



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

DEAN HEALTH PLAN, INC
1277 DEMING WAY
MADISON WI 53717

dated May 26, 2010, and served upon the company on June 16, 2010, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 9th day of May, 2011.

Theodore K. Nickel

Commissioner of Insurance

**STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE**

MARKET CONDUCT EXAMINATION

OF

**DEAN HEALTH PLAN, INC
MADISON, WISCONSIN**

MAY 10, 2010 – MAY 26, 2010

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State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Sean Dilweg, Commissioner

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June 16, 2010

Honorable Sean Dilweg
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted May 10, 2010 to May 26, 2010 of:

DEAN HEALTH PLAN, INC.
Madison, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Dean Health Plan, Inc. (the company) was incorporated in 1983 and is a for-profit group model health maintenance organization (HMO) insurer. As a result of a merger in 1996, DHP is a wholly owned subsidiary of Dean Health Insurance Inc (formerly known as Premier Medical Group) which is 53% owned by Dean Health Systems and SSM Health Care, a St. Louis based order which owns St. Mary's Hospital and St. Claire Hospital in Baraboo. The company currently operates in 20 counties in southern Wisconsin excluding Milwaukee, Ozaukee and Sheboygan counties. The HMO offers individual, group and association policies, as well as, Medicare select, Medicare Cost and Medicare Part D plans. The company contracts

with the state of Wisconsin Department of Health Services BadgerCare program to provide coverage to Medicaid enrollees. It offers insurance products that include HMO, point of service (POS), preferred provider organization (PPO), and Dean Third Party Administrators (TPA) for self-funded groups. The company is licensed to write only in Wisconsin.

The majority of the premium written by the company in 2008 and 2009 was comprehensive health.

The following table summarizes the premium written and incurred losses in Wisconsin for 2008 and 2009 broken down by line of business.

2008				
Line Of Business	Net Premium Income	% of Total Premium	Net Losses Incurred	Medical Loss Ratio
Comprehensive	692,604,586	85.4%	646,764,205	93.4%
Medicare Supplement	19,849,499	2.4%	16,026,714	80.7%
Dental Only	0	0.0%	0	0.0%
Vision Only	0	0.0%	0	0.0%
All Other Health(FHPP, Medicaid)	98,831,182	12.2%	97,782,813	98.9%
Life and P&C	0	0.0%	0	0.0%
Total	811,285,267		760,573,732	93.7%

2009				
Line Of Business	Net Premium Income	% of Total Premium	Net Losses Incurred	Medical Loss Ratio
Comprehensive	737,370,484	78.6%	679,244,560	92.1%
Medicare Supplement	20,446,156	2.2%	16,179,129	79.1%
Dental Only	0	0.0%	0	0.0%
Vision Only	0	0.0%	0	0.0%
All Other Health (FHPP, Medicaid)	180,528,130	19.2%	177,738,226	98.5%
Life and P&C	0	0.0%	0	0.0%
Total	938,344,770		873,161,915	93.1%

Complaints

The Office of the Commissioner of Insurance received 162 complaints against the company between January 1, 2008 through March 31, 2010. A complaint is defined as 'a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent.' The majority of complaints involved claim handling which included issues with medical necessity, exclusions, referrals, coordination of benefits and pre-

existing conditions. The company was not listed on the above average complaint list published by the OCI for 2008. It was listed as 10th on the above average complaint list for individual health insurance for 2009.

The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

2008												
Reason Type Coverage Type	Total		Underwriting		Marketing & Sales		Claims		Plychldr Service		Other	
	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Indiv A & H	2	2.90%		%		%		%	2	25%		%
Group A & H		%		%		%		%		%		%
HMO	63	91.30%	3	100%		%	53	94.64%	5	62.50%	2	100%
PPO	3	4.35%		%		%	2	3.57%	1	12.50%		%
All Others	1	1.45%		%		%	1	1.79%		%		%
Total	69	100%	3	100%			56	100%	8	100%	2	100%

2009												
Reason Type Coverage Type	Total		Underwriting		Marketing & Sales		Claims		Plychldr Service		Other	
	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Indiv A & H	1	1.33%	1	6.67%		%		%		%		%
Group A & H	1	1.33%		%		%		%	1	16.67%		%
HMO	71	94.67%	13	86.67%		%	52	98.11%	5	83.33%	1	100%
PPO	2	2.67%	1	6.67%		%	1	1.89%		%		%
All Others		%		%		%		%		%		%
Total	75	100%	15	100%			53	100%	6	100%	1	100%

2010.												
Reason Type Coverage Type	Total		Underwriting		Marketing & Sales		Claims		Plychldr Service		Other	
	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Indiv A & H		%		%		%		%		%		%
Group A & H	1	5.5%		%		%	1	14.2%		%		%
HMO	17	94.4%	4	100%	1	100%	6	85.7%	6	100%		%
PPO		%		%		%		%		%		%
All Others		%		%		%		%		%		%
Total	18	100%	4	100%	1	100%	7	100%	6	100%		

Grievances

The company submitted annual grievance experience reports to OCI for 2008 and 2009 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as, "any

dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan, or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured.”

The grievance report for 2008 indicated the company received 485 grievances, 205 or 42% were reversed. The majority of the grievances filed with the company in 2008 were related to benefit denial, prior authorization and plan administration.

The grievance report for 2009 indicated the company received 320 grievances. The majority of the grievances filed with the company in 2009 involved prior authorization, not covered benefit and plan administration.

Category	2009	2008
Access to Care	1	1
Drug and Drug Formulary	22	20
Continuity of Care	1	2
Emergency Services	0	2
Experimental Treatment	16	6
Prior authorization	64	99
Noncovered Benefit	61	120
Not Medically Necessary	38	40
Plan Providers	0	11
Plan Administration	59	94
Request for Referral	58	86
Other	0	4
Total	320	485

Independent Review Organizations

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the OCI annual reports for the prior calendar year’s experience indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent review include adverse and experimental treatment determinations. The IRO reports indicate that for 2008 the company had eight IRO requests filed and for 2009 the company had nine IRO requests filed involving the company.

The following tables summarize the IRO review requests for the company for the last two years:

2009									
Total Review Requests Received	IPRO	Maximus -CHDR	MCMC	Medical Inst. Of America	National Medical Reviews	Permedion	Prest	Upheld	Reversed
9	0	2	1	2	0	3	1	7	2
2008									
8	1	2	1	1	0	3	0	4	4

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine compliance with recommendations made in the previous market conduct examination dated January 2004 and to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2008 through March 31, 2010 for individual and group health and Medicare Select products. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to, a review of the company's operations in the areas of claims; electronic commerce; marketing, sales and advertising; underwriting and new business; policy forms; grievances and IRO; managed care; small employer; policyholder service and complaints; privacy; producer licensing and company operations and management.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted January 28, 2004, contained eight recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Electronic Commerce

1. It is recommended that DHP develop and implement a process for ensuring that the provider directories available on its website are current and do not include providers whose contracts have been terminated.

Action: Compliance

2. It is recommended that DHP develop and implement a procedure for monitoring agent websites to ensure that all advertisements are included in the company's advertising file, as required by s. Ins 3.27, Wis. Adm. Code

Action: Compliance

Managed Care

3. It is recommended that DHP annually submit to the OCI the certification of its access standards as required by s. Ins 9.34 (1), Wis. Adm. Code.

Action: Compliance

Producer Licensing

4. It is recommended that DHP develop and implement procedures, including reconciling the annual billing statement from OCI, for maintaining accurate and current information on its agent database that corresponds with the OCI listing information in order to document compliance with s. Ins 6.57, Wis. Adm. Code.

Action: Compliance

5. It is again recommended that DHP maintain documentation in its agency files that agents whose listing are terminated receive written notice of termination including a request for return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

Action: Non-compliance

Rates and Forms

6. It is recommended that DHP ensure that it maintains documentation that all forms are filed with and approved by the OCI prior to use, in order to comply with s. 631.20 (1), Wis. State.

Action: Non-compliance

Company Operations and Management

7. It is recommended that DHP ensure its provider contracts and provider manuals contain grievance language that is compliant with s. Ins 18.03 (2) (c) 1a, Wis. Adm. Code.

Action: Compliance

8. It is again recommended that DHP institute procedures to ensure that it is in compliance with prior examination report recommendations and submit these procedures to OCI within 60 days of the adoption of this examination report.

Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to the OCI claim interrogatory, its claim administration processes and procedures, explanation of benefit (EOB) and remittance advice (RA) forms, claim adjustment (ANSI) codes, and claim methodology. The company paid its network providers on a capitation basis. For out of network providers, the company used the services of Multiplan, Inc. to reprice claims or to negotiate a fee reduction if no agreement existed with the provider and Multiplan. If no agreement existed, the company paid the claim based on the CMS Resource Based Relative Value System (RBRVS). The company utilized the services of Navitus as its pharmacy vendor.

The examiners reviewed the company's processes and procedures for paying the new Wisconsin health mandates, including autism, cochlear implants, licensed mental health professionals, and dependents to age 27. The examiners also reviewed a random sample of 25 claims for the new mandates. No exceptions were noted.

The examiners reviewed a random sample of 50 paid and 50 denied individual and group claims. The review included documenting that claims were paid timely, that interest was paid on delayed claims and that payment was correctly calculated. No exceptions were noted.

Privacy

The examiners reviewed the company's response to the OCI privacy of consumer financial and health information interrogatory, its privacy policies and procedures manual; privacy notices, and HIPAA training DVD.

The examiners found that the company had developed a privacy program, including oversight by the board of directors and executive staff. It had appointed a privacy officer who was responsible for developing the privacy policy and reports directly to the corporate compliance officer. The privacy officer also was a member of the company's committee on

access, privacy and security, which was responsible for the oversight of privacy and security of protected health information maintained in an electronic format.

The examiners documented that the company had a process for orientation of new employees to its privacy and confidentiality process and that it had a formal, scheduled training program for existing employees. The company required its employees to sign a confidentiality agreement annually. DHP also required that its agents sign a business associate agreement regarding the confidentiality of medical and personal information.

The examiners requested the company provide a list of internal or external privacy audits conducted during the period of review. The company conducted internal audits of compliance with the HIPPA privacy rule in September, 2009, and in January, 2010, and contracted with a vendor that performed a security audit to validate security of externally accessible websites.

The examiners found that effective January 1, 2008, the company stopped using social security numbers as identifiers for its Medicare supplement business and began using random numbers.

The company provided a copy of its reporting process to the U.S. Department of Health and Human Services. The company stated that as a HIPAA-covered entity it had a reporting process in place for reporting breaches of unsecured protected health information (PHI) and it complied with all state and federal laws for reporting information breaches. No exceptions were noted regarding the company's compliance with s. 610.70, Wis. Stat., and ch. Ins 25, Wis. Adm. Code.

Underwriting & Rating

The examiner reviewed the company's response to the OCI new business underwriting and rating interrogatory, field sales underwriting guides and rating and underwriting

procedure manuals. The examiners documented that all individual rates used during the period of review were filed with the OCI within 30 days of use.

The examiners reviewed the company's termination provisions for its Medicare Select policies. The examiners found that the company's internal procedures did not match the language in its policy forms.. The procedure stated that coverage would terminate at the end of the month in which verbal or written notice had been received regardless if the member had proof of enrollment into another policy or not. The Medicare Select outline, form 3025-0509 filed May 4, 2009, stated that the company required written notification prior to the month in which the member wished to terminate (end) coverage. The company stated that the actual process in place allowed members to disenroll verbally or in writing. The request for termination was effective at the conclusion of the last day of the month in which the company received written or verbal notification.

1. **Recommendation:** It is recommended that the company revise its Medicare supplement outline of coverage termination language to reflect the company procedures.

The examiners reviewed a random sample of 25 issued individual applications. No exceptions were noted.

The examiners reviewed 25 declined individual applications to determine that the company complied with its underwriting standards, that the applications and policy forms were filed with the OCI and that the writing agents were licensed and appointed with the company.

The examiners reviewed 25 issued and 25 terminated Medicare supplement applications for completion and to ensure that Medicare beneficiaries within their open enrollment were not subjected to underwriting. The examiners found that five of the applications reviewed were not signed by the selling agent. Section Ins 3.39 (23) (a), (b) and (c), Wis. Adm. Code, provides that application forms for Medicare supplement coverage shall be signed by the applicant and agent. A copy of the notice signed by the applicant and the agent shall be provided to the applicant and an additional signed copy shall be retained by the issuer.

2. **Recommendation:** It is recommended that the company require that all applications and supplemental forms for Medicare supplement policies be signed by the agent to ensure compliance with s. Ins 3.39 (23) (a), (b) and (c), Wis. Adm. Code.

The examiners found that the company sent renewal notices to a closed block of individual health plan members that inferred that the new mandates of autism and hearing aid/cochlear implant would impact the premium rates effective with the member's renewal. A review of the actuarial memorandum submitted with the rate increase did not indicate that the increase was due to the new Wisconsin health mandates. The company stated that it mailed the notice to 768 members. It also stated that it would draft a new letter for use regarding all future rate increases to avoid further confusion.

Small Employer

The examiners reviewed the company's response to OCI small employer interrogatory, its field underwriting guide and underwriting manuals, rating methodology, new business rates, renewal processes, actuarial certifications and waiver and disclosure forms.

The examiners reviewed a random sample of 50 issued small employer group files to document compliance with s. Ins 8.44 (2), Wis. Adm. Code. Section Ins 8.44 (2) Wis. Adm. Code, provides that a small employer insurer notify employers at signing that if the employer employs less than 2 or more than 25 eligible employees during at least 50% of the number of weeks in any 12-month period, or moves the business enterprise outside of Wisconsin, the protections under ch. 635, Wis. Stat., will cease to apply on renewal. Section 635.11, Wis. Stat. requires that the form be provided prior to a sale. The examiners found that the solicitation disclosure form used by the company did not address all the requirements of s. Ins 8.44 (2), Wis. Adm. Code. The form did not provide notice to an employer that if the employer employs less than 2 or more than 25 eligible employees during at least 50% of the

number of weeks in any 12 month period, the protections under ch. 635, Wis. Stat. would cease to apply on renewal.

- 3. Recommendation:** It is recommended that the company revise its written notification to small employers when policies are issued to ensure compliance with s. Ins 8.44 (2), Wis. Adm. Code.

The examiners reviewed a random sample of 50 issued small employer groups. The examiners found 6 small employer groups whose employer applications were completed after January 1, 2010. The examiners asked the company to explain how question 36 in the employer application, which stated "our standard dependent termination, applied to all small employer groups, is end of year at age 19 for non full-time students and age 25 for full-time student", complied with s. 632.885, Wis. Stat., which changed dependent eligibility to age 27 effective January 1, 2010. The company responded that it had not updated the employer group application but would in the future. The company indicated that it began administering the over age dependent mandate internally as of January 1, 2010, and provided copies of internal procedures and external communications. The examiners found that the external communications provided were for existing policyholders and agents. The examiners were unable to document that a new employer applying for coverage would have knowledge of the new dependent mandate. Section 632.885, Wis. Stat., provides that every insurer that issues a disability insurance policy shall offer and provide coverage for an adult child of the applicant or insured as a dependent if the child satisfies all of the following criteria: the child is over age 17 but less than 27 years of age; is not married and is not eligible under a group health benefit plan that is offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent.

- 4. Recommendation:** It is recommended that the company update and refile its Employer Group Application to ensure compliance with s. 632.885, Wis. Stat.

The examiners reviewed a random sample of 25 small employer quotes to document the timely processing of quotes. No exceptions were noted.

Producer Licensing

The examiners reviewed the company's response to OCI producer licensing interrogatory, agency agreements, agent listing and termination procedures.

The examiners reviewed the company's agency agreement and agent appointment contract. The company contracted with insurance agencies and did not independently contract with individual agents. The insurance agency submitted their agent contracts to the company sales and retention department for appointment processing.

The examiners reviewed a random sample of 25 issued agent files. No exceptions were noted.

The examiners requested the company provide documentation of compliance with the prior examination recommendation regarding developing and implementing procedures including reconciling the annual billing statement from OCI, for maintaining accurate and current information on its agent database that corresponds with the OCI listing information in order to document compliance with s. Ins 6.57, Wis. Adm. Code. The company provided a copy of the procedures it followed to reconcile the annual billing statement. The procedures stated that the annual OCI appointment listing would be fully reviewed and used to validate the company's agent appointment records. All reconciliations would be processed within 31 days of receipt of the appointment notice. The company provided a copy of the audit performed on the 2010 agent billing notice.

The examiners compared company active agent data to the OCI agent licensing database. The examiners found seven agents active in the company database but terminated in the OCI database, which included two from 2008; three from 2009 and two from 2010.

- 5. Recommendation:** It is recommended that the company develop a process to annually reconcile its agent database with OCI listing and termination confirmation notices to document compliance with s. Ins 6.57, Wis. Adm. Code.

The examiners reviewed a random sample of 25 agent termination files. The examiners found two files that did not include documentation that the company sent a termination letter to the agent within 15 days of termination or that the letter requested the return of indicia. The company indicated that it would update the agency agreement it used in 2010 to incorporate language to reflect the responsibility of the agency to notify it of agent terminations within 7 days. Section Ins. 6.57 (2), Wis. Adm. Code, states that notice of termination of appointment of an individual intermediary in accordance with s. 628.11, Wis. Stat., shall be filed prior to or within 30 calendar days of the termination date with the Office of the Commissioner of Insurance. In addition, prior to or within 15 days of filing this termination notice, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative. This notice should include a formal demand for the return of all indicia of agency. The "Termination Date" means the date on which the insurer effectively severs the agency relationships with its intermediary-agent and withdraws the agent's authority to represent the company in any capacity.

6. **Recommendation:** It is recommended that the company develop and implement a supervisory and oversight process by incorporating language in its agent/agency contracts to notify the company of termination to ensure compliance with s. Ins. 6.57 (2), Wis. Adm. Code.
7. **Recommendation:** It is again recommended that the company maintain documentation in its agency files that agents whose listing are terminated receive written notice of termination including a request for return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm.

Marketing, Sales & Advertising

The examiners reviewed the company's response to the OCI marketing, sales and advertising interrogatory, producer sales and training guides, and the company's advertising files. The examiners also interviewed the company's marketing director.

The company's sales department was responsible for working with agents through the quoting, underwriting/application and enrollment process. The company's Medicare sales

representatives reported to the government programs department. The company had two agents assigned to sell only company-sponsored Medicare products. The marketing communications department was responsible for developing marketing material, advertising, promotions, event planning and website marketing. The retention department was responsible for servicing existing members.

The examiners reviewed the on-site advertisement files. The examiners found that the company kept two sets of advertisements. One set was kept in the form of physical files maintained in a file cabinet and another set was stored electronically.

The examiners reviewed a random sample of 50 company advertisements. The company stated that it did not advertise its Medicare select plan during the period of review. The examiners found six advertisements did not contain a form number. The company indicated that the advertisements were for TV and radio and that it did not supply form numbers on commercials. Section Ins 3.27 (5) (a) 1, Wis. Adm. Code, provides that an advertisement relating to accident and sickness insurance for the purpose of this rule includes printed and published material, audio visual material and descriptive literature of an insurer used in newspapers, magazines, other periodicals, radio and TV scripts, the internet, web pages, electronic or computer presentations, billboards and similar displays. Section Ins 3.27 (26), Wis. Adm. Code, provides that an advertisement that is an invitation to apply or an invitation to inquire and which is mass-produced shall be identified by a form number. The form number shall be sufficient to distinguish it from any other advertising form or any policy, application or other form used by the insurer.

8. **Recommendation:** It is recommended that the company provide all advertisements with a form number as required by s Ins. 3.27 (26), Wis. Adm. Code.

Electronic-Commerce

The examiners reviewed the company's response to OCI electronic commerce interrogatory, the company's corporate website, and security process.

The company website had both secure and unsecure areas. The secure website area included sections for company employees, physicians, and employer groups. Consumers were able to print applications to apply for individual products from the website but could not complete the application on-line. Provider directories, drug formularies, sign-up for health classes and links to health reform information were available from the website. The site allowed a consumer to link to the Dean Health System (clinics) and Dean Health Foundation. Prior to 2010, the company did not advertise on other entities websites.

The examiners found that the company had a process and procedure for annually auditing insurance agency websites. The company reviewed all appointed and contracted agency websites. Any company information found on an agency website was reviewed to document it had been approved by the company. New information would be sent to the marketing communications manager for approval and documentation in the agency records.

The examiners found that the company's website contained an online provider directory. The examiners requested from the company a listing of those providers terminated within the last six months of the period of review. The company procedures indicate that additions and deletions of providers are done in the claim system and within 24 hours the changes are available for on-line viewing. The examiners compared 18 of the 66 terminated provider names to the company website. No exceptions were noted.

The examiners reviewed the company website to determine what providers were listed that treated autism. At the time of review, the examiners were unable to locate any autism providers listed in the on-line provider directory. The company did provide a list of autism providers in response to an interrogatory question.

Policy forms

The examiners reviewed the company's response to the policy forms interrogatory. The Legal/Compliance Department was responsible for rate and form filings. It also managed the company's regulatory compliance activities in implementing new state and federal health insurance legislation.

The examiners compared a listing provided by the company of the policy forms it marketed or that were in-force during the period of review with that maintained on the OCI's approved policy form database. The examiners found the company was unable to provide documentation that ten forms were filed and approved by the OCI. Section 631.20 Wis. Stat., provides that no form subject to s. 631.01 (1), except as exempted under par. (c), sub. (1g) or s. 631.01 (2) to (5) or by rule under par. (b), may be used unless it has been filed with and approved by the commissioner and unless the insurer certifies that the form complies with chs. 600 to 655 and rules promulgated under chs 600 to 655.

9. **Recommendation:** It is again recommended that the company ensure that it maintains documentation that all forms are filed with and approved by the OCI prior to use, in order to comply with s. 631.20 (1), Wis. Stat

The examiners reviewed the company's coding of products it submitted to the OCI utilizing SERFF (system for electronic rate and form filing), a web-based application that allows companies to submit electronically its policy form submissions. The company filed 133 documents during the period of review. Beginning July 1, 2008, s. 631.20, Wis. Stat., was amended to allow certain policy forms to be filed as "file and use" rather than on a prior approval basis. The examiners found that the company filed 66 forms that did not include accurate HMO product codes. The company included with its policy form filings certificates of compliance, as required by s. Ins 6.05, Wis. Adm. Code, and in which the company certified pursuant to s. 631.20 (1m) (a) 3, Wis. Stat., that the forms were in compliance with all applicable provisions of the Wisconsin insurance laws and regulations. After the on-site examination was completed,

the company provided a chart of the product codes it would use when filing its forms through SERFF.

10. Recommendation: It is recommended that the company develop and follow its process to ensure that when submitting policy forms to OCI pursuant to s. 631.20, Wis. Stat., it include correct product identification and coding of all policy forms.

The examiners asked the company to describe whether it received individual business electronically and to provide documentation that the electronic application was filed with the OCI. The company stated it did not accept electronic applications. The examiners found that the company did market its individual health product through a website called ehealth.com that allowed electronic applications to be completed. The electronic application reviewed by the examiners did not contain a policy form number. The company stated that the electronic applications were printed out and processed like a paper application. The company provided a copy of the form filing transmittal for paper application form number 1007-0410 filed April 13, 2010. The examiners did not find a record that the electronic application was filed with the OCI.

The examiners reviewed a random sample of 17 form filings submitted during the period of review to verify that the company had submitted to OCI and received approval of language in its policy and certificate forms of the requirements of Act 14 and Act 28. The examiners found that the company had filed language to comply with the mandates enacted during the period of review.

The examiners reviewed 10 policy certificate forms filed by the company from July 1, 2009 to March 31, 2010 for compliance with the amendment to s. 632.835 (3), Wis. Stat., that provided removal of the \$25 independent review organization (IRO) filing fee effective July 1, 2009. The examiners found the certificate forms still contained language requiring that a \$25 fee was payable to the IRO.

11. Recommendation: It is recommended that within 30 days of the adoption of this report, the company amend and refile with OCI the policy forms that are identified

in this report as not being in complete compliance with Wisconsin insurance laws and/or administrative rules, certifying, as required by s. 631.20 (1m) (a) 3., Wis. Stat., that the forms have been brought into compliance.

Policyholder Service & Complaints

The examiners reviewed the company's response to OCI's policyholder service and complaints interrogatory, its complaint handling policies and procedures, its complaint log and OCI complaints.

The company provided a list of complaints received during the period of review. The examiners noted that the list did not contain complaints received from the OCI. The examiners found that the company maintained two complaint systems. One was for complaints that were received through the company call center and the other system captured complaints received from the OCI, which were handled by the grievance and appeals department.

The company procedure for handling complaints stated that quality of care, service and access complaints would be investigated through the quality assurance (QA) process. QA staff notified the member within five business days that the complaint was received and would be investigated. Prior to January 1, 2010, complaints were investigated and responded to within 20 business days. Beginning January 1, 2010, for non QA related complaints, company procedures stated that a member would be notified by phone of the disposition of the complaint within 10 business days. The company conducted an internal audit of its complaints in mid-2009 to validate that the issue being noted in the complaint system was actually a complaint. The examiners found 44 complaints in the company data exceeded the completion timeframe required by company procedures.

- 12. Recommendation:** It is recommended that the company ensure that it follows its written procedures for handling a complaint.

The examiners reviewed a random sample of 50 complaints. The complaint sample did not include any complaints related to new Wisconsin health mandates or to federal mental health parity. No exceptions were noted.

Managed Care

The examiners reviewed the company's response to OCI's managed care interrogatory, policy forms, and policies and procedures regarding the company's plan administration, compliance program, quality assurance and improvement, access standards, credentialing and recredentialing. The examiners' review of the company's plan administration activities included review of its organization charts, board of director meeting minutes, medical director position description, provider directories and provider agreements. The company was credentialed with the National Committee for Quality Assurance (NCQA) and had achieved an excellent accreditation status in 2010 for the tenth consecutive year.

The examiners verified that the company's board of directors exercised oversight of the quality assurance and improvement aspects of its plans. The board of directors delegated authority for operating the medical management program to its quality improvement committee (QIC). The QIC met quarterly to assess clinical and administrative matters related to the care delivery. The QIC had four subcommittees to monitor care management activities (medical directors committee; credentialing committee, utilization management committee and medical peer review committee). The CMO (Care Management Organization) was responsible for monitoring and implementing the medical management program and for assuring corrective action was taken when improvement opportunities were identified. The examiners found that the company's quality assurance standards met the requirements set forth in s. 609.32 (1), Wis. Stat.

The examiners verified that the company had a process for annually filing with the OCI its certification of preferred provider plans, certification of managed care plans, quality assurance plan and certification of access standards.

The examiners reviewed the company's credentialing and recredentialing activities, including its credentialing and recredentialing policies and procedures, and committee minutes. The examiners verified that the company had a process for reporting disciplinary actions taken against a participating provider. No exceptions were noted.

The examiners reviewed the company's access standards. The board of directors assigned oversight of its access standards to its QIC committee. The examiners verified that the company had a process in place for updating its provider list on an ongoing basis and for disseminating the list to its members. The examiners found that the company submitted a certification of access standards report for plan years 2008 and 2009, as required by s. Ins 9.34, Wis. Adm. Code, to show compliance with s. 609.22, Wis. Stat.

The examiners reviewed the company's standard provider agreement templates. The examiners reviewed the company's contracting process for licensed mental health professionals under s. 632.89, Wis. Stat., as amended 2009. The examiners also reviewed the company's process for contracting with providers of autism spectrum services to ensure compliance with s. 632.895 (12m), Wis. Stat. No exceptions were not regarding the company's provider contracting and credentialing process.

Grievance and IRO

The examiners reviewed the company's response to the grievance and independent review interrogatory; its grievance procedures, annual grievance experience reports for 2008 and 2009, company explanation of benefits (EOB) and remittance advice (RA) forms and its procedures for handling independent review requests from Wisconsin insured's.

Grievance

The examiners reviewed the company's member complaint and appeal procedure (RR2500-C). The examiners found that the member rights and responsibilities section of the document stated that members had 180 days after notification of a denial to file a grievance. The company's customer service complaints and grievances tool included a time filing limit of 180 days from the date of the denial. The company's explanation of benefits provided to insured's also included reference to the 180 day time filing limit. Section Ins 18.03, Wis. Stat., does not provide for a time filing limit for filing a grievance.

- 13. Recommendation:** It is recommended that the company revise its member complaint and appeal procedure, its customer service complaints and grievance tool and its explanation of benefits forms to remove the 180 day time limit to file a grievance to be in compliance with s. Ins. 18.03 (1), Wis. Adm. Code.

The examiners compared the company's grievance data with the grievance reports it filed as required by s. Ins 18.06 (2), Wis. Adm. Code. The examiners found that the information it provided in its annual grievance reports for the period of review did not match the information provided as part of the examination data call. The company reported 320 grievances in its 2009 grievance report. The company data indicated 291 grievances for 2009. The company reported 485 grievances in its 2008 grievance report. The company data indicated 451 grievances for 2008. The company explained that the annual grievance reports contained grievances for group health, individual health, Medicare supplement, Medicare Cost and Medicaid. The examiners found that the annual grievance reports were not accurate because the company should not have included Medicaid grievances as they do not meet the definition of a health benefit plan as defined by s. 632.83, Wis. Stat. Section Ins 18.06 (2), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall submit a grievance experience report required by s. 632.83 (2) (c), Wis. Stat. to the OCI by March 1, of each year.

- 14. Recommendation:** It is recommended that the company create a process to ensure that it only file grievances involving health benefit plans in its annual grievance report to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.

The examiners reviewed the company grievance data for compliance with s. Ins 18.03 (4), Wis. Adm. Code, which provides that an acknowledgment letter be sent within five business days of receipt of the grievance. The examiners found that 113 of the 812 company's grievance records showed the acknowledgement letter was sent more than 5 business days or 7 calendar days after receipt. Section Ins 18.03 (4), Wis. Adm. Code, provides that an acknowledgement to a grievance will be delivered within 5 business days of receipt of the grievance.

15. Recommendation: It is recommended that the company follow its procedures and send acknowledgement letters to a grievant within 5 business days of receipt to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.

Independent Review

The examiners reviewed the company's informational material provided to members regarding the IRO process, including notices in the denial letters, expedited review procedures and grievance resolution letter. The examiners also reviewed the company's procedures for providing all documentation to an IRO when the company received an IRO review request.

The examiners reviewed the company's member complaint and appeal procedure (RR2500). Item number 25 in the document stated "If the (IRO) request exceeds the four month limitation time frame, the member's fee will be returned along with a letter of explanation." The examiners found that this language was not compliant with the July 2009 amendment to s. 632.835 (3), Wis. Stat., that eliminated the requirement that insured's requesting independent review pay a \$25 filing fee.

The examiners reviewed the company's nine IRO files for 2009 and four IRO files for 2010. The examiners found that three files indicated that enrollees had paid the \$25 IRO fee after July 2009 when the fee was eliminated, but did not include documentation that the fee was refunded. The examiners also found one file indicated that the notice to the independent review organization selected by the insured or authorized representative was not sent within two business days of receipt as required by s. Ins 18.11 (3) (a), Wis. Adm. Code.

Prior to the adoption of this report, the company conducted an audit of the \$25 IRO collection fees that were eliminated as of July 2009 and provided a copy of the audit results to the OCI. The company ensured that all language for collecting the \$25 had been removed and any fees collected had been refunded.

16. Recommendation: It is recommended that the company conduct an audit to ensure that it has refunded the \$25 IRO fees paid by its enrollees after July 1, 2009, and report the results of its audit to the OCI within 60 days of the adoption of the examination report to document compliance with s. 632.835 (3), Wis. Stat.

17. Recommendation: It is recommended that the company revise its member complaint and appeal procedure form RR2500 and remove the language regarding the IRO fee in order to document compliance with s. 632.835 (3), Wis. Stat.

Company Operations and Management

The examiners reviewed the company's response to the company operations and management interrogatory, network agreements, audit reports, board of director minutes and compliance program.

The examiners found that the company lost two key staff members in the corporate compliance area in 2009, and as a result, company planned audits were not completed. The examiners found that the company had focused during the period of review on audits on its government business and not its HMO business. The examiners found that the company had not exercised during the period of review compliance oversight of its policy form filing process. The examiners also found that the company did not document that it exercised oversight over the insurance agencies to which it delegated responsibility for agent appointments.

18. Recommendation: It is recommended that the company include as part of its compliance program a compliance plan for reviewing its policy form filing process and agent appointment process.

V. CONCLUSION

This market conduct examination involved a targeted market conduct examination of Dean Health Plan, Inc. practices and procedures for the period January 1, 2008 to March 31, 2010. The examiners found that the company did not comply with two of the eight recommendations from the market conduct examination that was adopted in 2004. This compliance examination resulted in 18 additional recommendations in the areas of, underwriting and rating, small employer, producer licensing, marketing, sales and advertising, policy forms, policyholder services and complaints, grievance and IRO.

VI. SUMMARY OF RECOMMENDATIONS

Underwriting and Rating

Page 11 1. It is recommended that the company revise its Medicare supplement outline of coverage termination language to reflect the company procedures.

Page 12 2. It is recommended that the company require that all applications and supplemental forms for Medicare supplement policies be signed by the agent to ensure compliance with s. Ins 3.39 (23) (a) (b) and (c), Wis. Adm. Code.

Small Employer

Page 13 3. It is recommended that the company revise its written notification to small employers when policies are issued to ensure compliance with s. Ins 8.44 (2), Wis. Adm. Code.

Page 13 4. It is recommended that the company update and refile its Employer Group Application to ensure compliance with s. 632.885, Wis. Stat

Producer Licensing

Page 14 5. It is recommended that the company develop and implement a process to annually reconcile its agent database with the OCI listing and termination confirmation notices in order to document compliance with s. Ins 6.57, Wis. Adm. Code.

Page 15 6. It is recommended that the company develop and implement a supervisory and oversight process by incorporating language in its agent/agency contracts to notify the company of termination to ensure compliance with s. Ins. 6.57 (2) Wis. Adm. Code.

Page 15 7. It is again recommended that the company maintain documentation in its agency files that agents whose listing are terminated receive written notice of termination including a request for return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

Marketing, Sales and Advertising

Page 16 8. It is recommended that the company provide all advertisements with a form number as required by s Ins. 3.27 (26), Wis. Adm. Code.

Policy Forms

- Page 18 9. It is again recommended that the company ensure that it maintains documentation that all forms are filed with and approved by the OCI prior to use, in order to comply with s. 631.20 (1), Wis. Stat.
- Page 19 10. It is recommended that the company develop written procedures and implement a process to ensure that when submitting policy forms to OCI pursuant to s. 631.20, Wis. Stat., it include correct product identification and coding of all policy forms.
- Page 19 11. It is recommended that within 30 days of the adoption of this report, the company amend and refile with OCI all policy forms that are identified in this report as not being in complete compliance with Wisconsin insurance laws and/or administrative rules, certifying, as required by s.631.20 (1m) (a) 3., Wis. Stat., that the forms have been brought into compliance.

Policyholder Service and Complaints

- Page 20 12. It is recommended that the company ensure that it follows its written procedures for handling a complaint.

Grievance and IRO

- Page 23 13. It is recommended that the company revise its member complaint and appeal procedure, its customer service complaints and grievance tool and the explanation of benefits forms to remove the 180 day time limit to file a grievance to be in compliance with s. Ins. 18.03 (1), Wis. Adm. Code.
- Page 23 14. It is recommended that the company create a process to ensure that it only file grievances involving health benefit plans in its annual grievance report to ensure compliance with s. Ins 18.06 (2), Wis. Adm. Code.
- Page 24 15. It is recommended that the company follow its procedures and send acknowledgement letters to a grievant within 5 business days of receipt to ensure compliance with s. Ins 18.03 (4), Wis. Adm. Code.
- Page 25 16. It is recommended that the company conduct an audit to ensure that it has refunded the \$25 IRO fees paid by its enrollees after July 1, 2009, and report the results of its audit to the OCI within 60 days of the adoption of the examination report to document compliance with s. 632.835 (3) Wis. Stat.
- Page 25 17. It is recommended that the company revise its member complaint and appeal procedure form RR2500 and remove the language regarding the IRO fee in order to document compliance with s. 632.835 (3), Wis. Stat.
- Page 25 18. It is recommended that the company include as part of its compliance program a compliance plan for reviewing its policy form filing process and agent appointment process.

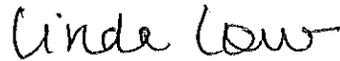
VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

<u>Name</u>	<u>Title</u>
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Bill Genne	Advanced Insurance Examiner
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Respectfully submitted,



Linda Low
Examiner-in-Charge