TPA's are done by the Companies. A limited review of MedImpact was done by the Companies National Compliance, Ethics & Integrity Office in conjunction with the Regional Compliance office. The review found the following:

- The current Service Agreement between Kaiser Foundation Health Plan, Inc. and MedImpact does not contain a signed addendum for the Northwest Region. MedImpact has been processing claims for the Region without a formal contract for several years.
- Neither clearly assigned oversight responsibility nor accountability for monitoring MedImpact activities exists at Kaiser Permanente NorthWest.
- MedImpact must increase its general liability insurance coverage to comply with its contractual agreement.
- MedImpact invoices are sent directly to the Northwest Region's Accounts Payable Department. The invoices are not reviewed for accuracy by Region personnel prior to payment.

### **Claims Processing**

Claim procedures, policies and directives are on the Kaiser Permanente Northwest intranet. The examiners were given access to the intranet pages, the national Kaiser website and the Companies' Diamond claim system. The procedures were found to be both detailed and complete. The examiners also interviewed the Companies' TPAs and were given access to the TPAs' claim files.

The Companies' claims are adjudicated on multiple systems that do not interface with each other. This makes it impossible for the Companies to automatically track accumulators and determine when a member has reached their out-of-pocket maximum. During the first quarter of 2007 the Companies sent Summary of Account letters to members with a deductible plan who received medical services in 2006. The Companies maintain that no members overpaid their out-of-pocket expenses in 2006.

### **Claims Review**

The examiners reviewed a random sample of claims and encounters processed during the exam period. The sample was pulled from the following populations:

Diamond	105,073	92 <sup>1</sup>
Tapestry	101,675	17 <sup>2</sup>
Team	24,822	0 <sup>3</sup>
Paper Claims <sup>4</sup>	20	1
CHP	20,346	25
MedImpact	12,544	25
EMI	4,473	25
William C. Earhart Company, Inc	155	25
<b>Total</b>	<b>269,108</b>	<b>210</b>

<sup>1</sup> A sample of 110 claims was initially selected. Ten (10) of the claims were pulled for purposes of COB review only. During the review process 18 of the samples were found to involve PEBB or Basic Health claims. Three (3) of the 18 involved the COB claim sample.

<sup>2</sup> A sample of 25 encounters was initially selected. During the review process 8 of the files were identified as having been mischaracterized as encounters.

<sup>3</sup> The existence of the Team encounters was not discovered until late in the review process. Samples were not pulled.

<sup>4</sup> These 20 claims represent out of area dental claims handled manually by Permanente Dental Associates

### Findings

The following Claims Standards passed without comment:

#	Claims Standards	Reference
1	The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area.	RCW 48.01.235(3)
2	All plans must provide female enrollees direct access to women's health care services.	RCW 48.42.100, WAC 284-43-250
4	All plans shall cover emergency services necessary to screen and stabilize a covered person.	RCW 48.43.093
5	Decisions concerning maternity care and services are to be made between the mother and the provider.	RCW 48.43.115
6	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist.	RCW 48.43.180, RCW 48.44.500
7	The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined.	RCW 48.43.520, WAC 284-43-410

#	Claims Standards	Reference
8	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.	RCW 48.43.525(1)
9	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).	RCW 48.44.440, WAC 284-44-450
10	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization.	RCW 48.44.465

The following Claims Standards passed with comment:

#	Claims Standards	Reference
3	All plans must include every category of provider.	RCW 48.43.045 WAC 284-43-205
11	The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on un-denied and unpaid clean claims that are more than 61 days old.	WAC 284-43-321(2)

**Claims Standard 3:**

A. It is difficult for members to access the provider listing of alternative care providers. The member information leads one to believe that they may obtain discounts from the Complementary Healthcare Plans (CHP). WAC 284-43-205(5) prohibits carriers from offering coverage for health services for certain categories of providers solely as a separately priced optional benefit. The Companies' plans do provide the required coverage for every category of provider but this is not readily evident from the directory.

B. The directory refers members to a website that lists the Companies' participating chiropractors under the heading of "The Kaiser Permanente Chiropractic Network" and explains how the Companies' self-referred chiropractic benefit works. The website also states that members must receive care from a provider located in the service area and who is part of CHP. The Kaiser website indicates that the member must receive care from a provider who is in the service area and is part of the ChiroNet Network. In fact, members must use the CHP network to receive benefits. This creates confusion as there are differing instructions depending on the source location.

**Claims Standard 11:**

The Companies failed to pay 95% of clean claims for two (2) providers within the prescribed time limit.

- One provider's contract fee schedule was not being applied correctly due to the Companies code editing software. The software was denying procedure code 99212 as an unbundled procedure which should be included in the service code Q0091. In this

instance the provider was a specialist, OBGYN, who may bill the procedures separately. This caused incorrect denials of claims. In OIC Sample 002, this problem caused payment of this claim to be delayed more than 60 days. The Companies found that this issue affected many claims for this provider. The provider's office and the Companies configuration team identified and corrected the problem. The Companies did not find any other providers impacted by this issue.

*Subsequent Event: Instructions were added on 4/26/2006 to the processing procedures regarding evaluation of a provider and specialty prior to bundling denials.*

- Sample file OIC 008 was paid 72 days after initial receipt. Adjudication of this providers' claim was delayed due to the Companies' delay in configuring the provider's second location within the Companies' system. Interest was paid on eight (8) of 14 claims submitted by this provider. The Companies determined that the delay occurred during training of a new Provider Contracting staff person.

The following Claims Standards failed:

#	Claims Standards	Reference
12	The denial of any claim must be communicated to the provider or facility with the specific reason claim denied.	WAC 284-43-321(4)
13	The Company administers Coordination of Benefits provisions as required.	Chapter 284-51 WAC

**Claims Standard 12:** The Companies started using the Diamond system in 2005 for claims processing. The Diamond system is a Regional system and should provide uniformity among the regional offices. In moving to the Diamond system the Companies experienced the following issues:

- Although the system correctly processed claims where the allowed amount was applied to the deductible, there was not a code in the system to explain this on the Explanation of Benefits (EOB) form. As a work around, the company manually forced code BN085 so that it could bypass system edits in this case. The explanation for BN085 stated that there was no payment due to bundling of charges. This was a problem because they were reporting denials instead of payments to both the provider and member, creating confusion for both customers. The Examiners found two instances of this in the sample.

*Subsequent Event: In August 2006, the Companies began using code BD001 which correctly indicated that the allowed amount was applied to the deductible. There were 406 claims found where the Companies used the code BN085. Of these 16 were correctly coded. There were 306 claims that had the incorrect code in the history.*

- Three (3) claims were initially denied using incorrect codes. A system configuration problem, as described under claims standard 11 above, caused claims for one (1) provider to be incorrectly denied. The adjuster for OIC claim 015 applied incorrect pricing to this claim causing it to be denied with the erroneous indicator of vendor contracted rates being exceeded. Denial for OIC claim 092 initially indicated that the member had reached their maximum benefit. The denial was overridden after it was found that authorization for treatment existed due to medical necessity.

**Claims Standard 13:** When the Companies determine that they are secondary for COB purposes, the Companies will pay the net difference between the primary carriers' allowed amount and paid amount. The Companies do not determine the members allowed amount under the Companies' plan nor do they calculate or track COB savings. The Companies' standard procedure is in violation of WAC 284-51-050(7).

The Companies' TPA, MedImpact, received daily eligibility data feeds from the Companies however the data did not include COB information. The TPA does not receive the information necessary to coordinate benefits on pharmacy claims.

## **AGENT ACTIVITY**

### **Agent Licensing and Appointment Procedures**

This section was not originally included in the scope of the exam. However, while pulling samples for the Underwriting Section of this examination, the Examiners found that the Companies do not check for agent licensing during the sales process. It is only after the application is signed and the company has accepted it that agent licensing is checked. Because of this violation of Washington law, the decision was made to include Agent Activities in the examination.

The Companies provided the examiners with their Northwest Broker Relations Manual Appointment Policy and Procedure document detailing:

- Appointment Policy
- Appointment Procedure
- Termination of Appointment Procedure

The Manual, in use during the exam period, did not require agent appointment for Kaiser Permanente Health Alternatives; consequently the only agent appointments in place were for Kaiser Foundation Health Plan of the Northwest. This issue is addressed under Agent Activity Standard Two.

*Subsequent Event: The Northwest Broker Relations Manual Appointment Policy and Procedure document was revised to reflect the requirement that agents be appointed with both Companies doing business in Washington. The Companies completed the appointment process for all of their agents by 8/31/2007.*

The examiners requested a list of internal employees who provide quotes and are involved in the sales process. A sales Account Management Staff list was provided which included both sales and support staff. A number of employees listed as Account Associates and Account Managers have hire dates a number of years prior to their license and appointment dates. Review of in-force business written prior to the exam period identified 3 contracts written by or involving account managers not licensed or appointed at time of sale (I13, I23 and I42). During the examination period, the Companies did not have a process in place to ensure proper licensing and appointment of employees within a timely manner and prior to solicitation and sale of business.

*Subsequent Event: The Companies developed a Staff Licensing – Policy and Procedures document effective 9/1/2007. The purpose of the policy is to ensure that all appropriate employees working in the Account Management and Consumer Sales department maintain all current and appropriate licensure. The procedures call for employees to become licensed within 90 days of date of hire.*

Agencies, agents and brokers contracted with the Companies are given access to its Online Quoting Tool once licensure and appointment has been confirmed. The Companies' Online Quoting Approval Policy and Procedure document details the license and appointment verification process. To ensure that all appointed agencies and agents maintain current and appropriate licensure the Companies have developed a License Auditing Policy and Procedure. As part of the process, nine (9) individual system queries (audit reports) are run on a monthly basis. The reports include such information as agent and agency licenses about to expire within 2 months, agents or agencies that are only licensed in Oregon but have written Washington groups, and groups that are associated with agents who have been terminated.

### **Agent Activity Review**

The sample of 100 new, 100 in-force policies and 35 quotes pulled for the underwriting section were used to test compliance for this section. The majority of quotes are generated by agents who have access to an on-line quoting tool provided by the Companies. Company employees can also generate quotes but do so only on an exception basis.

### **Findings**

Note: Standards 1 and 2 have a zero tolerance level.

The following Agent Activity Standard Passed without Comment:

3	<b>The Company must provide the agent with written notice of termination of appointment and send a copy to the OIC.</b>	<b>RCW 48.17.160(3)</b>
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The following Agent Activity Standards failed:

1	<b>The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.</b>	<b>RCW 48.17.060(1) RCW 48.17.060(2) RCW 48.44.011(2)</b>
2	<b>The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.</b>	<b>RCW 48.17.160 RCW 48.44.011(2)</b>

**Agent Activity Standard 1:** Two (2) applications for new business were signed by individuals not licensed in Washington at the time of sale. The commission payment for two (2) new groups was issued to an agency not licensed at the time the application was completed. One (1) group renewing during the examination period was assigned to a Company representative not licensed at the time this assignment was made. There was no independent agent involvement in the initial sale or renewal of the group.

See Appendix 1.

Two (2) quotes (Q33 and Q35) were produced during the examination period by employees of the Companies. Applications for the groups were not retained as the quotes did not result in sales. The Companies were unable to determine which employees generated the quotes so proper licensing could not be determined.

*Subsequent event: The Companies are currently testing a system enhancement to its online quoting tool which will allow it to determine who developed the original quote.*

**Agent Activity Standard 2:** The quotes generated by the Companies' on-line quoting tool include the premium for all of the Companies' products. Kaiser Permanente Health Alternatives is the underwriting Company for all the Point of Service (POS) and dental plans. There were no agent appointments for KPHA during the exam period. All quotes presented to groups which include KPHA products are in violation of this standard.

Eighteen of the sample underwriting files reviewed include groups sold KPHA products, four (4) quotes for business that was eventually written also included KPHA products and two (2) groups with KPHA products were identified in which the writing agent was appointed with

neither KPHA nor KFHPNW. Ten (10) groups with coverage underwritten by KFHPNW involved the sale by agents not appointed with KFHPNW.

See Appendix 2.

## **RATE AND FORM FILING**

The Companies offered the following products in 2006:

- Traditional Plan – A traditional managed care co-payment plan.
- Deductible Plan – A managed care plan with a deductible.
- Added Choice Plan – A point-of-service plan offering benefits from either a plan provider, an-out-of-network provider, or a 3-tier plan in which members can access plan providers, out-of-network providers, or PPO providers.
- Optional Dental and Vision coverage.

Each contract issued to a group contains a “Face Sheet” which documents each group’s specific contract amendments.

Prior to the start of the exam the OIC had identified and addressed issues with the Companies’ rate and form filings for the 2006 coverage period. The Companies attempted to file endorsements for changes for the 2006 new plan year. The changes included, in part: reduction of out-of-pocket expense limitations, increases to lifetime benefit maximums, removal of some benefits from the deductible, increases in benefit limits for chemical dependency, and changes to comply with HIPAA. The Companies began making these changes to many plans as they were renewed since the products are “file and use” under RCW 48.44.040. The OIC found that the enhancements to benefits in the Companies plans constituted replacement of all of its guaranteed-renewable small group products. By replacing all of its small group plans, the Companies violated RCW 48.43.035(2) which requires all health plans to contain or incorporate by endorsement a guarantee of the continuity of coverage of the plans. At OIC’s direction, the Companies withdrew the 2006 endorsements and re-filed the new products in their entirety with new form numbers. These issues caused a significant delay in the issuance of plans to both new and renewing groups. Contracts for 2006 were not issued until September 2006, regardless of a group’s plan effective date. The Companies’ vendor, Benefit Nation Incorporated (BNI), is responsible for mailing Certificates of Coverage (COC). The Companies began sending COC data to BNI in September 2006. BNI was not able to send out COC’s until April 2007 so in many cases group members received COC’s after expiration of their 2006 contracts.

The issuance of contracts to groups is a very manual process completed by the Contract Administration department. Contract Administration receives a routing form from underwriting which lists the group number. The group number is keyed into the Companies’ Facet system which outlines each group’s coverage. Contracts and endorsements are shelf products and an assembler is responsible for manually assembling the group contract and

including all applicable endorsements. During the exam period the Companies had one person responsible for this task; with no back-up personnel or quality assurance system in place.

### Rate and Form Filing Review

The sample of 50 new groups and 50 in-force groups pulled for the underwriting section of this exam were also used to test compliance with the rate and form filing standards. The Companies provided the examiners with a manual listing of the contracts issued to each group in the selected sample; the listing includes contract and form numbers as well as form filing dates.

### Findings

A number of the findings listed here were reported by the Companies at the start of the exam. The following errors were noted during review of the materials provided by the Companies:

- H456-21 DED Emergency Services & Urgent Care (Plan 21) – This is a base benefit listed in the contract. The Companies noted during exam preparation that this base benefit was printed as an amendment in error.
- H3085-2M Lifetime Maximum – The wrong form number was used in production, number H9998-W ENGSBGDED (5/06) should have been used.
- H586-BV X-Ray, Laboratory and Special Procedures – This form was filed with the OIC however during production the form number was transposed to H585-BV.
- The Calendar Year Deductible amendment was filed with the Number H3080-1K/3K but due to a production error was printed on the Face Sheet as H3080-1G/3G.
- Each of the three (3) plans offered are filed as separate contracts however some of them are offered as bundled plans. Prior to the Companies' 6/15/2006 filing, the group application used did not show the bundled plan offerings. This issue was identified and addressed prior to the start of the exam.
- OIC N09 – The face sheet for this small group product does not include the small employer definition H621. The Companies advise that this was a production error.

*Subsequent Event: At the direction of the OIC the Companies are currently auditing the filings process.*

Note: Standards 1 and 2 have a zero tolerance level.

The following Rate and Form Filing Standard passed without comment:

<b>3</b>	<b>All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner.</b>	<b>WAC 284-43-925</b>
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The following Rate and Form Filing Standards failed:

1	All contract forms have been filed with the OIC prior to use.	RCW 48.44.040, WAC 284-43-920
2	All rates have been filed with the OIC prior to use.	RCW 48.44.040, WAC 284-43-920

**Rate and Form Filing Standard 1:** As noted above the OIC asked the Companies to withdraw their initial 2006 filings. The Companies corrected filings were submitted June 21, 2006, and were accepted. All new policies sold prior to the corrected filing date and all in-force policies renewing prior to the filing date are in violation of this standard.

In preparing documents for the examiners the Companies noted that Amendment H3031-U Preventive Care (Plan U) was not filed. The amendment was used with 30 of the 100 sample files reviewed.

**Rate and Form Filing Standard 2:** The filing of rates is done in conjunction with the filing of forms. The issues noted above with the forms required that the rates initially filed also be withdrawn and refiled with the forms. All rates quoted and sold prior to the June rate filing are in violation of this standard. The rates eventually filed and approved by the OIC mirror those that the Companies initially submitted and subsequently withdrew at the direction of the OIC.

The Companies' business can be rated in a number of ways. Renewing groups go through the Common Membership (CM) system auto-renewal process or the groups may renew manually via Underwriting using Excel rating models. New groups are quoted on the Access or web-based model. The Excel rating model is updated based on information filed. The resulting rates from the model are checked with the rate filing. The CM, Access and web-based models are then checked against the Excel model. Testing is conducted across all models to ensure a threshold of only a few cents difference. Due to the various types of rating models used the Companies can not assure exact rates across all models but test so that pricing varies by a few cents at most. During review of the sample files the following was determined:

- During the first quarter of 2006 the Access model contained an incorrect pharmacy rate adjustment factor of 1.574 as opposed to the correct factor of 1.516. This error will have impacted new groups that were quoted, and sold, using the Access model. The error will have caused a lower rate for those groups impacted with the amount at issue being well under \$1 for most groups. The Companies are unable to identify which groups were rated in Access versus any other rating model system as they have no way to identify every group without reviewing every 2006 group individually. Five (5) of the 50 new groups in the sample used the incorrect pharmacy rate adjustment factor. N01, N02, N07, N10 (honored original quote), N12
- OIC file N26 contained a note indicating that final rates revealed an error in the rating model. Apparently Excel had a rate adjustment factor (RAF) of 1.260 on base

medical rate while the Access RAF was input as 1.2594. The note also states that this is the last group of the 2<sup>nd</sup> quarter so rather than fix the second quarter rating model the group should be run in Excel. The Companies advise that there were numerous changes to the 2<sup>nd</sup> quarter 2006 RAF calculation in the Excel model as well as to the Access model. In this instance the Companies could not determine what had occurred due to the amount of time that has elapsed. The Companies state that errors did occur between the Access and Excel models and upon discovery were typically corrected within one (1) day.

See Appendix 3.

*Subsequent Event: Use of the Access model was discontinued in the last quarter of 2006 at which time the Excel rating model was put in use for quoting new groups.*

## UNDERWRITING

### Underwriting Manuals and Procedures

The Companies provided the examiners with underwriting guidelines and procedures for review. While the examiners found the procedures to be detailed and comprehensive the Companies did not update all documents in a timely fashion to reflect actual operating procedures.

- The Actuarial and Underwriting guidelines on the Companies' intranet site require 100% of eligible employees to enroll for groups of 2-25 eligible employees. The actual guidelines being followed require 100% participation of eligible employees for groups of (2) two to (3) three and participation of 75% of employees for groups with (4) four to 25 employees.
- The Actuarial and Underwriting guidelines on the Companies' intranet site state that all groups must have (1) eligible employee in Washington to qualify as a group. A different document produced by the Companies outlining medical plan guidelines for 2006 as well as the online quoting tool correctly require (2) eligible employees in order to be classified as a small group.
- The Actuarial and Underwriting guidelines for groups of 2 – 50 on the Companies' intranet site indicate a minimum of two (2) enrolled employees eligible for coverage are required when providing a dental plan on a new sale. The application for coverage completed by new groups during the exam period stipulates only that a group must have at least 10 enrolled subscribers if selecting dental coverage. The Companies' actual guidelines were revised in June, 2005 to lower the minimum requirement from 10 to 5 subscribers. The requirement was again lowered from 5 to 2 subscribers on July 1, 2006.

*Subsequent Event: Updates to the Rules and Guidelines found on the Companies' intranet site have been finalized and are pending final management approval before being posted.*

## **Findings**

The majority of groups written during the examination period represent small groups. The system in place for processing a new small group calls for an audit of the group information using a New Sales Checklist developed by the Companies. The audit is used to verify that census data and waiver information has been received; employment, payroll, and business license documents have been reviewed; and, all eligibility criteria have been met. This audit process is not repeated at renewal. Census forms are not required for renewal nor are new waiver forms required. This can potentially result in renewing groups no longer meeting the Companies' eligibility criteria and renewal of the group inappropriately.

The following issues impacting specific groups were identified during review of both new and in-force business:

- OIC N29 – This group reported 7 employees on its census form, 2 of the employees opted not to purchase insurance and signed waivers but did not indicate that they had other coverage. This does not meet the Companies' 75% participation requirement.
- OIC I01 – At renewal the Companies did not identify that this group had moved outside of the Companies' territory of operations. This issue is also noted under Company Operations and Management.
- OIC I04 – This group had vision coverage in 2005. There is no documentation in the file indicating the group requested removal of the coverage, however the vision coverage was not included in the 2006 contract.

*Subsequent Event: The Companies' investigation found that the group wanted to add vision coverage in 2005. This was not done, but the increased premium was charged for this benefit. This error continued into 2006. The Company stated that they will refund the 2005 overpaid premium.*

Underwriting file OIC N50 included a document noting that the Companies limit the number of female patients assigned to a provider. The Companies customer service representative referred to this as the Companies doctors having a "male vs. female" patient quota. The examiners requested additional information and were told the Companies recommend that a provider limit the number of female patients that are accepted to a practice for Family Practice and Internal Medicine Physicians to 70% of their entire panel of patients. Per the Companies, statistics show that female patients access services at a significantly higher rate and have appointments longer in duration than male patients. The limitation is intended to balance the workload of all physicians. The Companies also maintain that this practice ensures that members have adequate access to their selected primary care physician. This recommendation is not outlined in the provider manual.

## Underwriting File Review

The following is a breakdown of the total population during the examination period and random sample selected for review:

<b>New Groups<sup>1</sup></b>		
Small Groups	266	45
Large Groups	5	5
<b>In-force Groups</b>		
Small Groups	2,090	46
Large Groups	136	3
Zero Employees <sup>2</sup>	48	1
<b>Declined Groups</b>	4	4
<b>Canceled and Terminated Groups</b>	298	7
<b>Quotes<sup>3</sup></b>		
Small Groups	1,877	34 <sup>4</sup>
Large Groups	28	1
<b>Total</b>	<b>4,752</b>	<b>146</b>

<sup>1</sup> The Companies initially reported a total population of 851 new small groups and 6 large groups. The Companies later determined that OR groups had been included in the initial data pull and the total population figures have been adjusted accordingly.

<sup>2</sup> Groups remain active for 3 to 6 months before terminating for no subscribers.

<sup>3</sup> Quotes are entered by brokers and agents; the Companies do not verify if the correct state has been entered unless the business is sold. The Companies were not able to guarantee the accuracy of the total population data provided.

<sup>4</sup> Examiners initially selected 43 quotes for review; the Companies did not retain documentation on 8 quotes not sold. A total of 34 quotes were reviewed.

### Findings

Underwriting standards 3, 4, 10, 11, 16 and 18 are not applicable to this examination as they apply only to coverage for individual policies which the Companies do not write in Washington.

The following Underwriting Standards passed without comment:

<b>1</b>	<b>The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.</b>	<b>RCW 48.01.235</b>
<b>2</b>	<b>The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage.</b>	<b>RCW 48.43.015 WAC 284-43-710</b>

5	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area.	RCW 48.43.025 RCW 48.43.035(1) WAC 284-43-720
7	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.	RCW 48.44.200 RCW 48.44.210
9	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.	RCW 48.44.220
12	Each group contract shall offer coverage for chiropractic care on the same basis as any other care.	RCW 48.44.310
13	All plans must include coverage for diabetes.	RWC 48.44.315
14	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.	RCW 48.44.335
15	Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents.	RCW 48.44.340(1) and (3) WAC 284-43-810
17	Adoptive children shall be covered on the same basis as other dependents.	RCW 48.44.420
19	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required.	RCW 48.44.460, WAC 284-44-042

The following Underwriting Standards passed with comment:

6	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).	RCW 48.43.028
8	All plans shall cover newborn infants and congenital anomalies from the moment of birth.	RCW 48.44.212(1)

**Underwriting Standard 6:** Two groups were identified as consisting of only one (1) eligible employee. RCW 48.43.005(24) defines small groups as any person, firm, corporation, partnership, association, sole proprietor, or self-employed individual that has employed at least two but no more than fifty eligible employees. Extending coverage to groups of one (1) is in violation of RCW 48.43.028.

Small Group Contracts renew annually. The small group is not required to submit an updated census to verify the group size. The Examiners found at least one instance in which this practice resulted in a group being renewed that did not meet the definition of small group.

See Appendix 4.

**Underwriting Standard 8:** New group administrators are provided with a system generated letter outlining enrollment and eligibility guidelines for newly eligible dependents. The letter indicates that new dependents are effective the first of the month following the date of marriage or birth. RCW 48.44.212(1) requires coverage from the moment of birth. The Companies' Group Agreements and Evidence of Coverage documents are in compliance and no instances of violations were found during review of underwriting files.

*Subsequent Event: The enrollment and eligibility guidelines form has been revised to indicate that newborns are covered from the moment of birth. The revised form has been in use since August 2, 2007.*

The following Underwriting Standard failed:

<b>20</b>	<b>The Company shall produce and provide Certificates of Coverage to the employer for distribution to each covered employee.</b>	<b>WAC 284-44-050</b>
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**Underwriting Standard 20:** The OIC identified issues in the 2006 plans filed by the Companies. Remediation of the issues caused a delay in the issuance of plans, as well as Certificates of Coverage to groups. The Companies contract with Benefit Nation Incorporated (BNI) to send out the certificates. Groups that received certificates for the 2006 benefit period did not begin receiving them until April of 2007.

Twelve groups did not receive Certificates of Coverage for the 2006 coverage period. Two (2) groups had terminated by the time the data pull for mailing occurred and therefore no certificates were mailed. Six (6) groups were in the data pull of groups to receive certificates but were not included after the Information Technology Department sorted the data to send to BNI. The Companies attribute this mistake to human error. Two (2) groups were not included in the initial data pull. The Companies attribute this to a deficiency in their membership certificate program in that the program does not always select 100% of the group subscribers for the file that goes to the vendor. The Companies have not been able to determine the cause of the problem or how many groups have been involved. Two (2) additional groups did not receive certificates due to the timing of the data pull. Group agreements had to have been in a completed state in the Companies' membership system and had to have active members at the time of the last 2006 data pull on December 12, 2006. The Companies changed their data pull

process beginning January 2007 and did not go back to the old process to capture the few groups that were not completed in the membership system on December 12, 2006.

See Appendix 5.

*Subsequent Event: The Companies discontinued using the membership program for producing subscriber Certificates of Coverage files beginning January 2007. The Companies are currently obtaining subscriber information for certificate production from their Data Warehouse.*

## **PROVIDER ACTIVITY**

### **Provider Contracting Process**

During the last quarter of 2006 and the first quarter of 2007 the Companies completed an assessment of their provider contracting process for both medical and dental providers. The Companies have formed a Provider Contracts Process Project team that is currently working to create and implement a process that ensures timely compliance with all applicable regulations.

### **Provider Activity Review**

The Rate and Forms Division within the Office of the Insurance Commissioner identified numerous problems with the Companies' provider contracts prior to the start of this examination. The OIC and the Companies are still in the process of resolving the issues. The examiners did not test compliance with the standards in this section but documented the following issues with contracts in use during the exam period:

- CCN Managed Care Provider Agreement – The Companies, in response to OIC's Rates and Forms Division, re-filed this contract which had previously been filed and approved. Subsequently, the Companies gave notice to the OIC that the re-filed contract was non-compliant. At the completion of the field work for this examination, the Companies had not filed a compliant contract.
- Apria Healthcare Inc.- Rates and Forms identified that the Companies were using this vendor to supply durable medical equipment to their members via a national agreement signed by Apria and Kaiser Foundation Health Plan, Inc., the Companies' parent corporation. The Companies filed an Addendum to the agreement in use in order to bring it into compliance with Washington State requirements. This filing was submitted and approved in 2007. The Agreement in use during the exam period was not in compliance.
- During the exam period the Companies had one agreement in place with an individual physician. The agreement in use was not filed and approved. At the completion of the field work for this examination the Companies were still in the process of filing a Provider Contracting Template.

*Subsequent Event: The Companies are working with the OIC Rates and Forms Division to bring all provider contracts into compliance.*

Working with the OIC Rates and Forms Division during the examination period the Companies agreed to meet provider contract filing timelines. The Companies failed to meet these deadlines according to the Rates and Forms division documentation.

The Provider Contracts Process Project team has not completed a review of all administrative contracts currently in place. The Companies contract with the following entities to provide claim payment services:

- Employers Mutual Inc. (EMI) – This entity is subcontracted under AMR and adjudicates ambulance claims.
- MedImpact – This administrator handles the Companies' external pharmacy claims
- William C. Earhart Company Inc. – This entity handles a limited number of the Companies' dental claims.

These contracts were identified during review of the Companies' claim operations and were not reviewed. If review of these contracts by the Provider Contracts Process Project team indicates that they include provisions allowing the entities to provide member services outside the scope of simply processing bills for payment the contracts should be submitted to the OIC for review.

## INSTRUCTIONS

#	Instruction	Page #
1	The Companies are instructed to communicate to providers and facilities the specific reason a claim is denied. The Companies are also instructed to monitor and verify their third party administrators' compliance with this requirement. WAC 284-43-321(4).	16
2	The Companies are instructed to comply with Chapter 284-51 WAC and coordinate on all claims as stipulated in the WAC or eliminate the COB provision from filed contracts.	16
3	The Companies are instructed to comply with RCW 48.17.060(1) and (2) and ensure that all agents and brokers are licensed in the appropriate line of business before allowing them to solicit business or represent the Companies in any way.	19
4	The Companies are instructed to comply with RCW 48.17.160 and RCW 48.44.011(2) and ensure that all agents are appointed with the Companies prior to allowing them to solicit business for the Companies.	19
5	The Companies are instructed to file all contracts, amendments and endorsements prior to use. RCW 48.44.040, WAC 284-43-920.	22
6	The Companies are instructed to file all rates with the OIC prior to use. RCW 48.44.040, WAC 284-43-920.	22
7	The Companies are instructed to provide Certificates of Coverage to all employers for distribution to each covered employee. WAC 284-44-050.	27

## RECOMMENDATIONS

#	Recommendation	Page #
1	It is recommended that the Companies cease the practice of referring to themselves as HMOs and refer to themselves only as HCSCs. The reference to the Companies being HMOs in internal documents can easily cause confusion to employees and may inadvertently lead to use of the term when dealing with the public. RCW 48.46.027.	9
2	It is recommended that the Companies develop and adhere to one set of standard utilization review criteria and apply the criteria to all members uniformly so as not to give the appearance of disparate treatment among plan members.	10, 11
3	It is recommended that the Companies perform audits of all TPA's on a regular basis to ensure compliance with applicable statutes as well as contractually set performance standards.	13
4	It is recommended that the Companies revise their provider directories to clarify when coverage for alternative care applies and how members can access a list of contracted alternative care providers.	15
5	It is recommended that the Companies develop a procedure for the continued timely and accurate payment of claims in the event system issues delay the adjudication of claims from individual providers. (Claim Standard 11)	15, 16
6	It is recommended that the Companies institute a quality assurance procedure step into their contract issuance procedure.	21
7	It is recommended that the Companies review each renewal for continued compliance with established underwriting criteria.	24
8	It is recommended that the Companies provide training for customer service employees so that they do not refer to recommendations as quotas. The Companies should also outline the female versus male patient limit recommendation in its' provider manual.	24
9	It is recommended that the Companies make a determination of group eligibility annually. (Underwriting Standard 6)	26
10	It is recommended the Companies review all of their administrative agreements, inclusive of the agreements with MedImpact, William C. Earhart Company Inc. and EMI. If any administrator does more than simply process bills for payment, for example, if they are involved in providing authorizations or handling disputes the Companies should file these agreements with the OIC for approval. RCW 48.43.550.	28, 29

## SUMMARY OF STANDARDS

### Company Operations and Management Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington. Reference: RCW 48.44.015(1).	8	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013.	9	X	
3	When the Company registers with the OIC, it is required to state its territory of operations. Reference: RCW 48.44.040.	9	X	
4	The Company is required to be registered with the Office of the Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington. Reference: 48.46.027(1).	9		X

### General Examination Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	9	X	
2	The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2).	10	X	
3	The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	10	X	

### Complaint Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055	12	X	
2	The Company maintains a fully operational, comprehensive grievance process. Reference: RCW 48.43.530, WAC 284-43-615	12	X	
3	The Company provides enrollees access to independent review services to resolve disputes. Reference: RCW 48.43.535	12	X	
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response	12	X	

#	STANDARD	PAGE	PASS	FAIL
	must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4			
5	The Company complies with procedures for health care service review decisions. Reference: WAC 284-43-620	12	X	

**Claims Standards:**

#	STANDARD	PAGE	PASS	FAIL
1	The company shall provide no less than urgent and emergent care to a child who does not reside in the company's service area. Reference: RCW 48.01.235(3).	14	X	
2	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250	14	X	
3	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205	15	X	
4	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093	14	X	
5	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115	14	X	
6	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500.	14	X	
7	The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410	14	X	
8	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization. Reference: RCW 48.43.525(1)	15	X	
9	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU). Reference: RCW 48.44.440, WAC 284-44-450	15	X	
10	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465	15	X	
11	The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on undenied and unpaid clean claims that are more than 61 days old. Reference: WAC 284-43-321(2).	15	X	

#	STANDARD	PAGE	PASS	FAIL
12	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	16		X
13	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	16		X

**Agent Activity Standards:**

#	STANDARD	PAGE	PASS	FAIL
1	The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2).	19		X
2	The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160, RCW 48.44.011(2).	19		X
3	The Company must provide the agent with written notice of revocation of appointment and send a copy to the OIC. Reference: RCW 48.17.160(3).	19	X	

**Rate and Form Filing Standards:**

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	22		X
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	22		X
3	All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	21	X	

**Underwriting Standards:**

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235.	25	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015 WAC 284-43-710	25	X	

#	STANDARD	PAGE	PASS	FAIL
3	An individual is not required to complete the standard health questionnaire if stated criteria are met. Reference: RCW 48.43.018(1)	N/A		
4	The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application. Reference: RCW 48.43.018(2)(b)	N/A		
5	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720	26	X	
6	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24). Reference: RCW 48.43.028	26	X	
7	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210.	26	X	
8	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212(1).	26	X	
9	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220.	26	X	
10	An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason. Reference: RCW 48.44.230	N/A		
11	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. Reference: RCW 48.44.260	N/A		
12	Each group contract shall offer coverage for chiropractic care on the same basis as any other care. Reference: RCW 48.44.310	26	X	
13	All plans must include coverage for diabetes. Reference: RCW 48.44.315	26	X	
14	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335	26	X	

#	STANDARD	PAGE	PASS	FAIL
15	Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents. Reference: RCW 48.44.340(1) and (3), WAC 284-43-810	26	X	
16	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400.	N/A		
17	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420.	26	X	
18	A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider. Reference: RCW 48.44.430	N/A		
19	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required. Reference: RCW 48.44.460, WAC 284-44-042.	26	X	
20	The Company shall produce and provide Certificates of Coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050	27		X

**Provider Activity Standards:**

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms shall contain procedures for the fair resolution of disputes arising out of the contract. Reference: RCW 48.43.055, WAC 284-43-320(11), WAC 284-43-322	Not Reviewed		
2	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	Not Reviewed		
3	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4) WAC 284-43-320(2)	Not Reviewed		
4	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330.	Not Reviewed		
5	Company standards for selection of participating providers and facilities do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a) and (b).	Not Reviewed		

#	STANDARD	PAGE	PASS	FAIL
6	The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information. Reference: WAC 284-43-320(1)	Not Reviewed		
7	The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs. Reference: WAC 284-43-320(4)	Not Reviewed		
8	The Company does not preclude the provider from informing the patient of care required and whether such case is consistent with medical necessity, medical appropriateness, or covered by the plan. Reference: WAC 284-43-320(5)(a)	Not Reviewed		
9	The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier. Reference: WAC 284-43-320(5)(b)	Not Reviewed		
10	The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause. Reference: WAC 284-43-320(7)	Not Reviewed		

## APPENDIX 1

**Agent Activity Standard 1:** The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2).

OIC #	Group #	Date Application Signed / Renewal Date	Comment
N03	13575	02/01/2006	Appears to have been direct sale; marketing representative involved was licensed on 07/10/2007.
N06	13722	01/20/2006	Agency listed on the application was licensed on 10/31/2006. The agent involved in the sale was licensed however she was not appointed with the Company at the time of sale.
N26	14014	05/17/2006	Agency listed on the application was licensed on 10/31/2006. The agent involved in the sale was licensed however she was not appointed with the Company at the time of sale.
N31	14156	07/20/2006	Neither the agency nor the agent listed on the application was licensed at the time of sale. The agency was licensed 10/31/2006.
I45	12994	06/01/2006	The renewal for this group was handled by a Company representative who was not licensed at the time of renewal. She obtained her license on 7/10/2007.

## APPENDIX 2

**Agent Activity Standard 2:** The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160, RCW 48.44.011(2).

OIC #	Group #	Date Application Signed	Comment
N01	13666	12/15/2005	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 6/20/06.
N02	13648	12/15/2005	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N04	13731	01/13/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 7/5/06.
N08	13768	01/25/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency received its brokers license 11/14/06.
N09	13823	02/16/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N10	13809	02/22/2006	The writing agent was not appointed at the time of sale. The agent was appointed with KFHPNW on 7/5/06.
N11	13810	02/21/2006	The writing agent was not appointed at the time of sale. The agent was appointed with KFHPNW on 7/5/06.
N13	13797	02/17/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 7/5/06.
N15	13863	03/15/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 7/5/06.
N19	13921	04/10/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 6/29/06.
N25	14042	05/23/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW 7/18/2006. Group coverage includes a POS and dental plan

			underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N42	14339	11/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N45	13857	04/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N48	13454	01/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N49	13709	02/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
N50	13984	05/15/2006	Neither the agency nor the writing agent was appointed at the time of sale. The agency was appointed with KFHPNW on 7/7/06. Group coverage includes a POS and dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
<b>OIC #</b>	<b>Group #</b>	<b>Renewal Date</b>	
I02	5543	02/01/2006	A new agent was appointed to this group effective 11/1/2006. The agent was not appointed with KFHPNW until 3/1/2007.
I07	2329	01/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I12	4590	09/01/2006	Group coverage includes a POS and dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I17	5850	03/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I27	9308	06/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I33	10368	01/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I35	11360	12/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.

I42	12079	05/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I44	12641	02/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I46	13162	07/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I47	13345	09/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I48	13414	10/01/2006	Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
I49	13424	10/01/2006	Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
OIC #	Group #	Quote Date	
Q07	14120	06/15/2006	Quote was sold and business written. Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
Q15	14315	10/15/2006	Quote was sold and business written. Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
Q30		66/27/2006	The agent was not appointed with KFHPNW until 7/5/06.
Q36	14095	07/26/2006	Quote was sold and business written. Group coverage includes a POS plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.
Q37	10629	08/23/2006	Quote was sold and business written. Group coverage includes a dental plan underwritten by KPHA. No agents were appointed by KPHA during the exam period.

OIC #	Group#	Date Application Signed / Renewal Date	Comment
N03	13575	02/01/2006	Appears to have been direct sale; marketing representative involved was licensed on 07/10/2007.
N06	13722	01/20/2006	Agency listed on the application was licensed on 10/31/2006. The agent involved in the sale was licensed however she was not appointed with the Company at the time of sale.
N26	14014	05/17/2006	Agency listed on the application was licensed on 10/31/2006. The agent involved in the sale was licensed however she was not appointed with the Company at the time of sale.
N31	14156	07/20/2006	Neither the agency nor the agent listed on the application was licensed at the time of sale. The agency was licensed 10/31/2006.
I45	12994	06/01/2006	The renewal for this group was handled by a Company representative who was not licensed at the time of renewal. She obtained her license on 7/10/2007.

### APPENDIX 3

**Rates and Forms Standard 1:** All contract forms have been filed with the OIC prior to use. RCW 48.44.040, WAC 284-43-920

Amendment	OIC Numbers	Comment
H3031-U Preventive Care (Plan U)	I10, I20, I22, I28, I29, I33, I35, I37, I44, I46, I47, I48, N03, N04, N09, N10, N11, N13, N15, N17, N18, N20, N25, N26, N29, N34, N35, N37, N43, N44	The Companies did not file the amendment which was used with the thirty group contracts listed.

**Rates and Forms Standard 2:** All rates have been filed with the OIC prior to use. RCW 48.44.040, WAC 284-43-920

OIC Numbers	Comment
N01, N02, N07, N12	Pharmacy rate adjustment factor of 1.1574 as opposed to the correct factor of 1.1516 was used.
N10	The initial quote for this group used the factor of 1.1574. The final quote in the file does have the correct factor however a note in the file indicates that the Companies would honor the original quote.

**APPENDIX 4**

**Underwriting Standard 6:** Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24). Reference: RCW 48.43.028

OIC #	Group #	Original Effective Date	Comment
I01	57	12/01/2001	Groups of 1 were allowed when this employer was written however the Companies should have non-renewed this group in 2005.
N33	10884	04/01/2004	This group re-enrolled 3/1/06 after requesting cancellation 1/1/06. At time of cancellation member stated that her husband had gotten a job that provides health care coverage. When this group was re-enrolled the Companies used the 2005 census listing the husband as an employee without additional verification of employment status. The Companies guidelines allow for a group to be re-enrolled within 6 months after cancellation without being subject to the same screening process as a new employer. The initial coverage of this group during the 2005 renewal is also questionable in that a note from the agent indicates that this group has only 1 employee.
N38	11755	04/01/2004	Groups of 1 were allowed when this employer was written however the Companies should have non-renewed this group in 2005.

## Appendix 5

**Underwriting Standard 20:** The Company shall produce and provide certificates of coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050

OIC #	Group #	Comment
I02	239	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor.
I03	819	Groups had termed by the time the data pull for mailing occurred and therefore no certificates were mailed.
I26	8768	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor.
I27	9308	Group was not included in the initial data pull due to deficiencies in the Companies' programs.
I34	10587	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor.
N08	13768	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor.
N09	13823	Groups had termed by the time the data pull for mailing occurred and therefore no certificates were mailed.
N12	13639	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor
N33	10884	Group was included in the initial data pull however due to human error the group was not included with the data sent to the vendor
N43	14389	Group was not included in the initial data pull as the contract was not completed prior to 12/12/06.
N44	14393	Group was not included in the initial data pull as the contract was not completed prior to 12/12/06
N45	13857	Group was not included in the initial data pull due to deficiencies in the Companies' programs.