

STATE OF WASHINGTON

MIKE KREIDLER  
STATE INSURANCE COMMISSIONER

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OFFICE OF  
INSURANCE COMMISSIONER

In the Matter of	)	No. 08-0078
	)	
The Market Conduct Examination of	)	FINDINGS, CONCLUSIONS,
	)	AND ORDER ADOPTING REPORT
<b>Kaiser Foundation Health Plan</b>	)	
<b>of the Northwest</b>	)	
<b>Kaiser Permanente Health Alternatives</b>	)	OF
	)	MARKET CONDUCT EXAMINATION
	)	
Authorized Foreign Health Care Service	)	
Contractors	)	

**BACKGROUND**

An examination of the market conduct of **Kaiser Foundation Health Plan of the Northwest and Kaiser Permanente Health Alternatives** (the Companies) as of December 31, 2006 was conducted by examiners of the Washington Office of the Insurance Commissioner (OIC). The Companies, domiciled in the state of Oregon, hold Washington certificates of registration as health care service contractors. This examination was conducted in compliance with the laws and regulations of the state of Washington and in accordance with the procedures promulgated by the National Association of Insurance Commissioners and the OIC.

The examination report with the findings, instructions, and recommendations was transmitted to the Companies for their comments on February 19, 2008. The Companies' response to the report is attached to this order only for the purpose of providing convenient review of the response.

The Commissioner or a designee has considered the report, the relevant portions of the examiners' work papers, and submissions by the Companies.

Subject to the right of the Companies to demand a hearing pursuant to Chapters 48.04 and 34.05 RCW, the Commissioner adopts the following findings, conclusions, and order.

**FINDINGS**

Findings in Examination Report. The Commissioner adopts as findings the findings of the examiners as contained in pages 3 through 45 of the report.



## CONCLUSIONS

It is appropriate and in accordance with law to adopt the attached examination report as the final report of the market conduct examination of **Kaiser Foundation Health Plan of the Northwest and Kaiser Permanente Health Alternatives** and to order the Companies to take the actions described in the Instructions and Recommendations sections of the report. The Commissioner acknowledges that the Companies may have implemented the Instructions and Recommendations prior to the date of this order. The Instructions and Recommendations in the report are an appropriate response to the matters found in the examination.

## ORDER

The market conduct examination report as filed, attached hereto as Exhibit A, and incorporated by reference, is hereby ADOPTED as the final examination report.

The Companies are ordered as follows, these being the Instructions and Recommendations contained in the examination report on page 30 and 31.

1. The Companies are ordered to communicate to providers and facilities the specific reason a claim is denied. The Companies are also ordered to monitor and verify their third party administrators' compliance with this requirement. WAC 284-43-321(4).
2. The Companies are ordered 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.
3. The Companies are ordered 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.
4. The Companies are ordered 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.
5. The Companies are ordered to file all contracts, amendments and endorsements prior to use. RCW 48.44.040, WAC 284-43-920.
6. The Companies are ordered to file all rates with the OIC prior to use. RCW 48.44.040, WAC 284-43-920.

7. The Companies are ordered to provide Certificates of Coverage to all employers for distribution to each covered employee. WAC 284-44-050.
8. The Companies are ordered to consider ceasing 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. The Companies are ordered to consider developing and adhering 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. The Companies are ordered to consider performing audits of all TPA's on a regular basis to ensure compliance with applicable statutes as well as contractually set performance standards.
11. The Companies are ordered to consider revising their provider directories to clarify when coverage for alternative care applies and how members can access a list of contracted alternative care providers.
12. The Companies are ordered to consider developing 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)
13. The Companies are ordered to consider instituting a quality assurance procedure step into their contract issuance procedure.
14. The Companies are ordered to consider reviewing each renewal for continued compliance with established underwriting criteria.
15. The Companies are ordered to consider providing 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.
16. The Companies are ordered to consider making a determination of group eligibility annually. (Underwriting Standard 6)

17. The Companies are ordered to consider reviewing 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.

IT IS FURTHER ORDERED THAT, the Companies file with the Chief Market Conduct Examiner, within 90 days of the date of this order, a detailed report specifying how the Companies have addressed each of the requirements of this order.

ENTERED at Olympia, Washington, this 22nd day of May 2008.

A handwritten signature in black ink, appearing to read "Mike Kreidler". The signature is fluid and cursive, with the first name "Mike" being more prominent than the last name "Kreidler".

MIKE KREIDLER  
Insurance Commissioner

March 5, 2008

**RECEIVED**  
 MAR 10 2008  
 INSURANCE COMMISSIONER  
 COMPANY SUPERVISION

James T. Odiorne, CPA, JD  
 Deputy Insurance Commissioner  
 Company Supervision Division  
 Washington State Office of the Insurance Commissioner  
 P.O. Box 40255  
 Olympia, WA 98504-0255

Re: Kaiser Foundation Health Plan of the Northwest and  
 Kaiser Permanente Health Alternatives Market Conduct Examination

Dear Mr. Odiorne:

I am writing in response to your cover letter of February 19, 2008 accompanying the draft final report for the 2006 Kaiser Foundation Health Plan of the Northwest and Kaiser Permanente Health Alternatives Market Conduct Examination. We have reviewed the draft report and have the following comments and changes for your consideration. Suggested changes are identified by an underline or strikethrough, as appropriate.

Page	Section	Comment / Change
All	Footer, Line 1	Kaiser <u>Foundation</u> Health Plan of the Northwest
16	<i>Findings, Claims Standard 12</i>	<u>In 2006, the Companies migrated from the SPARKS Tapestry system to the Tapestry Diamond claim processing system in 2006 to properly accumulate benefits, and migrated from the OSCAR system to the Diamond system for claims processing. The Diamond system is a Regional system and should provide uniformity among the regional offices. As of 2007, Diamond supports both benefit accumulation and claims processing.</u>
18-19	Last sentence of last paragraph under <i>Agent Licensing and Appointment Procedures</i>	The following statement is incorrect: <i>"The policies and procedures allow the Companies to address existing issues but do not aid in the prevention of current groups written by agents or agencies not appropriately licensed or appointed."</i> Rather, the policies and procedures identify the process for running the reports which ensure that all appointed agencies and agents maintain current and appropriate licensure. Agencies or agents who lose current and appropriate licensure—as identified by the reports—are then prohibited from accessing the Online Quoting Tool.

29	Last sentence of third bullet under <i>Provider Activity Review</i>	The following statement is incorrect: <i>"The physician eventually rolled onto the Medical Service Agreement Template in 2007."</i> The physician did not roll onto the template in 2007.
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I hope that this fully addresses your request. Please feel free to contact me if you need clarification or additional information.

Sincerely,



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Integrity, Compliance, and Ethics Department  
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cc: Missy Maese, Regional Compliance Director, KFHPNW