REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

AS OF JUNE 30, 2013

Conducted from October 26, 2015

Through

March 31, 2017

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 52-0954463
NAIC: 95639

COMMONWEALTH OF VIRGINIA

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I, Brant Lyons, Senior Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. as of June 30, 2013, conducted at the Company's office in Rockville, Maryland is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2017-00217 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 5th day of December, 2017.

Brant Lyons
Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (hereinafter referred to as Kaiser), a Health Maintenance Organization (HMO), was conducted under the authority of various sections of the Code of Virginia and regulations found in the Virginia Administrative Code, including but not necessarily limited to the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-1809, 38.2-3407.15 C, and 38.2-4315 of the Code of Virginia (hereinafter referred to as "the Code") and 14 VAC 5-90-170 A.

A Multi-State investigation involving Maryland, the District of Columbia, and Virginia was conducted in 2008. As a result of that investigation, Kaiser made a monetary settlement offer that was accepted by the State Corporation Commission on February 20, 2009, in Case No. INS-2009-00031.

A previous Market Conduct Examination covering the period of July 1, 2006 through December 31, 2006 was concluded on February 20, 2008. As a result of that examination, Kaiser made a monetary settlement offer that was accepted by the State Corporation Commission on January 22, 2009, in Case No. INS-2008-00210.

The current examination revealed violations that were noted in the previous Report. Although Kaiser had agreed after the previous Report to change its practices to comply with the Code and regulations, the current examination revealed instances where Kaiser had not done so. In the examiners' opinion; therefore, Kaiser in some instances knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The period of time covered for the current examination, generally, was January 1, 2013 through June 30, 2013. The examination was initiated on October 26, 2015 at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia. The on-site examination was conducted at Kaiser's office in Rockville, Maryland from October 26, 2015 through October 29, 2015 and completed at the office of the State Corporation Commission's Bureau of Insurance in Richmond, Virginia on March 31, 2017. The violations cited and the comments included in this Report are the opinions of the examiners. The examiners may not have discovered every unacceptable or non-compliant activity in which the company was engaged. Failure to identify, comment on, or criticize specific company practices in Virginia or in other jurisdictions does not constitute acceptance of such practices.

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

14 VAC 5-90-10 et seq.	Rules Governing Advertisement of Accident and Sickness Insurance;
14 VAC 5-180-10 et seq.	Rules Governing Underwriting Practices and Coverage Limitations and Exclusions for Acquired Immunodeficiency Syndrome (AIDS);
14 VAC 5-211-10 et seq.	Rules Governing Health Maintenance Organizations; and
14 VAC 5-216-10 et seq.	Rules Governing Internal Appeal and External Review.

The examination included the following areas:

- Operations/Organization Documents
- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Advertising
- Policy and Other Forms
- Agents
- Underwriting/Unfair Discrimination/Insurance Information and Privacy Protection Act
- Premium Notices/Collections/Reinstatements
- Cancellations/Nonrenewals
- Complaints
- Claim Practices
- Internal Appeal and External Review

Examples referred to in this Report are keyed to the number of the Review Sheet furnished to Kaiser during the examination.

II. COMPANY HISTORY

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser) was licensed in Virginia as a Health Maintenance Organization on November 4, 1981 under the name Kaiser-Georgetown Community Health Plan, Inc. The Articles of Incorporation were amended on December 10, 1984 to change the name to Kaiser. Kaiser-Georgetown Community Health Plan, Inc. was originally incorporated in the District of Columbia on July 21, 1972, to promote and operate a non-profit health care plan in the Washington, D.C. metropolitan area. Kaiser received approval from the Maryland Insurance Commissioner on March 28, 1995, to be re-domesticated to Maryland.

On January 31, 1997, Kaiser entered into an assignment and assumption agreement with Humana Group Health Plan, Inc. (Humana) whereby all of Humana's contracts, leases and subleases were transferred to Kaiser. The agreement added 5 Medical Centers in the Washington, D.C. area and approximately 1,500 primary and specialty care physicians in the community. Kaiser is a subsidiary of Kaiser Foundation Health Plan, Inc., which operates with its subsidiaries under the trade name of Kaiser Permanente.

Kaiser's service area includes the Virginia cities of Falls Church, Fairfax, Fredericksburg, Alexandria, King George, Manassas, and Manassas Park; the Virginia counties of Arlington, Fairfax, Prince William, Spotsylvania, Stafford, and Loudoun; and portions of Caroline, Culpepper, Fauquier, Hanover, King George, Louisa, Orange, and Westmoreland counties. The service area also includes the Maryland city of Baltimore; the Maryland counties of Baltimore, Carroll, Harford, Anne Arundel, Howard,

Montgomery, and Prince George's; portions of Calvert, Charles, and Frederick counties; and the District of Columbia.

Marketing efforts are conducted by sales representatives, general agents, and brokers. Kaiser offers group, individual, Medicare, and Medicaid coverage. Net Admitted Assets as of June 30, 2013, totaled $1,124,112,565. As of June 30, 2013, total accident and health insurance premiums in Virginia were $219,463,538.

III. OPERATIONS/ORGANIZATION DOCUMENTS

The purpose of this review was to determine if Kaiser is operating within the scope of its basic organizational documents, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301 B of the Code.

ENROLLEE PARTICIPATION

Section 38.2-4301 B 10 of the Code requires an HMO to submit to the Commission with its application for license a description of the mechanism by which enrollees will be given an opportunity to participate in matters of policy and operation as provided in § 38.2-4304 B of the Code.

The review revealed that Kaiser had established its enrollee participation mechanism in accordance with its filed documents.

IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

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

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons, at the time of enrollment or at the time the contract or evidence of coverage is issued, and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.

2. A description of the service area or areas within which the MCHIP shall provide health care services.

3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.

4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that Kaiser was in substantial compliance.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain for each of its MCHIPs a complaint system approved by the Commission and

the State Health Commissioner. 14 VAC 5-211-150 A states that an HMO shall establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The examiners reviewed a sample of 29 from a total population of 216 complaints and a sample of 21 from a total population of 157 appeals received during the examination time frame.

TIMELINESS

Kaiser's approved complaint system requires a written response to a complaint within 30 days unless notification is sent that additional time is required. Section 8.2 of Kaiser's Commercial Member Complaints procedures states that standard (non-urgent) complaints will be resolved within 30 calendar days from the date the complaint is received. Section 9.12 of Kaiser's Commercial Member Complaints procedures states that written complaints are acknowledged within 5 calendar days of receipt. The review revealed 1 instance where Kaiser failed to maintain its established complaint system approved by the Commission, in violation of § 38.2-5804 A of the Code and 14 VAC 5-211-150 A, and 1 instance of non-compliance with Kaiser's established internal procedures. As discussed in Review Sheet CP02, Kaiser took 83 days to respond to a complaint and failed to include documentation that an acknowledgement was sent or that additional time was requested. Kaiser agreed with the examiners' observations.

14 VAC 5-216-40 E 1 states that if an internal appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal. Section 10.2 of Kaiser's Standard and Expedited Appeals for Commercial Members procedures states that the time frame for processing

a member's standard pre-service appeal is as expeditiously as the member's health requires, but no longer than 30 calendar days from the receipt date. As discussed in Review Sheet CP01, Kaiser failed to respond within 30 days from the date the appeal was received, placing it in violation of 14 VAC 5-216-40 E 1 in 1 instance and in non-compliance with its established internal procedures. Kaiser agreed with the examiners' observations.

14 VAC 5-216-40 E 2 requires the health carrier to notify the covered person of its decision within 60 days of receipt of the appeal if the internal appeal involves a post-service claim review request. Section 9.2.2.1 of Kaiser's Commercial Member Appeals procedures states that there will be a decision within 60 calendar days from the receipt date of a standard retrospective appeal. As discussed in Review Sheet CP03, Kaiser did not respond and resolve an appeal until 254 days after it was first received. Kaiser disagreed with the examiners' observations, stating:

> A review of the file indicates that the member's claim was processed by Kaiser Permanente Insurance Company (KPIC). KPIC is the insurance company that underwrites the non-plan level of benefits and is for profit. KPIC is a separate entity from Kaiser Foundation Health Plan (KFHP). On 09/05/2012, KPIC received an appeal from the member and the review was completed by them. On 03/20/2013, a second level appeal was sent by the member to KPIC. In the second level appeal, the member made reference to the services being related to an emergency. Claims and appeals for emergency services are processed by KFHP. As a courtesy, on 04/05/2013, KPIC sent the appeal to KFHP for review. On 05/17/2013, a decision letter was sent to the member. The resolution letter was sent to the member timely within 44 days.

The examiners responded that it is unclear why the claim was not initially identified by KFHP as an emergency claim. The first appeal, received by KPIC on September 5, 2012, stated that the services were related to an emergency room visit and should have been forwarded to KFHP at that time. Although KPIC is a separate entity, it is an

affiliate of KFHP and has been given the responsibility of seeing that any claim, complaint, or appeal that should be directed to KFHP is forwarded to the plan timely. In this case, the appeal was not forwarded to KFHP until April 5, 2013 after a second appeal was received by KPIC. KFHP is responsible for the timely processing of claims and for timely responses to its members regarding appeals. KFHP failed to ensure that the initial appeal was handled timely, placing it in violation of 14 VAC 5-216-40 E 2 in 1 instance and in non-compliance with its established internal procedures.

PROVIDER CONTRACTS

The examiners reviewed a sample of 56 provider contracts from a total population of 7,903 provider contracts in force during the examination time frame. The examiners also reviewed Kaiser's 6 contracts negotiated with intermediary organizations for the purpose of providing health care services pursuant to an MCHIP.

Section 38.2-5805 C 1 of the Code requires an HMO to include in its provider contracts a provision stating that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination. The review revealed that 1 of Kaiser's provider contracts failed to contain the required provision, in violation of this section. The violation is discussed in Review Sheet MC08. Kaiser agreed with the examiners' observations.

Section 38.2-5805 C 6 of the Code states that an agreement to provide health care services between an intermediary organization and a health carrier subject to subsection B of § 38.2-5801 shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination. The review revealed that 1 of Kaiser's

provider contracts failed to contain the required provision, in violation of this section. As discussed in Review Sheet MC02, Kaiser disagreed with the examiners' observations based on the position that the Virginia situs plans applicable to this agreement were transitioned to a different contract on January 1, 2015 that contains the required provision. The examiners responded that actions subsequent to the time frame under review do not affect the examiners' observations during the course of the examination.

Section 38.2-5805 C 7 of the Code states that an agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination. The review revealed that 10 of Kaiser's provider contracts failed to contain the required provision, in violation of this section. An example is discussed in Review Sheet MC07. Kaiser agreed with the examiners' observations.

Section 38.2-5805 C 8 of the Code states that an HMO shall maintain its executed contracts enabling it to provide health care services and make them available for review and examination for a period of five years after the expiration of any such contract. The review revealed 5 violations of this section. An example is discussed in Review Sheet MC05, where Kaiser was unable to locate a copy of the contract to provide to the examiners. Kaiser agreed with the examiners' observations.

Section 38.2-5805 C 9 of the Code states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to covered persons. The review revealed that 44 of Kaiser's provider contracts failed to contain the required provision, in

violation of this section. An example is discussed in Review Sheet MC16. Kaiser agreed with the examiners' observations.

Section 38.2-5805 C 10 of the Code and 14 VAC 5-211-30 C require that if there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization. The review revealed that 13 of Kaiser's provider contracts failed to contain the required provision, in violation of these sections. An example is discussed in Review Sheet MC10. Kaiser agreed with the examiners' observations.

V. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES

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

PROVIDER CONTRACTS

The examiners reviewed a sample of 56 from a total population of 7,903 provider contracts in force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

The review revealed 163 instances where Kaiser's provider contracts failed to contain 1 of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	12	EF16
§ 38.2-3407.15 B 2	18	EF03
§ 38.2-3407.15 B 3	10	EF12
§ 38.2-3407.15 B 4	8	EF13
§ 38.2-3407.15 B 5	6	EF05
§ 38.2-3407.15 B 6	18	EF10
§ 38.2-3407.15 B 7	9	EF15
§ 38.2-3407.15 B 8	14	EF26
§ 38.2-3407.15 B 9	17	EF20
§ 38.2-3407.15 B 10	49	EF17
§ 38.2-3407.15 B 11	2	EF18

An example is discussed in Review Sheet EF15, where the contract failed to contain a provision requiring the carrier to furnish to the provider any proposed

amendment or proposed new addenda, schedule, exhibit, or policy at least 60 calendar days before the effective date, in violation of § 38.2-3407.15 B 9 of the Code. Kaiser agreed with the examiners' observations.

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. Kaiser's failure to amend its provider contracts to comply with § 38.2-3407.15 B of the Code occurred with such frequency as to indicate a general business practice, placing Kaiser in violation of § 38.2-510 A 15 of the Code.

PROVIDER CLAIMS

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

The examiners reviewed a sample of 150 claims from a total population of 8,466 claims processed under the 56 provider contracts selected for review.

Section 38.2-3407.15 B 1 of the Code states that a carrier shall pay any clean claim within 40 days of receipt of the claim. The review revealed 3 instances where Kaiser failed to pay a clean claim within 40 days, in violation of § 38.2-3407.15 B 1 of the Code. An example is discussed in Review Sheet EFCL03. Kaiser agreed with the examiners' observations.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

The review of the sample claims revealed that Kaiser underpaid the fee schedule specified for the health care service provided in 1 instance, in violation of § 38.2-3407.15 B 8 of the Code. An example is discussed in Review Sheet EFCL07. Kaiser agreed with the examiners' observations.

The review also revealed that Kaiser allowed more than the contracted amount in 1 instance. While allowing more than the contracted amount is not considered to be a violation of the Code, this practice may result in an increase in the coinsurance owed by the member on a given claim. Kaiser is cautioned to the potential of future violations.

Kaiser's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.

VI. ADVERTISING

A review was conducted of Kaiser's advertising materials to determine compliance with § 38.2-4312 of the Code and the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503, and 38.2-504, as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

14 VAC 5-90-170 A requires an HMO to maintain at its home or principal office a complete file of all advertisements with a notation indicating the manner and extent of distribution and the form number of any policy referred to in the advertisement.

The examiners reviewed a sample of 38 from a population of 215 advertisements. The review revealed that Kaiser was in substantial compliance.

VII. POLICY AND OTHER FORMS

A review of policy forms in use during the examination time frame was performed to determine if Kaiser complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Sections 38.2-4306 A 2, 38.2-316 A, and 38.2-316 C 1 of the Code and 14 VAC 5-211-60 A prohibit the use of contracts, evidences of coverage (EOCs), and any applicable amendments to these forms prior to filing the forms with and receiving approval from the Commission. 14 VAC 5-211-60 A requires all contracts, EOCs, and applicable amendments to be identified by a form number in the lower left-hand corner of the first page of the form. Other forms, such as the application and enrollment forms, must also be filed with the Commission for approval under §§ 38.2-316 B and 38.2-316 C 1 of the Code.

GROUP CONTRACTS

The examiners reviewed the entire population of 10 group contracts issued during the examination time frame.

The review revealed that the group contracts were filed and approved as required.

INDIVIDUAL CONTRACTS

The examiners reviewed a sample of 30 from a total population of 528 individual contracts issued during the examination time frame.

The review revealed that the individual contracts were filed and approved as required.

EVIDENCE OF COVERAGE

Section 38.2-4306 A 2 of the Code and 14 VAC 5-211-60 A state that no evidence of coverage (EOC), or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form has been filed with and approved by the Commission.

The review revealed that Kaiser was in substantial compliance with these sections.

APPLICATIONS/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code require that application and enrollment forms be filed with and approved by the Commission.

The review revealed that Kaiser was in substantial compliance with these sections.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each insurer issuing an accident and sickness policy shall file its EOB forms for approval with the Commission. These forms are subject to the requirements of §§ 38.2-316 and 38.2-4306 of the Code, as applicable.

A previous investigation initiated by the Consumer Services Section of the Life and Health Market Regulation Division of the Bureau of Insurance revealed that Kaiser sent EOBs that were not filed for approval to 4,461 policyholders from March 1, 2010 until March 20, 2013. As a result of that investigation, Kaiser was ordered by the State Corporation Commission to cease and desist from any conduct which constitutes

a violation of subsection A of § 38.2-3407.4 of the Code on March 31, 2014, in Case No. INS-2014-00036.

In addition to the violations addressed through the Consumer Services investigation, the exam review revealed that the EOB sent to members in the processing of ambulance and medical transport claims was not filed for approval. These violations are discussed in Review Sheets PF01M and PF01BW. Kaiser agreed with the examiners' observations.

SCHEDULE OF CHARGES

Section 38.2-4306 B 1 of the Code and 14 VAC 5-211-60 B prohibit the use of schedules of charges or amendments to the schedules of charges for enrollee coverage for health services until a copy of the schedule or amendment has been filed with and approved by the Commission.

The review revealed that Kaiser was in substantial compliance.

COPAYMENTS

14 VAC 5-211-90 B sets forth the requirements for the establishment, maintenance, and member notification of copayments. If an HMO has an established copayment maximum, it shall keep accurate records of each enrollee's copayment expenses and notify the enrollee when the maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the copayment maximum is reached. The HMO shall not charge additional copayments for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all copayments charged after the copayment maximum is reached.

The examiners reviewed a sample of 40 from a total population of 171 enrollees who had met their copayment maximum during the examination time frame. The review revealed 25 violations of 14 VAC 5-211-90 B. An example is discussed in Review Sheet PF05J, where Kaiser failed to keep an accurate record of the enrollee's copayment expenses, failed to notify the enrollee 30 days after it had processed sufficient claims to determine that the copayment maximum was reached, and failed to promptly refund the excess copayments charged to the enrollee. Kaiser agreed with the examiners' observations.

Kaiser's procedures were also in non-compliance with 14 VAC 5-211-90 B. As discussed in Review Sheet PF01BL, Kaiser's procedures regarding refunds when a member or family maximum has been exceeded state that "…Additional amounts are paid to the submitting provider…" and that the provider "…determines if associated dollars collected from member should be reimbursed…." Kaiser partially disagreed based on the position that reimbursement was actually made to enrollees during the time frame in cases of internal encounters and pharmacy claims for high deductible plans. The examiners would respond that the language in the procedures indicating that reimbursement will be made to the provider fails to comply with the requirements of 14 VAC 5-211-90 B, which states that the HMO shall promptly refund to the enrollee all copayments charged after the copayment maximum is reached, and that Kaiser was in non-compliance in each instance in which the utilization of these procedures resulted in the failure to provide the required refund to the enrollee.

Subsection 1 of § 38.2-502 of the Code states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that

misrepresents the benefits, advantages, conditions or terms of any insurance policy. The review revealed 4 violations of this section. An example is discussed in Review Sheet PF08DA, where Kaiser sent a letter incorrectly notifying the enrollee that the out-of-pocket maximum had been reached when this amount had not actually been satisfied and the enrollee was still responsible for future out-of-pocket amounts. Kaiser agreed with the examiners' observations.

Due to the fact that violations of 14 VAC 5-211-90 B were discussed in the prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

VIII. AGENTS

The purpose of this review was to determine compliance with the various sections of Title 38.2, Chapter 18 and § 38.2-4313 of the Code. A sample of 10 from a total population of 119 agents and agencies appointed during the time frame was selected for review. In addition, the writing agents or agencies designated in the 40 new business files were reviewed.

LICENSED AGENT REVIEW

Section 38.2-1822 A of the Code requires that a person be licensed prior to soliciting contracts.

The review revealed that Kaiser was in substantial compliance with this section.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires an HMO to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed that Kaiser was in substantial compliance with this section.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the direct or indirect payment of commissions or other valuable considerations to an agent or agency that is not appointed and that was not licensed at the time of the transaction.

The review revealed that Kaiser was in substantial compliance with this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an HMO notify the agent within 5 calendar days and the Commission within 30 calendar days upon termination of the agent's appointment. An initial sample of 15 was selected from a total population of 62 agents whose appointments terminated during the examination time frame. As the examiners identified additional agent terminations during the examination time frame that were not included in the provided population, an additional sample of 15 was selected.

The review revealed 18 violations of § 38.2-1834 D of the Code of Virginia. An example is discussed in Review Sheet AG01DA, where Kaiser failed to notify the agent within 5 calendar days upon termination of the agent's appointment. Kaiser agreed with the examiners' observations.

IX. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of Kaiser's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514, the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620, as well as 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions For Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine if Kaiser's underwriting guidelines were unfairly discriminatory and whether applications were underwritten in accordance with Kaiser's guidelines and that correct premiums were charged. The review included both group and individual "Direct-Pay" products.

UNDERWRITING REVIEW

Issued

The examiners reviewed a sample of 30 from a total population of 528 individual contracts and the entire population of 10 group contracts issued during the examination time frame.

The review revealed no evidence of unfair discrimination.

Declined

The examiners reviewed a sample of 30 from a total population of 425 individuals and a sample of 17 from a total population of 83 groups that were declined or not issued coverage during the time frame.

Kaiser's underwriting guidelines state that an applicant "…that falls within 30-50 debits…should be declined the base rate but offered a Rate Up on KPIF plan selected upon initial submission."

The review revealed 1 instance of non-compliance with Kaiser's established underwriting guidelines. An example is discussed in Review Sheet UN01, where Kaiser declined an applicant who was assigned between 30 and 50 debits and should have been offered coverage with a rate up. Kaiser agreed with the examiners' observations.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions with regard to HIV infection and AIDS.

The review revealed that Kaiser was in substantial compliance.

MECHANICAL RATING REVIEW

The review revealed that Kaiser calculated premium amounts in accordance with its established guidelines.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires an HMO to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions.

NOTICE OF INSURANCE INFORMATION PRACTICES

Section 38.2-604 of the Code requires that a Notice of Insurance Information Practices (NIP), either full or abbreviated, be provided to all applicants that are individually underwritten.

The review revealed that Kaiser was in substantial compliance with this section.

NOTICE OF FINANCIAL INFORMATION PRACTICES

Section 38.2-604.1 of the Code sets forth the requirements for a notice of financial information collection and disclosure practices, either long form or short form, to be provided to all applicants that are individually underwritten.

The review revealed that Kaiser was in substantial compliance with this section.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of disclosure authorization forms to be used when collecting personal or privileged information about individuals.

The review revealed that the disclosure authorizations used by Kaiser were in substantial compliance.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that, in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

The review revealed the Kaiser was in substantial compliance with this section.

X. PREMIUM NOTICES/COLLECTIONS/REINSTATEMENTS

PREMIUM NOTICES

Kaiser's practices for the billing and collection of premiums were reviewed for compliance with its established procedures in addition to the notification requirements of § 38.2-3407.14 of the Code.

The renewal rate sheets are released no later than 90 days prior to the group's renewal date and reviewed for accuracy. The renewal letter, rate sheet, membership report, and any appropriate marketing collateral are prepared for delivery by Federal Express and delivered to the mail room for processing no later than 65 days prior to the group's renewal date.

The review revealed that Kaiser's premium notices were generated in accordance with its established procedures.

Section 38.2-3407.14 A of the Code states that each HMO shall provide in conjunction with the proposed renewal of coverage under any such policies, contracts or plans, prior written notice of intent to increase premium by more than 35%. Section 38.2-3407.14 B of the Code states that the notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage.

The examiners reviewed a sample of 25 from a population of 78 groups with premium increases of more than 35% at renewal to determine compliance with this section. The review revealed that Kaiser was in substantial compliance with the notification requirements.

COLLECTIONS

A yearly schedule is created for the delinquent process. Delinquent data is run on a monthly basis according to the schedule. Delinquent reports and letters are sent for validation and distribution, and the delinquent letters are mailed.

The review revealed that Kaiser was in substantial compliance with its established procedures for collections.

REINSTATEMENTS

Kaiser's procedures require a subscriber to request reinstatement within 10 business days from the date of the termination notice for termination due to non-payment of premium. The procedures state that if the subscriber has not had a prior termination for non-payment within a rolling 12-month period and contacts the Health Plan within 10 business days following the date of the termination notice, the subscriber will be eligible for reinstatement along with any eligible family members. The subscriber must agree to pay the total amount past due, plus the current month's premium.

The examiners reviewed a sample of 24 from a total population of 132 individual reinstatement requests approved during the examination time frame and the total population of 11 individual reinstatement requests denied during the examination time frame. The review revealed that Kaiser was in substantial compliance with its established reinstatement procedures.

XI. CANCELLATIONS/NONRENEWALS

The examination included a review of Kaiser's cancellation/nonrenewal practices and procedures to determine compliance with its contract provisions, the requirements of § 38.2-508 of the Code covering unfair discrimination, and the notification requirements of § 38.2-3542 of the Code and 14 VAC 5-211-230 B.

Group

A sample of 11 was selected from a total population of 46 group contracts that were cancelled, non-renewed, or terminated during the examination time frame. During the sample selection process, the examiners were notified that several groups in the provided population actually terminated on December 31, 2012, and were outside of the examination time frame.

14 VAC 5-211-210 B 17 states that an EOC shall contain a provision that the contract holder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first premium and that during the grace period the coverage shall continue in force unless the contract holder has given the HMO written notice of discontinuance in accordance with the terms of the contract and in advance of the date of discontinuance.

The review revealed 1 violation of this section. As discussed in Review Sheet CN01, Kaiser failed to provide a grace period of 31 days by terminating a group effective February 28, 2013 for non-payment of premium due February 1, 2013. In addition, Kaiser's established internal procedures failed to allow for a 31 day grace period when the coverage month had fewer than 31 days, as discussed in Review Sheet CN02. Kaiser agreed with the examiners' observations in both instances. The examiners note that additional documentation provided by Kaiser indicates that its

internal procedures were revised after the examination time frame to consistently provide a 31 day grace period.

Individual

A sample of 10 from a total population of 134 individual contracts that were cancelled, non-renewed, or terminated during the examination time frame was reviewed. The review revealed that Kaiser was in substantial compliance with its established procedures and the notification requirements of 14 VAC 5-211-230 B.

Conversions

The examiners reviewed a sample of 10 from a total population of 50 Conversions. The review revealed that Kaiser was in substantial compliance with its established procedures.

XII. COMPLAINTS

Section 38.2-511 of the Code requires that a complete record of complaints be maintained for all complaints received since the last examination or during the last 5 years, whichever is the more recent time period, and such records shall indicate the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

A sample of 29 from a total population of 216 written complaints and 21 from a total population of 157 appeals was reviewed. The review revealed 1 violation of this section. As discussed in Review Sheet CP01, there was no documentation of the disposition of the complaint in the file reviewed by the examiners. Kaiser agreed with the examiners' observations.

XIII. CLAIM PRACTICES

The purpose of the examination was to review the claim practices for compliance with §§ 38.2-510 and 38.2-4306.1 of the Code, as well as 14 VAC 5-211-10 et seq., Rules Governing Health Maintenance Organizations.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims and encounters. Claims are defined as submissions for negotiated fee-for-service, per diem, per case payments for health care services provided by inpatient and outpatient physicians and facilities. Encounters consist of capitation payments made to providers by Kaiser.

Kaiser has contracted with intermediaries for the processing of its claims and encounters for ambulance, pharmacy, and dental services. Employer's Mutual, Inc. (EMI) processes ambulance and medical transportation service claims. MedImpact Healthcare Systems, Inc. and Catamaran LLC process in-area pharmacy claims. Dominion Dental Services USA, Inc. processes dental claims.

PAID CLAIM REVIEW

Professional

A sample of 56 was selected from a total population of 37,899 professional claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 9 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice,

not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 8 instances. In addition, the review revealed that Kaiser was in non-compliance with its EOC in 2 instances. An example of Kaiser's non-compliance with these 3 sections and its EOC is discussed in Review Sheet CL06BW. Although Kaiser's EOC specifies that diabetic equipment and supplies are covered with no member cost-sharing, Kaiser applied 50% coinsurance on a claim for diabetic equipment. Kaiser agreed with the examiners' observations.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that Kaiser was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL09BW, Kaiser initially denied the claim in error and failed to provide a reasonable explanation of the basis for the denial. Kaiser agreed with the examiners' observations.

Institutional

A sample of 21 was selected from a total population of 13,634 institutional claims paid during the examination time frame. Of the 21 sampled claims, 1 was determined to be a Medicare cost plan claim and was not reviewed.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at

issue. The review revealed that Kaiser was in non-compliance with this section in 5 instances. Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed that Kaiser was in violation of this section in 4 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 5 instances. An example of Kaiser's non-compliance with these 3 sections is discussed in Review Sheet CL15BW. Kaiser's EOB erroneously indicated that the member was responsible for a $250 deductible on a claim for inpatient hospital services when, in fact, the member was responsible for a $250 per-admission copayment. Kaiser disagreed, stating:

> The copay for Hospital Inpatient Care was $250 per admission. For ease of configuration, the copay has always been reflected in the "Total Deductible" field on the claims detail screen, and the Diamond claims processing system treats the amount in that field as a copay, and not as a deductible. The member was aware of the benefit and the responsibility for the copay as reflected on the EOB….

The examiners would respond that the EOB erroneously indicated that the member was responsible for a $250 deductible on this claim, Kaiser's EOB has a separate column designated for "Coinsurance/Copay" that was populated with zeroes, and the information provided on the EOB is incorrect. The EOB did not clearly and accurately disclose the method of benefit calculation, misrepresented pertinent facts relating to the

coverages at issue, and did not accurately and clearly set forth the benefits payable under the contract.

Ambulance

A sample of 3 was selected from a total population of 1,894 ambulance and medical transport claims paid during the examination time frame.

The review revealed that the claims were processed in accordance with the contract provisions.

Mental Health

A sample of 40 was selected from a total population of 5,286 mental health claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 8 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 8 instances. An example of Kaiser's non-compliance with both of these sections is discussed in Review Sheet CL27BW. Although the claim was submitted by a non-participating provider, Kaiser's EOB indicated that there was no copayment, coinsurance, or member liability associated with this claim. The EOB failed to indicate that the member was responsible for the difference between the allowable charge and the amount billed by the non-participating provider. Kaiser disagreed, stating:

> Claim was correctly paid using the reasonable and customary rate for the geographical area. The member's cost share was limited to the amount indicated on the EOB under "Member Responsibility." And as stated on

> the EOB "Kaiser Permanente pays for services provided by non-contracted professional providers at the reasonable and customary rate for that particular geographic region. Non-contracted providers usually accept this payment as payment in full. If you receive a bill from the provider, please contact Member Services at 800-777-7902 and we will resolve the situation without any further liability to you."

Although the examiners have no comments regarding the adjudication of the claim itself, Kaiser's EOB indicated that there is no member liability for the difference between the allowable charge and the amount billed by the non-participating provider (the "Not Covered" column on the EOB is populated with zeroes). Since the provider did not participate in Kaiser's network, Kaiser did not have a contract with the provider to ensure that the member would not be balanced-billed; therefore, Kaiser's EOB did not accurately reflect the member's liability. While the examiners acknowledge Kaiser's statement on the EOB, Kaiser's offer to potentially resolve this liability on behalf of the member is not a benefit provided under the coverage that Kaiser is obligated to perform; therefore, the EOB misrepresented pertinent facts related to the coverages at issue and failed to accurately and clearly set forth the benefits payable.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed that Kaiser was in violation of this section in 2 instances. An example is discussed in Review Sheet CL29BW. Kaiser's EOB erroneously indicated that there was a $6,021.71 allowable charge on the claim. According to Kaiser's claim system documentation, the allowable charge was actually $6,015.00 and there was interest due

of $6.71. The EOB included a remark code “AINT1” that has a description of “Interest,” but the EOB did not indicate the amount of interest that was paid. Kaiser’s EOB failed to accurately specify the allowable charge and the amount of interest paid on this claim. Kaiser agreed with the examiners’ observations.

Dental

A sample of 50 was selected from a total population of 5,256 dental claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 3 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Kaiser was in non-compliance with this section in 3 instances. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that Kaiser was in non-compliance with this section in 4 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 2 instances. In addition, the review revealed that Kaiser was in non-compliance with its EOC in 1 instance. An example of Kaiser’s non-compliance with these 4 sections and its EOC is discussed in Review Sheet CL38BW. Procedure code D4355 was denied, and an alternate benefit was approved. Neither the dental benefit rider in Kaiser’s EOC nor the Second Level

Point-of-Service Plan Description of Benefits and Member Copayments contains any language, limitation, or exclusion that indicates that Kaiser processes alternate benefits for certain procedures. Therefore, Kaiser was in non-compliance with its EOC, misrepresented pertinent facts relating to the coverage at issue, failed to make a fair and equitable settlement of the claim, failed to provide a reasonable explanation of the basis for a compromise settlement, and its EOB failed to accurately and clearly set forth the benefits payable under the contract. Kaiser agreed with the examiners' observations.

Pharmacy

A sample of 25 was selected from a total population of 330,507 pharmacy claims paid during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Encounters

A sample of 105 was selected from a total population of 163,384 encounters paid during the examination time frame. Section 38.2-3407.3 A of the Code states that an HMO that issues a contract pursuant to which the enrollee is required to pay a specified percentage of the cost of covered services, shall calculate such amount payable based upon an amount not to exceed the total amount actually paid or payable to the provider of such services for the services provided to the enrollee. "Coinsurance" is defined in 14 VAC 5-211-20 as "…a copayment expressed as a percentage of the allowable charge for a specific health care service."

As discussed in Review Sheet CL42M, the review revealed that the coinsurance amounts calculated for 49 of the sample capitated encounters were calculated using a dollar amount that exceeded the total amount actually paid or payable to the provider.

Kaiser disagreed with the examiners' observations based on the position that the intended application of § 38.2-3407.3 of the Code does not extend to Kaiser's utilization of an integrated delivery system where Kaiser serves as both a carrier and provider and that Kaiser's allowable amounts on which the coinsurance is calculated take into account the costs incurred in providing services. The examiners would respond that there is no language in § 38.2-3407.3 of the Code exempting this type of model from its requirements and Kaiser was unable to successfully show the correlation between the allowed amount on which the coinsurance is calculated and the total amount actually paid or payable to the provider through the Company's different provider reimbursement models.

Interest

Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment.

The review revealed 2 violations of this section. An example is discussed in Review Sheet CL37BW, where Kaiser took 62 days to pay a claim and failed to pay the statutory interest due. Kaiser agreed with the examiners' observations.

DENIED CLAIM REVIEW

Professional

A sample of 55 was selected from a total population of 10,715 claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

Institutional

A sample of 12 was selected from a total population of 2,189 claims denied during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. Section 38.2-510 A 6 of the Code prohibits as a general business practice, not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. Section 38.2-3407.4 B of the Code requires that an EOB shall accurately and clearly set forth the benefits payable under the contract. As discussed in Review Sheet CL38M, the review revealed 1 instance of non-compliance with each of these 3 sections and the EOC. In this instance, Kaiser held the member responsible for a $30 copay and 10% coinsurance, but Kaiser's EOC indicates that a $30 per visit copay is required for outpatient chemotherapy with no corresponding coinsurance. Kaiser agreed with the examiners' observations.

Ambulance

A sample of 3 was selected from a total population of 226 denied ambulance/medical transport claims. The review revealed that the claims were processed in accordance with the contract provisions.

Mental Health & Substance Abuse

A sample of 13 was selected from a total population of 1,451 mental health and substance abuse claims denied or adjusted during the examination time frame.

14 VAC 5-211-160 6 states that an HMO shall provide, or arrange for the provision of basic health care services. These services shall include medically necessary services for the treatment of biologically based mental illnesses.

Section 38.2-3412.1:01 A of the Code states that each HMO providing a health care plan for health care services shall provide coverage for biologically based mental illnesses. The review revealed 1 violation of each of these sections. As discussed in Review Sheet CL29M, Kaiser denied a claim with an authorization on file for a biologically based mental illness, stating on the EOB, “Not Covered, Service was not Authorized.” Kaiser agreed with the examiners’ observations.

14 VAC 5-211-160 6 b 3 states that treatment for all other mental health and substance abuse services shall at a minimum include twenty outpatient visits per enrollee per contract year. The review revealed that Kaiser was in violation of this section in 1 instance. Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-510 A 4 of the Code prohibits as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim. The review revealed that Kaiser was in non-compliance with this section in 3 instances. In addition, the review revealed that Kaiser was in non-compliance with its EOC in 2 instances. An example of Kaiser’s non-compliance with these 5 sections and its EOC is discussed in Review Sheet

CL23M. Kaiser denied an outpatient claim for a psychiatric diagnostic evaluation, stating on the EOB, "Not Reimbursable Per Contract." The "Chemical Dependency and Mental Health Services" section of Kaiser's EOC contains the following language:

> In an outpatient setting, Kaiser covers all necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:
>
> - Evaluations….

Kaiser agreed with the examiners' observations and stated that "The claim was auto-adjudicated and denied in error. The claim has since been adjusted…."

Dental

A sample of 25 was selected from a total population of 257 claims denied during the examination time frame.

Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed 13 instances of non-compliance with this section. As discussed in Review Sheet CL40M, Kaiser failed to provide EOBs to the members communicating the basis for denial of their claims. Kaiser disagreed with the examiners' observations, stating that:

> As a business practice, Dominion Dental does not generate EOB's for claims and services rendered by its general dentists under the Kaiser Preventive Plan. As with all services performed under this plan, the member is responsible for only the listed copayment for covered services to be collected at the time of service. Dominion has a contractual agreement with the dentists, whereby they are paid a supplement (i.e. $30) for each preventive visit. These provider supplements have no bearing on the member's coverage or financial responsibility. In the event there is a denial of a provider supplement, (because member is ineligible), the member will receive the basis for the denial from the plan.

The examiners responded that a reasonable explanation for denial must be promptly provided to the member if the claim or any claim lines are denied, regardless of whether or not the member is being held responsible for any part of the denied charges. Kaiser did not provide EOBs to the members and, therefore, failed in each instance to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for the denial of the claim.

Pharmacy

A sample of 13 was selected from a total population of 15,786 claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the contract provisions.

SUMMARY

Kaiser's failure to comply with §§ 38.2-510 A 1 and 38.2-510 A 14 of the Code occurred with such frequency as to indicate a general business practice, placing it in violation of these sections.

Due to the fact that violations of § 38.2-3407.4 B of the Code were discussed in the previous Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

TIME SETTLEMENT STUDY

The time settlement study was performed to determine compliance with § 38.2-510 A 5 of the Code, which requires that coverage of claims be affirmed or denied within a reasonable time after proof of loss statements have been completed. The normally acceptable "reasonable time" is 15 working days from the receipt of proof

of loss to the date a claim is either affirmed or denied. The term "working days" does not include Saturdays, Sundays, or holidays.

Kaiser's established practice was to settle claims within 30 calendar days of receipt; therefore, the examiners allowed for a 30-calendar day time frame to determine a reasonable time to affirm or deny claims after proof of loss was received.

The review revealed that Kaiser failed to affirm or deny coverage within a reasonable time in 182 instances, in non-compliance with § 38.2-510 A 5 of the Code. An example is discussed in Review Sheet CL01BW, where Kaiser took 45 calendar days to affirm the claim. Kaiser's failure to perform the required actions occurred with such frequency as to indicate a general business practice, placing Kaiser in violation of this section. The majority of these instances were due to Kaiser's failure to provide EOBs for dental claims processed under the preventive plan and for encounters.

Due to the fact that violations of § 38.2-510 A 5 of the Code were discussed in the previous Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

THREATENED LITIGATION

The total population of 6 files involving threatened litigation was reviewed. The review revealed that Kaiser handled the files in substantial compliance with its procedures and policy provisions.

XIV. INTERNAL APPEAL AND EXTERNAL REVIEW

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

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

The examiners reviewed the entire population of 2 appeals that obtained an external review of a final adverse determination during the examination time frame. In addition, the 29 sample complaint files and the 21 sample appeal files were reviewed for compliance with the notice requirements for external review.

14 VAC 5-216-40 E requires a health carrier to notify the covered person of the final benefit determination within a reasonable period of time.

14 VAC 5-216-70 A 5 requires an adverse determination to include a statement indicating whether any additional internal appeals are available or whether the covered person has received a final adverse determination.

Section 13.1.4 of Kaiser's Commercial Member Appeals procedures, regarding Virginia members, states that "if the denial is a final adverse determination based on medical review, the decision letter will include the statement 'this is a final adverse decision', describe the criteria used to make the decision including the clinical reason for the decision, and provide specific information concerning the covered person's independent external review rights. The letter will contain a reference to enclosed forms

and related instructions for submitting an external appeal request to the Virginia Bureau of Insurance."

The review revealed 5 violations of each section and 5 instances of non-compliance with Kaiser's established internal procedures. An example is discussed in Review Sheet EX01 where Kaiser issued a letter that appeared to be a final adverse determination. Although the letter included some of the required components, it failed to state that it was a final adverse determination, as required. Kaiser agreed with the examiners' observations.

Section 38.2-3559 D states that the health carrier shall include the standard and expedited external review procedures and any forms with the notice of the right to external review. Administrative Letter 2011-05 states, in part, "In the case of a final adverse determination, the health carrier must provide the forms needed to request an independent standard or expedited external review."

The review revealed 3 violations of this section and 3 instances of non-compliance with Administrative Letter 2011-05 and Kaiser's established internal procedures. An example is discussed in Review Sheet EX12 where Kaiser sent a final adverse determination, but the letter gave no indication that external review forms were enclosed, as required. Kaiser agreed with the examiners' observations but provided documentation that the Plan's Member Decision Letter template was revised in 2014, after the examination time frame, to state that external review request forms were enclosed with the letter.

Section 38.2-3561 A of the Code states that within 120 days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be

exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission.

The review revealed 13 violations of this section. An example is discussed in Review Sheet EX13, where a final adverse determination letter was sent to the member incorrectly advising that the member has "the right to file a request for external review by an independent organization within 4 months of your receipt of our decision on your appeal." Kaiser agreed with the examiners' observations but provided documentation that the Plan's Member Decision Letter template was revised in 2014, after the examination time frame, to specify 120 days rather than 4 months.

Section 38.2-5904 of the Code sets forth the responsibilities of the Office of the Managed Care Ombudsman, and mediation of appeals is not included in these responsibilities. In 13 instances, Kaiser sent a final adverse determination letter incorrectly stating, "The Virginia Bureau of Insurance's Office of [sic] Managed Care Ombudsman is available to assist you, free of charge, in both mediating and filing an appeal under this internal appeal process." An example is discussed in Review Sheet EX02. Kaiser agreed with the examiners' observations but provided documentation that the Plan's Member Decision Letter template was revised in 2014, after the examination time frame, to remove the reference to mediating by the Office of the Managed Care Ombudsman.

In addition to the violations of the Code and 14 VAC 5-216-10 et seq. and the instances of non-compliance with Administrative Letter 2011-05 discussed in the preceding paragraphs, there were, in the aggregate, 8 instances where Kaiser also failed to comply with its established internal procedures. Although the plan's

established internal procedures included the requirements for external review, not all of these procedures were followed during the examination time frame.

XV. CORRECTIVE ACTION PLAN

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

1. Review and strengthen its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by 14 VAC 5-211-150 A and § 38.2-5804 A of the Code;
2. Review and strengthen its procedures to ensure timely response to pre-service and post-service appeals as required by 14 VAC 5-216-40 E 1 and 14 VAC 5-216-40 E 2;
3. As recommended in the prior Report, establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination, as required by § 38.2-5805 C 1 of the Code;
4. Establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination, as required by § 38.2-5805 C 6 of the Code;
5. As recommended in the prior Report, establish and maintain procedures to ensure that contracts between Kaiser's intermediary organizations and health care providers require the health care providers to give sixty days' advance notice of termination of the contract to the intermediary organization, as required by § 38.2-5805 C 7 of the Code;

6. Establish and maintain procedures to ensure that the health carrier and any applicable intermediary organization maintain its executed contracts for a period of five years after the expiration of any such contract, as required by § 38.2-5805 C 8 of the Code;

7. As recommended in the prior Report, establish and maintain procedures to ensure that all "hold harmless" clauses read essentially as set forth in § 38.2-5805 C 9 of the Code;

8. As recommended in the prior Report, establish and maintain procedures to ensure that the "hold harmless" clause in contracts between the health carrier on behalf of the MCHIP and the intermediary organization is amended to include non-payment by the plan, health carrier and intermediary organization, and is included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization, as required by § 38.2-5805 C 10 of the Code;

9. As recommended in the prior report, establish and maintain procedures to ensure that all provider contracts contain and comply with the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code;

10. Review and strengthen procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;

11. Establish and maintain procedures to ensure that all EOBs are filed for approval prior to use, as required by § 38.2-3407.4 A of the Code;

12. As recommended in the prior report, establish and maintain procedures to ensure that, when an enrollee meets the copayment maximum, Kaiser complies with the terms of the EOC and the requirements of 14 VAC 5-211-90 B;

13. Review and reopen all claims for all enrollees who exceeded his or her copayment/out-of-pocket maximum during the years of 2013, 2014, 2015, 2016, and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee/provider to whom benefits and interest are due. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the copayment/out-of-pocket maximum was collected in error. Please accept this refund amount." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized;

14. Establish and maintain procedures to ensure that correspondence notifying enrollees that a copayment maximum has been reached contains accurate information, as required by subsection 1 § 38.2-502 of the Code;

15. Review and strengthen its procedures for notifying agents and agencies within 5 calendar days and the Commission within 30 calendar days of appointment termination, as required by § 38.2-1834 D of the Code;

16. Implement and maintain appropriate controls and personnel training to ensure compliance with established underwriting guidelines so that applicants are not incorrectly declined coverage;

17. Review and strengthen its procedures to ensure that a complete record is maintained for all complaints, as required by § 38.2-511 of the Code;

18. Establish and maintain procedures for compliance with § 38.2-510 A 1 of the Code, which prohibits misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

19. Establish and maintain procedures to ensure that claims are affirmed or denied within a reasonable time, as required by § 38.2-510 A 5 of the Code;

20. Establish and maintain procedures to ensure that a reasonable explanation is promptly provided for denial of a claim, as required by § 38.2-510 A 14 of the Code. This shall include promptly providing an explanation for the denial of dental claims processed under the preventive plan;

21. Review and strengthen its procedures for compliance with §§ 38.2-510 A 4 and 38.2-510 A 6 of the Code;

22. Review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, and clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by §§ 38.2-3407.4 B and 38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, allowable amounts, deductibles, coinsurance and copayments on its EOBs;

23. Review and strengthen its procedures to ensure that all claims are adjudicated in accordance with the EOC;

24. Review and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;

25. Review and consider for re-adjudication all paid dental claims that took greater than 30 calendar days to pay for the years of 2013, 2014, 2015, 2016 and the current year and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

26. Review all auto-adjudicated denied mental health and substance abuse claims for the years for the years 2013, 2014, 2015, 2016, and the current year. Determine those instances where the claim had been denied in error and send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the member/provider to whom benefits and interest are due. All checks for reimbursement should be accompanied by a letter of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that an error in the payment of this claim was found. Please accept this check for an additional payment." Kaiser should provide the examiners with documentation that the required amounts have been paid within 180 days of this Report being finalized;

27. Provide the examiners with documentation substantiating that Kaiser has corrected the processing of the claims discussed in Review Sheets CL06BW,

CL07BW, and CL38BW and that Kaiser has refunded any monies owed to the members;

28. Establish and maintain procedures to ensure that a notification of the right to request an external review states that the covered person may submit a written request within 120 days after the receipt of notice of the right to an external review, as specified by § 38.2-3561 A of the Code;

29. Implement and maintain appropriate controls and personnel training to ensure compliance with 14 VAC 5-216-40 E, 14 VAC 5-216-70 A 5, and established procedures regarding notification of a final adverse determination;

30. Establish and maintain procedures and implement and maintain appropriate controls and personnel training to ensure that final adverse benefit determinations and final adverse determinations do not contradict § 38.2-5904 of the Code by stating that Virginia's Office of the Managed Care Ombudsman mediates appeals; and

31. Within 180 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XVI. ACKNOWLEDGMENT

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

Brant Lyons, MCM, Bryan Wachter, FLMI, CIE, AIRC, MCM, Laura Wilson, MCM, Melissa Gerachis, FLMI, AIRC, AMCM, Freddie Oliver, Janay Brown, and Daniel Abbondanzo of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

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

XVII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
§ 38.2-5804 A and 14 VAC 5-211-150 A, 1 violation, CP02
14 VAC 5-216-40 E 1, 1 violation, CP01
14 VAC 5-216-40 E 2, 1 violation, CP03
Provider Contracts
§ 38.2-5805 C 1, 1 violation, MC08
§ 38.2-5805 C 6, 1 violation, MC02
§ 38.2-5805 C 7, 10 violations, MC07 (4), MC15 (4), MC16, MC17
§ 38.2-5805 C 8, 5 violations, MC05, MC07 (4)
§ 38.2-5805 C 9, 44 violations, MC02, MC08, MC15 (4), MC16, MC17, MC18 (36)
§ 38.2-5805 C 10, 13 violations, MC02, MC07 (4), MC10, MC11, MC15 (4), MC16, MC17
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Provider Contracts
§§ 38.2-3407.15 B 1, 12 violations, EF05 (4), EF16, EF18, EF26 (6)
§§ 38.2-3407.15 B 2, 18 violations, EF01 (7), EF02, EF03, EF04, EF05 (4), EF14, EF16, EF18, EF25
§§ 38.2-3407.15 B 3, 10 violations, EF05 (4), EF11, EF12, EF14, EF16, EF18, EF25
§§ 38.2-3407.15 B 4, 8 violations, EF05 (4), EF13, EF15, EF16, EF18
§§ 38.2-3407.15 B 5, 6 violations, EF05 (4), EF16, EF18
§§ 38.2-3407.15 B 6, 18 violations, EF01 (7), EF02, EF03, EF04, EF05 (4), EF10, EF13, EF16, EF18
§§ 38.2-3407,15 B 7, 9 violations, EF05 (4), EF15, EF16, EF18, EF20 (2)

§§ 38.2-3407.15 B 8, 14 violations, EF05 (4), EF16, EF18, EF20 (2), EF26 (6)
§§ 38.2-3407.15 B 9, 17 violations, EF01 (7), EF05 (4), EF13, EF15, EF16, EF18, EF20 (2)
§§ 38.2-3407.15 B 10, 49 violations, EF01 (7), EF02, EF03, EF04, EF05 (4), EF06 (5), EF07 (7), EF08 (6), EF09 (2), EF10, EF11, EF12, EF13, EF14, EF15, EF16, EF17, EF18, EF19 (2), EF20 (2), EF23, EF25
§§ 38.2-3407.15 B 11, 2 violations, EF18, EF21
Provider Claims
§ 38.2-3407.15 B 1, 3 violations, EFCL03, EFCL04, EFCL05
§ 38.2-3407.15 B 8, 1 violation, EFCL07
POLICY AND OTHER FORMS
§ 38.2-3407.4 A, 6 violations, PF01BW (3), PF01M (3)
14 VAC 5-211-90 B, 25 violations, PF01DA, PF02DA, PF03DA, PF04DA, PF05DA, PF06DA, PF07DA, PF08DA, PF09DA, PF10DA, PF12DA, PF13DA, PF14DA, PF15DA, PF16DA, PF17DA, PF01J, PF02J, PF03J, PF04J, PF05J, PF06J, PF07, PF08J, PF09J
Subsection 1 of § 38.2-502, 4 violations, PF01DA, PF02DA, PF05DA, PF08DA
AGENTS
§ 38.2-1834 D, 18 violations, AG01DA, AG02DA, AD03DA, AG04DA (15)
CANCELLATIONS / NONRENEWALS
14 VAC 5-211-210 B 17, 1 violation, CN01
COMPLAINTS
§ 38.2-511, 1 violation, CP01
CLAIM PRACTICES
§ 38.2-514 B, 6 violations, CL15BW, CL16BW, CL18BW, CL19BW, CL29BW, CL30BW
§ 38.2-3407.3 A, 49 violations, CL42M

§ 38.2-3407.4 B, 24 violations, CL03BW, CL06BW, CL07BW, CL10BW, CL11BW, CL12BW, CL13BW, CL14BW, CL15BW, CL16BW, CL18BW, CL19BW, CL23BW, CL24BW, CL25BW, CL26BW, CL27BW, CL28BW, CL29BW, CL30BW, CL36BW, CL38BW, CL41BW, CL38M
§ 38.2-3412.1:01 A, 1 violation, CL29M
§ 38.2-4306.1 B, 2 violations, CL35BW, CL37BW
14 VAC 5-211-160 6, 1 violation, CL29M
14 VAC 5-211-160 6 b 3, 1 violation, CL23M
§ 38.2-510 A 1, 28 violations, CL03BW, CL06BW, CL07BW, CL09BW, CL10BW, CL11BW, CL12BW, CL13BW, CL14BW, CL15BW, CL16BW, CL18BW, CL19BW, CL23BW, CL24BW, CL25BW, CL26BW, CL27BW, CL28BW, CL29BW, CL30BW, CL34BW, CL36BW, CL38BW, CL41BW, CL23M, CL29M, CL38M
§ 38.2-510 A 4, 2 instances of non-compliance, CL23M, CL29M
§ 38.2-510 A 5, 182 violations, CL01BW, CL02BW, CL04BW, CL05BW, CL08BW, CL17BW, CL19BW, CL20BW, CL22BW, CL26BW, CL31BW, CL32BW (27), CL34BW, CL35BW, CL37BW, CL39BW, CL40BW, CL01M, CL02M, CL03M, CL04M, CL05M, CL07M, CL08M, CL09M, CL10M, CL11M, CL12M, CL13M, CL14M, CL15M, CL16M, CL17M, CL18M, CL19M, CL20M, CL21M, CL22M, CL24M, CL26M, CL27M, CL28M, CL29M, CL30M, CL31M, CL32M, CL33M, CL34M, CL35M, CL36M, CL37M, CL43M (49), CL44M (56)
§ 38.2-510 A 6, 8 instances of non-compliance, CL06BW, CL07BW, CL34BW, CL36BW, CL38BW, CL23M, CL29M, CL38M
§ 38.2-510 A 14, 21 violations, CL09BW, CL34BW, CL36BW, CL38BW, CL39BW, CL23M, CL25M, CL29M, CL40M (13)
INTERNAL APPEAL AND EXTERNAL REVIEW
§ 38.2-3559 D, 3 violations, EX01, EX12, EX13

§ 38.2-3561 A, 13 violations, EX01, EX02, EX03, EX04, EX05, EX06, EX07, EX08, EX09, EX10, EX11, EX12, EX13
§ 38.2-5904, 13 violations, EX01, EX02, EX03, EX04, EX05, EX06, EX07, EX08, EX09, EX10, EX11, EX12, EX13
14 VAC 5-216-40 E, 5 violations, EX01, EX02, EX06, EX12, EX13
14 VAC 5-216-70 A 5, 5 violations, EX01, EX02, EX06, EX12, EX13

COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION
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August 8, 2017

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RETURN RECEIPT REQUESTED

Mr. Jeff Van Luyn, CHC
Director, Audit Readiness Legislative and Product Compliance, Regional Compliance Dept.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

RE: Market Conduct Examination Report
Exposure Draft

Dear Mr. Van Luyn:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for the period of January 1, 2013 through June 30, 2013. A preliminary draft of the Report is enclosed for your review.

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

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

Thank you for your prompt attention to this matter.

Yours truly,

Julie R. Fairbanks

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

JRF:mhh
Enclosure
cc: Julie Blauvelt

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Sent via Email and Secure File Transfer (FTP site)

September 21, 2017

Julie Fairbanks, AIE, AIRC, FLMI, ACS, MCM
VA Bureau of Insurance Manager
1300 E Main Street
Richmond, VA 23219

Re: Market Conduct Examination Draft Report

Dear Ms. Fairbanks:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Health Plan" or "Plan") is in receipt of the Bureau's draft Market Conduct Examination Report for the examination period of January 1, 2013 – June 30, 2013. We appreciate the opportunity to respond to the issues identified within the report. Below please find our responses to the corrective action plans recommended under Section XV of the draft report.

VBOI Recommended CAP #1: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by 14 VAC 5-211-150 A and § 38.2-5804 A of the Code.

Related Bureau Finding(s):

- 1 violation of Section 38.2-5804 A of the Code of Virginia which states that a health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in, or established pursuant to, provisions in Title 58 and Title 32.1.

- 1 violation of 14 VAC 5-211-150 A of the Virginia Administrative Code which states that a health maintenance organization shall establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints in accordance with Chapter 5 (§ 32.1-137.1 et seq.) of Title 32.1 and Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia. In addition, a health maintenance organization shall establish and maintain an internal appeals procedure in accordance with Chapter 5 (§ 32.1-137.1 et seq.) of Title 32.1 and Chapter 35.1 (§ 38.2-3556 et seq.) of Chapter 58 (§ 38.2-5800 et seq.) of Title 38.2 of the Code of Virginia and applicable regulations.

VBOI Recommended CAP #2: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures to ensure timely response to pre-service and post-service appeals as required by 14 VAC 5-216-40 E 1 and 14 VAC 5-216-40 E 2;

Related Bureau Finding(s):

- 1 violation of 14 VAC 5-216-40 E 1 of the Virginia Administrative Code which states that if an internal appeal involves a pre-service claim review request, the health carrier shall notify the covered person of its decision within 30 days after receipt of the appeal.

- 1 violation of 14 VAC 5-216-40 E 2 of the Virginia Administrative Code which states that if an internal appeal involves a post-service claim review request, the health carrier shall notify the covered person of its decision within 60 days after receipt of the appeal.

VBOI Recommended CAP #3: Health Plan accepts the Bureau's finding(s). As recommended in the prior Report, plan will establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination, as required by § 38.2-5805 C 1 of the Code;

> ***Related Bureau Finding:*** 1 violation of section 38.2-5805 C 1 of the Code of Virginia which states that such contracts shall require that if the provider terminates the agreement, the provider shall give the health carrier at least sixty days' advance notice of termination.

VBOI Recommended CAP #4: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that its provider contracts contain a provision stating that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination, as required by § 38.2-5805 C 6 of the Code;

> ***Related Bureau Finding:*** 1 violation of section 38.2-5805 C 6 of the Code of Virginia which states that an agreement to provide health care services between an intermediary organization and a health carrier subject to subsection B of § 38.2-5801 shall require that if the intermediary organization terminates the agreement, the intermediary organization shall give the health carrier at least sixty days' advance notice of termination.

VBOI Recommended CAP #5: Health Plan accepts the Bureau's finding(s). As recommended in the prior Report, plan will establish and maintain procedures to ensure that contracts between Kaiser's intermediary organizations and health care providers require the health care providers to give sixty days' advance notice of termination of the contract to the intermediary organization, as required by § 38.2-5805 C 7 of the Code;

> ***Related Bureau Finding:*** 10 violations of section 38.2-5805 C 7 of the Code of Virginia which states that an agreement to provide health care services between an intermediary organization and a provider shall require that if the provider terminates the agreement, the provider shall give the intermediary organization at least sixty days' advance notice of termination.

VBOI Recommended CAP #6: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that the health carrier and any applicable intermediary organization maintain its executed contracts for a period of five years after the expiration of any such contract, as required by § 38.2-5805 C 8 of the Code;

> ***Related Bureau Finding:*** 5 violations of section 38.2-5805 C 8 of the Code of Virginia which states that each such health carrier and intermediary organization shall be responsible for maintaining its executed contracts enabling it to provide health care services. These contracts shall be available for the Commission's review and examination for a period of five years after the expiration of any such contract.

VBOI Recommended CAP #7: Health Plan accepts the Bureau's finding(s). As recommended in the prior Report, plan will establish and maintain procedures to ensure that all "hold harmless" clauses read essentially as set forth in § 38.2-5805 C 9 of the Code;

> ***Related Bureau Finding:*** 44 violations of section 38.2-5805 C 9 of the Code of Virginia which states that the "hold harmless" clause required by this section shall read essentially as set forth in this subdivision. The health carrier may use a corresponding provision of different wording approved by the Commission that is not less favorable in any respect to the covered persons

VBOI Recommended CAP #8: Health Plan accepts the Bureau's finding(s). As recommended in the prior Report, plan will establish and maintain procedures to ensure that the "hold harmless" clause in contracts between the health carrier on behalf of the MCHIP and an intermediary organization is amended to include non-payment by the plan, health carrier and intermediary organization, and is included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization, as required by § 38.2-5805 C 10 of the Code;

> ***Related Bureau Finding:*** 13 violations of section 38.2-5805 C 10 of the Code of Virginia which states that if there is an intermediary organization between the health carrier and the health care providers, the hold harmless clause set forth in subdivision 5 shall be amended to include nonpayment by the plan, the health carrier, and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the health carrier on behalf of the MCHIP and the intermediary organization.

VBOI Recommended CAP #9: Health Plan accepts the Bureau's finding(s). As recommended in the prior report, plan will establish and maintain procedures to ensure that all provider contracts contain and comply with the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code;

Related Bureau Finding(s):

- 12 violations of section 38.2-3407.15 B 1 of the Code of Virginia which requires a carrier to pay any claim within 40 days of receipt unless the claim is determined not to be a clean claim or the claim was submitted fraudulently.

- 18 violations of section 38.2-3407.15 B 2 of the Code of Virginia which requires a carrier, within 30 days after receipt of a claim, to request electronically or in writing the information

and documentation that the carrier reasonably believes will be required to process and pay the claim.

- 10 violations of section 38.2-3407.15 B 3 of the Code of Virginia which requires that any interest owing or accruing on a claim be paid at the time the claim is paid or within 60 days thereafter.

- 8 violations of section 38.2-3407.15 B 4 of the Code of Virginia which requires that

  a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.
  b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

- 6 violations of section 38.2-3407.15 B 5 of the Code of Virginia which requires a carrier to pay a claim if the carrier has previously authorized the service or has advised the provider or enrollee in advance that the service is medically necessary and a covered benefit.

- 18 violations of section 38.2-3407.15 B 6 of the Code of Virginia which prohibits a carrier from imposing any retroactive denial unless the carrier has provided the reason and the original claim was submitted fraudulently, the original claim payment was incorrect, or the time which has elapsed since the date of the original payment does not exceed the lesser of 12 months or the number of days within which the carrier requires the provider to submit a claim.

- 9 violations of section 38.2-3407.15 B 7 of the Code of Virginia which prohibits a carrier from imposing a retroactive denial unless the carrier specifies in writing the claim or claims being retroactively denied or for which refund is sought, and the written communication must contain an explanation of why the claim is being retroactively adjusted.

- 14 violations of section 38.2-3407.15 B 8 of the Code of Virginia which requires that a provider contract include or attach the fee schedule and all applicable material addenda, schedules and exhibits.

- 17 violations of section 38.2-3407.15 B 9 of the Code of Virginia which requires a carrier to furnish to the provider any proposed amendment or proposed new addenda, schedule, exhibit or policy at least 60 calendar days before the effective date.

- 49 violations of section 38.2-3407.15 B 10 of the Code of Virginia which states that if the carrier's provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead provide a clear written explanation of the policy as it applies to the provider.

- 2 violations of section 38.2-3407.15 B 11 of the Code of Virginia which states that all carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

VBOI Recommended CAP #10: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;

> ***Related Bureau Finding:*** Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection.

VBOI Recommended CAP #11: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that all EOBs are filed for approval prior to use, as required by § 38.2-3407.4 A of the Code;

> ***Related Bureau Finding:*** 6 violations of section 38.2-3407.4 A of the code of Virginia which states each insurer issuing an accident and sickness insurance policy shall file for approval its explanation of benefits forms. These explanation of benefit forms shall be subject to the requirements of § 38.2-316 or § 38.2-4306 as applicable.

VBOI Recommended CAP #12: Health Plan accepts the Bureau's finding(s). As recommended in the prior report, plan will establish and maintain procedures to ensure that, when an enrollee meets the copayment maximum, Kaiser complies with the terms of the EOC and the requirements of 14 VAC 5-211-90 B;

VBOI Recommended CAP #13: Health Plan accepts the Bureau's findings. Plan will review and reopen all claims for all enrollees who exceeded his or her copayment/out-of-pocket maximum during the years of 2013, 2014, 2015, 2016, and the current year. Send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the enrollee/provider to whom benefits and interest are due. Include with each check, an explanation stating that, "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that an amount in excess of the copayment/out-of-pocket maximum was collected in error. Please accept this refund amount." After which, furnish the examiners with documentation that the required amounts have been refunded within 180 days of this Report being finalized;

> ***Related Bureau Finding (for CAPs #12 & #13):*** 25 violations of 14 VAC 5-211-90 B which states that if the health maintenance organization has an established copayment maximum, it shall keep accurate records of each enrollee's copayment expenses and notify the enrollee when his copayment maximum is reached. The notification shall be given no later than 30 days after the health maintenance organization has processed sufficient claims to determine that the copayment maximum is reached. The health maintenance organization shall not charge additional copayments for the remainder of the contract or calendar year, as appropriate. The health maintenance organization shall also promptly refund to the enrollee all copayments charged after the copayment maximum is reached. Any maximum copayment amount shall be shown in the evidence of coverage as a specified dollar amount, and the evidence of coverage shall clearly state the health maintenance organization's procedure for meeting the requirements of this subsection.

VBOI Recommended CAP #14: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that correspondence notifying enrollees that a copayment maximum has been reached contains accurate information, as required by subsection 1 § 38.2-502 of the Code;

> ***Related Bureau Finding:*** 4 violations of subsection 1 of 38.2-502 of the Code of Virginia which states that no person shall make, issue, circulate, cause or knowingly allow to be made, issued or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison that misrepresents the benefits, advantages, conditions or terms of any insurance policy.

VBOI Recommended CAP #15: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures for notifying agents and agencies within 5 calendar days and the Commission within 30 calendar days of appointment termination, as required by § 38.2-1834 D of the Code;

> ***Related Bureau Finding:*** 18 violations of section 38.2-1834 D of the Code of Virginia which requires that upon the termination of the appointment of an agent by an insurer, the insurer shall notify the agent of such termination within five calendar days and the Commission within 30 calendar days in a manner acceptable to the Commission.

VBOI Recommended CAP #16: Health Plan accepts the Bureau's finding(s). Plan will implement and maintain appropriate controls and personnel training to ensure compliance with established underwriting guidelines so that applicants are not incorrectly declined coverage;

> ***Related Bureau Finding:*** The review revealed 1 instance of non-compliance with Kaiser's established underwriting guidelines. An example is discussed in Review Sheet UN01, where Kaiser declined an applicant who was assigned between 30 and 50 debits and should have been offered coverage with a rate up. Kaiser agreed with the examiners' observations.

VBOI Recommended CAP #17: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures to ensure that a complete record is maintained for all complaints, as required by § 38.2-511 of the Code;

> ***Related Bureau Finding:*** 1 violation of Section 38.2-511 of the Code of Virginia which states that no person other than agents or brokers, shall fail to maintain a complete record of all the complaints that it has received since the date of its last examination under § 38.2-1317, provided that the records of complaints of a health carrier subject to Chapter 58 (§ 38.2-5800 et seq.) of this title shall be retained for no less than five years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint.

VBOI Recommended CAP #18: Health Plan accepts the Bureau finding(s). Plan will establish and maintain procedures for compliance with § 38.2-510 A 1 of the Code, which prohibits misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

> ***Related Bureau Finding:*** 28 violations of section 38.2-510 A 1 of the Code of Virginia which states that no person shall, with such frequency as to indicate a general business practice, misrepresent pertinent facts or insurance policy provisions relating to the coverages at issue.

VBOI Recommended CAP #19: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that claims are affirmed or denied within a reasonable time, as required by § 38.2-510 A 5 of the Code;

> ***Related Bureau Finding:*** 182 violations of section 38.2-510 A 5 of the Code of Virginia which states that no person shall, with such frequency as to indicate a general business practice, fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

VBOI Recommended CAP #20: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that a reasonable explanation is promptly provided for denial of a claim, as required by § 38.2-510 A 14 of the Code. This shall include promptly providing an explanation for the denial of dental claims processed under the preventive plan;

> ***Related Bureau Finding:*** 21 violations of section 38.2-510 A 14 of the Code of Virginia which states that no person shall, with such frequency as to indicate a general business practice, fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

VBOI Recommended CAP #21: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures for compliance with §§ 38.2-510 A 4 and 38.2-510 A 6 of the Code;

Related Bureau Finding(s):

- 2 instances of non-compliance with section 38.2-510 A 4 of the Code of Virginia which states that no person shall, with such frequency as to indicate a general business practice, refuse arbitrarily and unreasonably to pay claims.

- 8 instances of non-compliance with section 38.2-510 A 6 of the Code of Virginia which states that no person shall, with such frequency as to indicate a general business practice, not attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

VBOI Recommended CAP #22: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, and clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by §§ 38.2-3407.4 B and 38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, allowable amounts, deductibles, coinsurance and copayments on its EOBs;

Related Bureau Finding(s):

- 24 violations of section 38.2-3407.4 B of the Code which states that the explanation of benefits shall accurately and clearly set forth the benefits payable under the contract.

- 6 violations of section 38.2-514 B of the Code which states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance contract, an explanation of benefits which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services.

VBOI Recommended CAP #23: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures to ensure that all claims are adjudicated in accordance with the EOC;

Related Bureau Finding: Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 9 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 8 instances. In addition, the review revealed that Kaiser was in non-compliance with its EOC in 2 instances. An example of Kaiser's non-compliance with these 3 sections and its EOC is discussed in Review Sheet CL06BW. Although Kaiser's EOC specifies that diabetic equipment and supplies are covered with no member cost-sharing, Kaiser

applied 50% coinsurance on a claim for diabetic equipment. Kaiser agreed with the examiners' observations.

VBOI Recommended CAP #24: Health Plan accepts the Bureau's finding(s). Plan will review and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;

> ***Related Bureau Finding:*** Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment.
> The review revealed 2 violations of this section. An example is discussed in Review Sheet CL37BW, where Kaiser took 62 days to pay a claim and failed to pay the statutory interest due. Kaiser agreed with the examiners' observations.

VBOI Recommended CAP #25: Health Plan accepts the Bureau's finding(s). Plan will review and consider for re-adjudication all paid dental claims that took greater than 30 calendar days to pay for the years of 2013, 2014, 2015, 2016 and the current year and make interest payments where necessary, as required by § 38.2-4306.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that "As a result of a Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this interest had not been paid previously." After which, furnish the examiners with documentation that the required interest has been paid within 180 days of this Report being finalized;

> ***Related Bureau Finding:*** 2 violations of section 38.2-4306.1 B of the Code of Virginia which states if no action is brought, interest upon the claim proceeds paid to the subscriber, claimant, or assignee entitled thereto shall be computed daily at the legal rate of interest from the date of thirty calendar days from the health maintenance organization's receipt of proof of loss to the date of claim payment.

VBOI Recommended CAP #26: Health Plan accepts the Bureau's finding(s). Plan will review all auto-adjudicated denied mental health and substance abuse claims for the years for the years 2013, 2014, 2015, 2016, and the current year. Determine those instances where the claim had been denied in error and send checks for the proper contractual benefits, plus any interest as required by § 38.2-4306.1 B of the Code to the member/provider to whom benefits and interest are due. All checks for reimbursement should be accompanied by a letter of explanation stating that, "As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that an error in the payment of this claim was found. Please accept this check for an additional payment." Kaiser should provide the examiners with documentation that the required amounts have been paid within 180 days of this Report being finalized;

> ***Related Bureau Finding:*** Section 38.2-3412.1:01 A of the Code states that each HMO providing a health care plan for health care services shall provide coverage for biologically based mental illnesses. The review revealed 1 violation of each of these sections. As discussed in Review Sheet CL29M, Kaiser denied a claim with an authorization on file for a biologically based mental illness, stating on the EOB, "Not Covered, Service was not authorized." Kaiser agreed with the examiners' observations.

VBOI Recommended CAP #27: Health Plan accepts the Bureau's finding(s). Plan will provide the examiners with documentation substantiating that Kaiser has corrected the processing of

the claims discussed in Review Sheets CL06BW,CL07BW, and CL38BW and that Kaiser has refunded any monies owed to the members;

Related Bureau Finding: Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that Kaiser was in non-compliance with this section in 9 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice,
not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that Kaiser was in non-compliance with this section in 2 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that Kaiser was in violation of this section in 8 instances. In addition, the review revealed that Kaiser was in non-compliance with its EOC in 2 instances. An example of Kaiser's non-compliance with these 3 sections and its EOC is discussed in Review Sheet CL06BW. Although Kaiser's EOC specifies that diabetic equipment and supplies are covered with no member cost-sharing, Kaiser applied 50% coinsurance on a claim for diabetic equipment. Kaiser agreed with the examiners' observations.

VBOI Recommended CAP #28: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures to ensure that a notification of the right to request an external review states that the covered person may submit a written request within 120 days after the receipt of notice of the right to an external review, as specified by § 38.2-3561 A of the Code;

Related Bureau Finding: 13 violations of section 38.2-3561 A of the Code of Virginia which states that within 120 days after the date of receipt of a notice of the right to an external review of a final adverse determination or an adverse determination if the internal appeal process has been deemed to be exhausted or waived, a covered person or his authorized representative may file a request for an external review in writing with the Commission.

VBOI Recommended CAP #29: Health Plan accepts the Bureau's finding(s). Plan will implement and maintain appropriate controls and personnel training to ensure compliance with 14 VAC 5-216-40 E, 14 VAC 5-216-70 A 5, and established procedures regarding notification of a final adverse determination;

Related Bureau Finding(s):

- 5 violations of 14 VAC 5-216-40 E of the Virginia Administrative Code which requires a health carrier to notify the covered person of the final benefit determination within a reasonable period of time appropriate to the medical circumstances, but not later than the timeframes established in subdivisions 1 and 2 of this subsection.

- 5 violations of 14 VAC 5-216-70 A 5 of the Virginia Administrative Code which requires an adverse benefit determination to include a statement indicating whether any additional internal appeals are available or whether the covered person has received a final adverse determination.

VBOI Recommended CAP # 30: Health Plan accepts the Bureau's finding(s). Plan will establish and maintain procedures and implement and maintain appropriate controls and personnel training to ensure that final adverse benefit determinations and final adverse determinations do not contradict § 38.2-5904 of the Code by stating that Virginia's Office of the Managed Care Ombudsman mediates appeals;

> ***Related Bureau Finding:*** 13 violations of Subsection B of § 38.2-5904 of the Code of Virginia which sets forth the responsibilities of the Office of the Managed Care Ombudsman.

VBOI Recommended CAP # 31: Health Plan accepts the Bureau's finding(s). Plan will, within 180 days of this report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

> ***Related Bureau Finding:*** N/A

We appreciate the Bureau's understanding and willingness to work with us to make this a successful examination. Once reviewed, please feel free to contact me if you have any further questions or concerns.

Sincerely,

Jeffrey C. Van Luyn

JACQUELINE K. CUNNINGHAM
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

COMMONWEALTH OF VIRGINIA

P.O. BOX 1157
RICHMOND, VIRGINIA 23218
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TDD/VOICE: (804) 371-9206
www.scc.virginia.gov/boi

October 19, 2017

CERTIFIED MAIL 1520 0003 0919 0102
RETURN RECEIPT REQUESTED

Mr. Jeff Van Luyn, CHC
Director, Audit Readiness Legislative and Product Compliance, Regional Compliance Dept.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

RE: Kaiser Foundation Health Plan of the Mid-Atlantic States Inc.'s (Kaiser) Response to the Draft Examination Report

Dear Mr. Van Luyn:

The examiners have received and reviewed Kaiser's response to the Draft Report dated September 21, 2017. The examiners acknowledge Kaiser's agreement and willingness to cooperate regarding the implementation of each of the Corrective Action Plan items. This response will address the areas of the Report where, upon further review, the examiners determined that modifications to the findings were necessary.

XI. CANCELLATIONS/NONRENEWALS

The violation of 14 VAC 5-211-230 B 1 under the Group Cancellations/Nonrenewals section will be changed to a violation of 14 VAC 5-211-210 B 17. The AREA VIOLATIONS SUMMARY BY REVIEW SHEET section will also be revised to reflect this change.

A copy of the entire Report with revised pages is attached and contains the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that Kaiser has violated the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, §§ 38.2-510 A 1, 38.2-510 A 5, 38.2-510 A 14, 38.2-510 A 15, 38.2-511, and 38.2-514 B of the Code.

It also appears that Kaiser has violated §§ 38.2-1834 D, 38.2-3407.3 A, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3,

38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 A, 38.2-3559 D, 38.2-3561 A, 38.2-4306.1 B, 38.2-5804 A, 38.2-5805 C 1, 38.2-5805 C 6, 38.2-5805 C 7, 38.2-5805 C 8, 38.2-5805 C 9, 38.2-5805 C 10, and 38.2-5904 of the Code, 14 VAC 5-211-90 B, 14 VAC 5-211-150 A, 14 VAC 5-211-160 6, 14 VAC 5-211-160 6 c, and 14 VAC 5-211-210 B 17 of Rules Governing Health Maintenance Organizations, and 14 VAC 5-216-40 E, 14 VAC 5-216-40 E 1, 14 VAC 5-216-40 E 2, and 14 VAC 5-216-70 A 5 of Rules Governing Internal Appeal and External Review.

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

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

Very truly yours,

Julie R. Fairbanks

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

Mr. Jeff Van Luyn, CHC
Director, Audit Readiness Legislative and Product Compliance, Regional Compliance Dept.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

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

RE: Alleged violations of the Unfair Trade Practices Act, specifically subsection 1 of § 38.2-502, §§ 38.2-510 A 1, 38.2-510 A 5, 38.2-510 A 14, 38.2-510 A 15, 38.2-511, and 38.2-514 B of the Code as well as §§ 38.2-1834 D, 38.2-3407.3 A, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3412.1:01 A, 38.2-3559 D, 38.2-3561 A, 38.2-4306.1 B, 38.2-5804 A, 38.2-5805 C 1, 38.2-5805 C 6, 38.2-5805 C 7, 38.2-5805 C 8, 38.2-5805 C 9, 38.2-5805 C 10, and 38.2-5904 of the Code, 14 VAC 5-211-90 B, 14 VAC 5-211-150 A, 14 VAC 5-211-160 6, 14 VAC 5-211-160 6 b 3, and 14 VAC 5-211-210 B 17 of Rules Governing Health Maintenance Organizations, and 14 VAC 5-216-40 E, 14 VAC 5-216-40 E 1, 14 VAC 5-216-40 E 2, and 14 VAC 5-216-70 A 5 of Rules Governing Internal Appeal and External Review.

Dear Ms. Blauvelt:

This will acknowledge receipt of your letter dated October 24, 2017, concerning the above-captioned matter.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Company) wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of $102,000, payable to the Treasurer of Virginia. The Company further understands that, as part of the State Corporation Commission's Order accepting the offer of settlement it waives its right to the hearing to which it is entitled; agrees to cease and desist from future violations of 38.2-3407.4 B of the Code and 14 VAC 5-211-90 B; and agrees to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

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

Yours very truly,

_____
Company Representative

_____
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

171210005

AT RICHMOND, DECEMBER 1, 2017

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2017-00217

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), violated: § 38.2-502 (1) of the Code of Virginia ("Code") by misrepresenting the terms of the policy; §§ 38.2-510 A (1), 38.2-510 A (5), 38.2-510 A (14), and 38.2-510 A (15) of the Code by failing to comply with claim settlement practices; § 38.2-511 of the Code by failing to maintain a complete record of complaints; § 38.2-514 B of the Code by failing to make proper disclosure on explanation of benefits forms; § 38.2-1834 D of the Code by failing to comply with agent appointment requirements; § 38.2-3407.3 A of the Code by failing to comply with calculation of cost-sharing provisions; § 38.2-3407.4 A of the Code by failing to file for approval by the Commission its explanation of benefits forms; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth the benefits payable under the contract in the explanation of benefits; §§ 38.2-3407.15 B (1), 38.2-3407.15 B (2), 38.2-3407.15 B (3), 38.2-3407.15 B (4), 38.2-3407.15 B (5), 38.2-3407.15 B (6), 38.2-3407.15 B (7), 38.2-3407.15 B (8), 38.2-3407.15 B (9), 38.2-3407.15 B (10), and 38.2-3407.15 B (11) of the Code by failing to

comply with ethics and fairness requirements for business practices; § 38.2-3412.1:01 A of the Code by failing to provide coverage for biologically based mental illness; § 38.2-3559 D of the Code by failing to comply with notice requirements for external review; § 38.2-3561 A of the Code by misrepresenting external review rights; § 38.2-4306.1 B of the Code by failing to comply with requirements for the payment of interest on claim proceeds; § 38.2-5804 A of the Code and 14 VAC 5-211-150 A of the Commission's Rules Governing Health Maintenance Organizations, 14 VAC 5-211-10 *et seq.* ("Rules"), by failing to maintain its established complaint system approved by the Commission; §§ 38.2-5805 C (1), 38.2-5805 C (6), 38.2-5805 C (7), 38.2-5805 C (8), 38.2-5805 C (9), and 38.2-5805 C (10) of the Code by failing to comply with provider contract requirements; § 38.2-5904 of the Code by misrepresenting the responsibilities of the Office of the Managed Care Ombudsman; 14 VAC 5-211-90 B, 14 VAC 5-211-160 (6), 14 VAC 5-211-160 (6) (b) (3), and 14 VAC 5-211-210 B (17) of the Commission's Rules by failing to comply with provisions related to health maintenance organizations; and 14 VAC 5-216-40 E, 14 VAC 5-216-40 E (1), 14 VAC 5-216-40 E (2), and 14 VAC 5-216-70 A (5) of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to comply with internal appeal and external review procedures.

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

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to

the Commission wherein the Defendant has tendered to Virginia the sum of One Hundred Two Thousand Dollars ($102,000) and waived its right to a hearing, agreed to the entry by the Commission of a cease and desist order, and agreed to comply with the Corrective Action Plan contained in the Market Conduct Examination Report as of June 30, 2013.

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

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

Accordingly, IT IS ORDERED THAT:

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

(2) The Defendant shall cease and desist from future violations of § 38.2-3407.4 B of the Code, and 14 VAC 5-211-90 B.

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

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to: Jeff Van Luyn, CHC, Director, Audit Readiness Legislative and Product Compliance, Regional Compliance Dept., 2101 East Jefferson Street, Rockville, Maryland 20852; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie S. Blauvelt.

A True Copy
Teste: Joel H. Peck
Clerk of the
State Corporation Commission