



State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott McCallum, Governor
Connie L. O'Connell, Commissioner

Wisconsin.gov

121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
Web Address: oci.wi.gov

Notice of Adoption and Filing of Examination Report

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

Wisconsin Physicians Service Insurance Corporation
1717 West Broadway
Madison WI 53713

dated July 9-23, 2001, and served upon the company on April 15, 2002, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Date at Madison, Wisconsin, this 25th day of October, 2002.

Connie L. O'Connell
Commissioner of Insurance

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

**MARKET CONDUCT EXAMINATION
OF**

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

MADISON, WISCONSIN

JULY 9 - 23, 2001

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Bureau of Market Regulation
121 East Wilson Street • P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-3585 • (800) 236-8517
Fax: (608) 264-8115
E-Mail: marketreg@oci.state.wi.us
Web Address: oci.wi.gov

July 23, 2001

Honorable Connie O'Connell
Commissioner of Insurance
121 East Wilson Street
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was made July 9-23, 2001 of Wisconsin Physicians Service Insurance Corporation, 1717 West Broadway, Madison, WI 53708. The report of this examination is herein respectfully submitted:

I. INTRODUCTION

Wisconsin Physicians Service, a Division of the State Medical Society, was created in 1946 under the authority of Chapter 148, Wis. Stat. With the enactment of Chapter 163, Wis. Stat., Wisconsin Physicians Service Insurance Corporation (WPS), a non-profit service insurance corporation was incorporated on April 27, 1977, as the successor organization to Wisconsin Physicians Service, and commenced business the same day.

WPS issues traditional indemnity and managed care policies and provides claims administrative services for self-funded employers and governmental agencies. WPS writes direct premium in Wisconsin only, and assumes business written in other states by its subsidiary, The EPIC Life Insurance Company through quota-share reinsurance agreements. WPS also assumes business from three external insurance companies.

WPS provides claims administrative services for Medicare Part B of Wisconsin, Illinois and Michigan programs, Medicare Part A of the Michigan program, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) now known as TRICARE. In September 2000, the company added Medicare Part B for Minnesota.

WPS has two wholly owned subsidiaries: The EPIC Life Insurance Company, a stock corporation whose primary business is group life, accident and health, and disability insurance; and Administrative and Technical Service Inc., a stock corporation specializing in providing office and light industrial temporary personnel and contract programming services.

In 2000 WPS ranked as the third largest writer of individual health and accident insurance in Wisconsin. In addition, the company ranked as the eleventh largest writer of group accident and health insurance. The total direct Wisconsin premium in 1996 through 2000 for all lines of business is summarized in Table A.

Table A: Five Year Premium and Loss Ratio Summary (000's omitted)

Year	Premiums Earned	Claims Incurred	Loss Ratio
2000	\$217,496	\$185,340	85.22
1999	\$197,783	\$162,423	82.12%
1998	\$245,400	\$207,551	84.58%
1997	\$311,890	\$281,431	90.23%
1996	\$333,418	\$296,568	88.95%

II. PURPOSE AND SCOPE

A targeted examination of Wisconsin Physicians Service Insurance Corporation (WPS) was conducted July 9 through July 23, 2001. The scope of the examination was limited to a review of the following company practices and procedures for the period January 2000 through April 1, 2001:

- Advertising
- Claims
- Complaints and Policyholder Services
- Grievances
- Managed Care Compliance
- Producer Records
- New Business-Health, Large Group
- New Business-Health, Small Group
- New Business-Health, Individual and Medicare Supplement
- Policy Forms

The company was ranked 20th on the OCI above-average complaint list in 2000 for group accident and health insurance, with a complaint ratio of .08 compared to the average of .05 complaints/\$100,000 of written premium for all group accident and health companies in the state. OCI complaints for the company for 1998, 1999 and the first quarter of 2000 are summarized in Table B:

Table B: Summary of Complaints

1/1/00 -3/6/00 Complaints	No. of Complaints Received		Complaint Summary By Reasons									
			Underwriting		Marketing & Sales		Claims		Policyholder Service		Other	
			No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Coverage	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Individual A&H	5	11.90%	3	42.86%	-	-	-	0.00%	-	-	-	-
Group A&H	33	78.57%	4	57.14%	-	-	36	97.30%	4	80.00%	-	-
All Others	4	9.52%	-	-	-	-	1	2.70%	1	20.00%	-	-
Total	42		7	14.29%			37	75.51%	5	10.20%		

1999 Complaints	No. of Complaints Received		Complaint Summary By Reasons									
			Underwriting		Marketing & Sales		Claims		Policyholder Service		Other	
			No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Coverage	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Individual A&H	50	21.19%	12	38.71%	5	100%	27	12.92%	6	33.33%	1	16.67%
Group A&H	121	51.27%	18	58.06%	-	-	96	45.93%	10	55.56%	5	83.33%
All Others	65	27.54%	1	3.23%	-	-	86	41.15%	2	11.11%	-	-
Total	236		31	11.52%	5	1.86%	209	77.70%	18	6.69%	6	2.23%

1998 Complaints	No. of Complaints Received		Complaint Summary By Reasons									
			Underwriting		Marketing & Sales		Claims		Policyholder Service		Other	
			No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Coverage	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total	No.	% of Total
Individual A&H	50	20.41%	7	20.00%	5	83.33%	2	0.95%	2	11.11%	-	-
Group A&H	139	56.73%	28	80.00%	-	-	174	82.46%	12	66.67%	5	62.50%
All Others	56	22.86%	-	-	1	16.67%	35	16.59%	4	22.22%	3	37.50%
Total	245		35	12.59%	6	2.16%	211	75.90%	18	6.47%	8	2.88%

OCI received a total of 215 complaints against the company for the year 2000 which was a decrease of 19 complaints from 1999. OCI had received 99 complaints against the company as of the end of April 2001. WPS reported 169 grievances in its annual grievance report to OCI for the year 2000 for its HMO and PPP products. The company received 90 grievances in the first 4 months of 2001.

II. ADVERTISING

The marketing, sales, and advertising functions are divided between the Marketing Services Department which is responsible for marketing strategies and research, the Corporate Communications Department which is responsible for advertising and sales materials, and the Sales Department which is responsible for all group and individual sales.

Leads for sales of the company's products are obtained from a combination of direct response mailings, independent agents, telephone and in-person contact, inquiries to the company's website and various kinds of advertising. Multiple weekly reports are generated by the Sales Department for use by management in monitoring trends and activity in sales.

Advertisements are developed and designed by the Corporate Communications Department. Most of the company's print and radio advertising is of an institutional nature with product specific advertising limited to brochures. The company maintains both hard copy and electronic files for all advertising and collateral sales materials. Each advertisement is assigned a form number. The form number, type of advertisement, name of publication, date published, cost, electronic file location and advertisement specifications are then entered into a database. Only the current year's advertisements are kept in an active advertising file and previous years are stored on disk and maintained for a period of seven years. The company also maintains binders, which contain advertising tear sheets and invoices for all advertisements for the current year. These binders are kept for a period of five years.

Advertisements for the company's Medicare supplement product are forwarded to Legal Services for review and filing with OCI. The company has written procedures, which prohibits the publication of Medicare supplement advertisements prior to filing them with OCI.

The company also maintains a website designed to provide customers with general product information. The web site pages devoted to individual products give the option of requesting a quote either electronically by completing and submitting a form or contacting a WPS representative at a toll-free number. Rate information on some individual products is also available on-line. Applications for individual products are available on-line, but the company does not accept completed applications electronically. The company does not strictly prohibit advertising by agents on personal websites and encourages agents interested in website advertising to use a link to the WPS homepage as an

alternative. The company requires that all Internet advertising materials used by agents as well as the site address where the advertisement will appear must be submitted to Corporate Communications for approval before use.

The company does not have any current plans to expand its marketing efforts via electronic commerce.

The examiners reviewed the company's advertising procedures, website, and a sample of 50 advertisements. The following exceptions were noted:

- A print advertisement identified as "Dream" and referenced as Item 16 on the examiners advertising spreadsheet contained a statistic related to customer satisfaction and did not reference the source of the statistic as required by s. Ins 3.27 (20) Wis. Adm. Code.
 - The company does not currently maintain hard copy screen prints of its website information in the advertising file as required by s. Ins 3.27 (28) Wis. Adm. Code.
1. It is recommended that the company revise its advertising procedures to ensure it includes the source of the statistic used in an advertisement, as required by s. Ins 3.27 (20) Wis. Adm. Code.
 2. It is recommended that the company maintain hard copy screen prints of its most current website pages in its advertising file, as required by s. Ins 3.27 (28) Wis. Adm. Code

IV. CLAIMS

All claims are processed at the company's Madison corporate office. Paper and electronic claims are either manually entered or scanned into the automated claim system within one day of receipt. The claim preparation process includes sorting claims by claim input type (OCR scanning or manual entry), sorting claims by claim type, imaging each claim and related documentation, assignment of a control number which indicates the date of receipt, and forwarding the claims to the Claims Department to enter additional information on-line into the automated processing system and adjudicate the claim.

The automated system checks for patient eligibility, pre-existing conditions within the waiting period, coordination of benefits information, potential workers compensation and subrogation cases, verifies correct statistical coding, determines available benefits, prices the claim, calculates deductibles and coinsurance, and determines medical necessity/cost containment based on a predetermined set of guidelines. Once the automated process is complete, the on-line system allows claims processors various options including paying, denying or pending the claim. The final step in the process is the generation of an explanation of benefits form (EOB) and check if payment is made. The company estimates that claims are processed on average within 14 days of receipt.

When determining the reasonable charge for a specific treatment service or supply, the company uses a reasonable allowance fee profile based on dental or medical claims data gathered by the company from similar health care providers for the same type of treatment, service or supply. Claim reimbursement levels are based on the 80th percentile of charges submitted by health care providers within the regional areas where the procedure was performed. The claims data is updated every six months. The company collects twelve months of claim charge data from all health care providers submitting claims and sorts the claim charges into seven regions within the state.

Eleven different reports are generated by the Claims Department on a daily, weekly and monthly basis to assist management in monitoring the efficiency of the claims process.

The examiners reviewed the company's claim procedures; Explanation of Benefits (EOB) forms, Remittance Advice (RA) forms and a sample of 100 denied and 100 paid claims. The following exceptions were noted:

- The EOB the company uses for its managed care products has language that requires the insured to file a grievance within 60 days of receiving the EOB in violation of s. Ins 9.33 (2) Wis. Adm. Code.
 - The examiners reviewed a sample of 100 paid claims. Two of these claims were not paid within 30 days and interest should have been paid as required by s. 628.46 Wis. Stat.
3. It is recommended that the company revise the EOB used for its managed care plans to comply with s. Ins 9.33 (2) Wis. Adm. Code, by deleting the time limit allowed to file a grievance.
 4. It is recommended that WPS improve its claims handling procedures to better ensure the identification of claims subject to payment of interest and promptly pay interest as required by s. 628.46 Wis. Stat.

V. COMPLAINTS & POLICYHOLDER SERVICES

The company has a Member Services Department divided into three areas, Customer Service, Administrative Systems, Support, Testing and Reporting, and Administrative Operations. The Customer Service Area oversees the call center and responds to customer and provider inquiries regarding benefits, claims and eligibility requirements. The Administrative Systems, Support, Testing and Reporting area tests systems for accuracy and appropriate information and generates reports for in-house and customer use. The Administrative Operations area is responsible for enrolling all clients and premium billing.

Member Service representatives typically handle telephone customer inquiries regarding benefits and claims processing decisions. The customers' concerns are documented by the representative and reviewed with a supervisor. If the customer is dissatisfied with the review findings, they are provided with information on how to file a grievance. The company maintains recordings of all calls to the Call Center. The tapes are labeled, coded and filed. Additionally, as the representative is taking the call, the contents of the conversation are documented in writing electronically for future reference.

Complaints referred from OCI are recorded and logged in two separate log forms. The first complaint log is created and maintained by the company's Legal Services Department for tracking purposes only. This log is used to create an annual complaint report that is distributed to the Regulatory Services Department, the Board of Directors and individual operational departments within the company.

OCI complaints are reviewed by the Legal Department and investigated by Senior Coordinators in the Regulatory Services Department.

The second complaint log is a working log established and maintained by the Regulatory Services Department and shows the date received, the date resolved and other identifying information. Monthly reports are generated based on this log to show complaint activity and resolution.

The Member Services Department no longer generates paper activity reports. It uses imaging to create electronic versions of all documents received, and the system records activity on-line from which regular system reports are generated.

The examiners reviewed the company's procedures in the area of Policyholder Services and Complaints, representative complaint log samples, and a sample of 25 OCI complaints. No exceptions were noted.

VI. GRIEVANCES

The company recorded 169 grievances in its annual grievance report to OCI for the year 2000, and received 90 grievances in the first four months of 2001. The examiners noted that 36% of the grievances received in 2000 were fully or partially resolved in the grievant's favor. Of the grievances received in the first 4 months of 2001, 43% were resolved fully or partially in favor of the grievant.

The WPS Claims Department is responsible for overseeing the grievance process. A synopsis of each grievance is prepared and presented to Grievance Committee members one week prior to the grievance meeting. A grievance specialist presents grievances to the Committee. Grievance Committee members include the Supervisor of the Appeals/Grievance area, the Director of WPS Operations, the Director of Regulatory Services, the Director of Medical Review, the Director of Underwriting, the Director of InsurTec Operations, and an enrollee member. Additionally, the Committee has a legal advisor, a provider reimbursement advisor, a medical advisor and a chiropractic advisor.

WPS's written grievance procedures describe a three-tier grievance procedure for its managed care products - Initial Review, Informal Grievance Review and Grievance Level Review.

At the Initial Review Level, the grievance is acknowledged within 5 days and a Customer Service Representative reviews the grievance. If a medical issue is involved, an opinion is obtained from the Health Services Review Department. If the issue is not resolved in the grievant's favor, a letter is sent to the grievant advising them of their right to file a "formal grievance" within 60 days and provides the address of the WPS Grievance Panel.

At the Informal Grievance Review Level, the grievance is acknowledged within 5 days and a Customer Service Representative reviews the grievance. If the grievance is not resolved at this level, it is referred to the Grievance Committee for hearing. If a medical issue is involved, the Medical Director also reviews the grievance.

Although the written procedures describe a third-level procedure which is the Grievance Review Level, company representatives informed the examiners that in practice there only 2 levels of review and the Initial Review and Grievance Review Level are one in the same.

The examiners reviewed the company's written grievance procedures, letters, grievance logs, Annual Grievance reports filed with OCI, provider contracts, and a sample of 50 grievances. The following exceptions were noted:

- Although the procedures and notification letters used for the handling of grievances at the Informal Grievance Review Level and Grievance Review Level comply with the requirements of s. Ins 9.33 Wis. Adm. Code, the examiners determined that grievances processed at the Initial Review Level are not counted or handled as grievances per the requirements of s. Ins 9.33 Wis. Adm. Code. At this first level, if the issue is resolved in favor of the grievant, it is not counted as a grievance. If the issue is not resolved in favor of the grievant, the grievant is effectively required to submit a second grievance within 60 days to take full advantage of their grievance rights under s. Ins 9.33 Wis. Adm. Code.
- The company's grievance procedures do not include a definition of "complaint" consistent with the definition in s. Ins 9.01 (3) Wis. Adm. Code.
- The company's grievance procedures do not include a procedure for the handling of expedited grievances per the requirements of s. Ins 9.33 (6) Wis. Adm. Code.
- Two grievance files in the sample of 50 had receipt dates that differed from the receipt dates in the company's Grievance Log and thirteen grievance files had a resolution date that differed from the resolution dates in the company's Grievance Log.
- One grievance file in the sample of 50 did not contain the acknowledgment letter required by s. Ins 9.33 (3) Wis. Adm. Code or the notification of the Grievance Committee meeting as required by s. Ins 9.33 (5) (b) Wis. Adm. Code.
- Five provider contracts were reviewed to include contracts for chiropractors, networks, hospitals, clinics and individual providers. The contracts do not have language that adequately satisfies the requirements of s. Ins 9.33 (7) (b) Wis. Adm. Code that requires providers to identify complaints and grievances and forward them to the company in a timely manner for resolution.

- The provider contracts do not have language adequate to address the provider's obligation to continue seeing insureds after the termination of their contract with the company under certain circumstances as required by the continuity of care provisions of s. Ins 9.35 Wis. Adm. Code. Further discussion of this exception is included in this report's Managed Care Compliance section.
5. It is recommended that WPS revise its existing grievance procedures for its managed care plans to count and initially process as grievances any written expressions of dissatisfaction handled at the Initial Review Level whether the grievance is resolved in the grievant's favor or not, and eliminate the procedure which effectively requires a grievant to submit a second grievance within 60 days if the matter is not resolved in the grievant's favor at the Initial Review Level.
 6. It is recommended that WPS revise its existing grievance procedures to include a definition of "complaint" consistent with the definition in s. Ins 9.01 (3) Wis. Adm. Code.
 7. It is recommended that WPS revise its existing grievance procedures to include a written procedure for the handling of expedited grievances per the requirements of s. Ins 9.33 (6) Wis. Adm. Code.
 8. It is recommended that WPS improve its existing grievance procedures to better ensure the accuracy of information contained in its Grievance Log.
 9. It is recommended that WPS improve its existing grievance procedures to better ensure that the acknowledgement and Grievance Committee meeting notification letters are sent and copies maintained in the individual grievance files.
 10. It is recommended that WPS revise its provider contracts by adding language that specifically requires providers to identify complaints and grievances and forward them in a timely manner to the company for resolution as required by s Ins 9.33 (7) (b) Wis. Adm. Code.

VII. MANAGED CARE COMPLIANCE

The examiners reviewed the company's managed care activities with respect to its PPP product, plan administration, quality assurance and improvement, utilization, credentialing, recredentialing, access, continuity of care, drug formularies, and experimental treatments.

The examiners' review of WPS's plan administration activities included a review of the company's organizational charts, committee meeting minutes, provider directories, and provider agreements. The meeting minutes indicate that the Medical Director is a physician. The provider agreements do not contain any gag clauses.

The examiners' review of WPS's quality assurance and improvement activities included a review of the company's Plan to Implement a Quality Assurance Plan and minutes from meetings of the Clinical Quality Management Committee. The examiners found that the plan's quality assurance standards meet the requirements of s. 609.32 (1), Wis. Stat., to the extent required by s. Ins 9.40 (3) (d), Wis. Adm. Code.

The examiners' review of WPS's utilization management activities included a review of minutes from meetings of the Utilization Review Committee. The company has a department called Value Care Review that is responsible for its utilization management activities. The medical director is involved in utilization review activities. The medical director is responsible for oversight of these activities, as required by s. 609.34, Wis. Stat. The examiners' reviewed WPS's credentialing and recredentialing procedures and the Plan to Implement a Quality Assurance Plan. The company delegates credentialing and recredentialing responsibilities to its plan providers. The medical director is also responsible for monitoring the activities of the providers. The company indicates that it is in the process of developing new credentialing and recredentialing procedures. The examiners found that the plan's credentialing and recredentialing procedures meet the requirements of s. 609.32 (2), Wis. Stat., to the extent required by s. Ins 9.40 (3) (d), Wis. Adm. Code.

The examiners' review of WPS's policies and procedures regarding member access included a review of the company's policies regarding access to primary and specialty care providers and access for underserved populations, as well as a review of the company's certificates of coverage. The following exception was noted:

- The company does not have in place a procedure for providing access to enrollees who speak foreign languages, are deaf, disabled, or otherwise underserved, as required by s. 609.22 (8), Wis. Stat.

The examiners reviewed WPS's policies and procedures regarding continuity of care, its managed care certificates of coverage, and its provider agreements. The following exception was noted:

- Four of the five provider agreements reviewed do not contain a continuity of care provision that obligates providers to continue providing care to enrollees after their agreement with the company terminates, as required by s. 609.24 (1) (e), Wis. Stat.

The examiners reviewed WPS's policies and procedures regarding drug formularies and experimental treatments and its certificates of coverage. The following exceptions were noted:

- Although the company has a procedure for reviewing a preauthorization request for drugs not routinely covered by the plan, it does not have a procedure for reviewing requests for devices not normally covered, as required by s. 632.853, Wis. Stat.
- Although the company's managed care certificates of coverage include language regarding coverage of experimental treatments, the language does not indicate who is authorized to make a determination on whether a treatment is considered experimental, as required by s. 632.855 (2) (a), Wis. Stat. In addition, the company failed to provide documentation to verify that it complies with the denial of treatment requirements outlined in s. 632.855 (3), Wis. Stat.

11. It is recommended that WPS revise its procedures to provide access to enrollees who do not speak English, are deaf, disabled, or otherwise underserved, as required by s. 609.22 (8), Wis. Stat.
12. It is recommended that WPS revise its provider agreements to include language that obligates the contracted provider to continue providing care to enrollees after their agreement with the company terminates, as required by s. 609.24 (1) (e), Wis. Stat.
13. It is recommended that WPS develop a procedure for reviewing requests for devices not normally covered by both its managed care and non-managed care plans, as required by s. 632.853, Wis. Stat.
14. It is recommended that WPS revise its certificates of coverage for both its managed care and non-managed care plans to positively state in the experimental treatment provision, the entity or person who is authorized to make a determination of whether a treatment is considered experimental as required by s. 632.855 (2) (a), Wis. Stat., and file the revisions with OCI within 30 days of the adoption of this report. In addition, it is recommended that WPS include with the form filing for the certificate revision, documentation of how it complies with the denial of treatment requirements outlined in s. 632.855 (3), Wis. Stat.

VIII. PRODUCER RECORDS

WPS contracts with approximately 365 insurance agencies, and holds these agencies contractually responsible for notifying the company of new agent listings and agent terminations. Upon receiving such notification from an agency, WPS forwards the listing or termination form to OCI. Prospective agents must submit to WPS an Individual Agent Listing Application, or a substitute form that contains all pertinent information, as well as a copy of their valid Wisconsin agent license. The company has an Agent Support Specialist, a salaried WPS employee, who is responsible for listing and terming agents and agencies, as well as all other aspects of the company maintained agent database. WPS employs 40.5 salaried agents and has a network of approximately 2,596 independent agents.

The examiners compared a list of all intermediary agents that represented the company as of June 15, 2001, which was provided by the company, to all agents appointed with the company according to OCI's records pursuant to s. Ins 6.57 (1), Wis. Adm. Code, as of that date. The examiners also reviewed a sample of 50 agent files maintained by the company. The following exceptions were noted:

- The examiners found one instance where the agent no longer represented the company and timely notice of this was not provided to OCI as required by s. Ins 6.57 (2), Wis. Adm. Code.
- The examiners found four intermediary agents listed with the company pursuant to s. Ins 6.57 (1), Wis. Adm. Code, which did not represent the company. The company has no record of these intermediary agents as being representatives of the company. The listing of these agents was effective between January 1991 and June 1999. One or more of these agents would have appeared on the company's Annual Renewal Billing sent by OCI in 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, and 2000.
- The examiners found one intermediary agent where the agent no longer represented the company. The company provided documentation indicating that a notice of termination was sent to OCI in accordance with s. Ins 6.57 (2), Wis. Adm. Code on February 4, 1998. The company has no record of receiving a validation report from OCI confirming the termination and did not follow up on the status of the termination. OCI's records indicate that the intermediary agent's listing was not terminated and the agent was still listed with the company as of June 15, 2001. In addition, this agent would have appeared on the company's Annual Renewal Billing sent by OCI in 1998, 1999 and 2000.

- The examiners found one intermediary agent where the company sent the agent listing to OCI pursuant to s. Ins 6.57 (1), Wis. Adm. Code, on March 9, 2000. The company has no record of receiving a validation report confirming the listing of this agent and did not follow up to ensure that the listing was received by OCI. Section Ins 6.57 (1), Wis. Adm. Code, provides that an application for an agent listing shall be submitted to the office of the commissioner of insurance on or before the date of appointment. In addition, s. Ins 6.57 (5), Wis. Adm. Code, provides no insurer shall accept business directly from any intermediary unless that intermediary is a licensed agent listed with that company.
- The examiners found two intermediary agents that the company records showed as representing the company as of June 15, 2001. OCI records showed that one agent's listing with the company (pursuant to s. Ins 6.57 (1), Wis. Adm. Code), was terminated by OCI effective April 16, 1997 when the agent's license was cancelled for failure to meet Wisconsin's continuing education requirements. This agent would not have appeared on the company's Annual Renewal Billings sent in 1997, 1998, 1999, and 2000 by OCI. OCI records showed that the second agent's appointment was terminated by OCI effective January 1, 2000 when the agent voluntarily surrendered his/her license. This agent would not have appeared on the company's Annual Renewal Billing sent in 2000 by OCI.
- The examiners found one intermediary agent where the company records showed that the agent represented the company as of June 15, 2001. Per OCI records, the agent was not listed with the company pursuant to s. Ins 6.57 (1), Wis. Adm. Code. The agent was suspended for failure to meet Wisconsin's continuing education requirements on February 15, 1997 and notice of the suspension was sent to the company on February 26, 1997. The agent's license was subsequently cancelled by OCI and all listings pursuant to s. Ins 6.57 (1), Wis. Adm. Code, were terminated effective April 16, 1997. On June 23, 1997, the individual re-applied for and received a new Wisconsin intermediary license. On June 30, 1997, the company was advised that the individual had gone through 're-licensing' and again held a valid license. The company failed to re-appoint the agent pursuant to s. Ins 6.57 (1), Wis. Adm. Code at the time it received documentation that the agent obtained a new license. The company accepted one piece of new business from the intermediary agent after June 23, 1997 in violation of s. Ins 6.57 (5) Wis. Adm. Code.

- Eight of the terminated agent files reviewed did not contain a termination letter requesting the return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.
15. It is recommended that the company carefully review and compare the Annual Renewal Billing sent by OCI to the company records and promptly initiate an investigation into the reason(s) an agent appears on the Annual Renewal Billing when that agent does not appear to represent the company. It is further recommended that, based on the findings of the company investigation, the company take the appropriate action to terminate agents pursuant to s. Ins 6.57 (2), Wis. Adm. Code when the agent does not in fact represent the company.
 16. To ensure compliance with ss. Ins 6.57 (1) and (5), Wis. Adm. Code, it is recommended that the company revise its procedures to ensure that follow up on the status of an agent's appointment is made when a validation report confirming the listing is not received within 30days of being sent to OCI.
 17. It is recommended that the company carefully review and compare the Annual Renewal Billing sent by OCI to the company records and promptly initiate an investigation into the reason(s) an agent currently representing the company does not appear on the Annual Renewal Billing. It is further recommended that based on the findings of the company investigation, that the company take the appropriate action to re-appoint agents pursuant to s. Ins 6.57 (1), Wis Adm. Code, or update the company system accordingly to show that the agent no longer represents the company.
 18. It is recommended that the company revise its procedures to ensure that termination letters are sent to agents whose license is revoked by OCI for failure to comply with continuing education requirements and that these letters specifically request the return of indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

IX. NEW BUSINESS—HEALTH, LARGE GROUP

The examiners reviewed the company's procedures and underwriting practices for large groups (50+) as well as a sample of 66 application files. The following exceptions were noted:

- One file where coverage was issued contained an application that was not signed or dated by the agent.
- Thirty files contained incomplete applications in that the applications either did not have the total number of employees in the group or the total number of employees enrolling in the plan.
- One file contained an application that was not signed or dated by the employer/applicant.

19. It is recommended that the company improve its existing procedures to ensure that applications for large group health insurance coverage are completed in their entirety and that the applications are dated and signed by the agent and applicant.

X. NEW BUSINESS-HEALTH, SMALL GROUP

The examiners reviewed the company's procedures and underwriting practices and rating practices for small groups (2-50) as well as a sample of 97 application files. The following exceptions were noted:

- The applications in three files were incomplete in that they did not include the number of employees in the group, the number of eligible employees, or the number of employees enrolling in the plan.
 - The company uses an enrollment form for its small employer groups which does not include a statement, in the waiver section of the form, advising the employee of the possible negative consequences of waiving coverage as required by s. Ins 8.65 (2) Wis. Adm. Code.
 - The company does not use a form that complies with the requirements of s. Ins 8.48 Wis. Adm. Code, which makes certain disclosures regarding rating and renewability of the policy. The company maintains that this information is adequately furnished in the Group Application, Master Policy and Outline of Coverage.
 - The company does not use a separate disclosure form issued with the policy, disclosing to the policyholder the circumstances under which the protections of Ch. 635 Wis. Stat., will cease to apply as required by s. Ins 8.44 (2), Wis. Adm. Code. While the company does disclose this information in the master policy issued to the policyholder, it is OCI's position that a separate disclosure form is required.
20. It is recommended that the company improve its existing procedures to ensure that applications for small employer health insurance coverage are completed in their entirety.
21. It is recommended that the company revise the enrollment form used for small employer groups to include a statement, in the waiver section of the form, advising the employee of the possible negative consequences of waiving coverage as required by s. Ins 8.65 (2) Wis. Adm. Code.
22. It is recommended that the company develop and use with small employer applications a rating and renewability disclosure form signed by the agent and employer before the application for coverage is taken as required by s. 635.11, Wis. Stat., and s. Ins 8.48 Wis. Adm. Code.
23. It is recommended that the company develop and use with small employer groups a separate disclosure form disclosing to the policyholder the circumstances under which the protections of Ch. 635 Wis. Stat. will cease to apply and that this form be delivered to the policyholder with the policy, as required by s. Ins 8.44 (2), Wis. Adm. Code.

XI. NEW BUSINESS-HEALTH, INDIVIDUAL & MEDICARE SUPPLEMENT

The examiners reviewed the company's procedures and underwriting practices for its individual health insurance and Medicare supplement products as well as a sample of 100 individual health insurance application files and 50 Medicare supplement application files. In addition, the examiners reviewed the company's commission schedules for its Medicare supplement policy and a sample of first year and renewal Medicare supplement commissions paid to 25 agencies during the period of review.

The following exceptions were noted:

- 3 applications for individual health insurance were not signed or dated by the writing agent.
- 6 applications for individual health insurance were not dated.
- The writing agent did not sign 2 applications for individual health insurance.
- 1 application for individual health insurance was signed by the writing agent 7 days prior to the applicant signing the application.
- 9 applications for individual health insurance were signed by the writing agent anywhere from 2 to 23 days after the applicant signed the application

No exceptions were noted with regard to the Medicare supplement product.

24. It is recommended that the company improve its existing procedures to ensure that applications for individual health insurance coverage are completed in their entirety and that the applications are dated and signed by the agent and applicant.

XII. POLICY FORMS

The company's Contract Development Department and Actuarial Services area are responsible for all form and rate filings. Regulatory Services provides compliance update bulletins and other information to Contract Development staff advising them of changes in state law and regulations which may require new filings.

The examiners reviewed the company's procedures in this area and compared the OCI data base of approved WPS policy forms with the list of forms provided by the company that were used during the period of review. The examiners also reviewed two policy forms that were deemed approved by OCI during the period of review. No exceptions were noted.

XIII. OTHER AREAS OF THE COMPANY

In addition to reviewing company operations in the areas described, the examiners performed a limited review of the company's practices and procedures with respect to sales, premium billing and refunds, and its terminations, nonrenewals and cancellation procedures. No exceptions were noted.

XIV. SUMMARY OF THE RECOMMENDATIONS

1. It is recommended that the company revise its advertising procedures to ensure it includes the source of any statistic used in an advertisement, as required by s. Ins 3.27 (20) Wis. Adm. Code.
2. It is recommended that the company maintain hard copy screen prints of its most current website pages in its advertising file, as required by s. Ins 3.27 (28) Wis. Adm. Code.
3. It is recommended that the company revise the EOB used for its managed care plans to comply with s. Ins 9.33 (2) Wis. Adm. Code, by deleting the time limit allowed to file a grievance.
4. It is recommended that WPS improve its claims handling procedures to better ensure the identification of claims subject to payment of interest and promptly pay interest as required by s. 628.46 Wis. Stat.
5. It is recommended that WPS revise its existing grievance procedures for its managed care plans to count and initially process as grievances any written expressions of dissatisfaction handled at the Initial Review Level whether the grievance is resolved in the grievant's favor or not, and eliminate the procedure which effectively requires a grievant to submit a second grievance within 60 days if the matter is not resolved in the grievant's favor at the Initial Review Level.
6. It is recommended that WPS revise its existing grievance procedures to include a definition of "complaint" consistent with the definition in s. Ins 9.01 (3) Wis. Adm. Code.
7. It is recommended that WPS revise its existing grievance procedures to include a written procedure for the handling of expedited grievances per the requirements of s. Ins 9.33 (6) Wis. Adm. Code.
8. It is recommended that WPS improve its existing grievance procedures to better ensure the accuracy of information contained in its Grievance Log.
9. It is recommended that WPS improve its existing grievance procedures to better ensure that the acknowledgement and Grievance Committee meeting notification letters are sent and copies maintained in the individual grievance files.
10. It is recommended that WPS revise its provider contracts by adding language that specifically requires providers to identify complaints and grievances and forward them in a timely manner to the company for resolution as required by s. Ins 9.33 (7) (b) Wis. Adm. Code.
11. It is recommended that WPS revise its procedures to provide access to enrollees who do not speak English, are deaf, disabled, or otherwise underserved, as required by s. 609.22 (8), Wis. Stat.
12. It is recommended that WPS revise its provider agreements to include language that obligates the contracted provider to continue providing care to enrollees after their agreement with the company terminates, as required by s. 609.24 (1) (e), Wis. Stat.
13. It is recommended that WPS develop a procedure for reviewing requests for devices not normally covered by both its managed care and non-managed care plans, as required by s. 632.853, Wis. Stat.
14. It is recommended that WPS revise its certificates of coverage to positively state in the experimental treatment provision, the entity or person who is authorized to make a determination of whether a treatment is considered experimental as required by s. 632.855 (2) (a), Wis. Stat., and file the revisions with OCI within 30 days of the adoption of this report. In addition, it is recommended that WPS include with the form filing for the certificate revision, documentation of how it complies with the denial of treatment requirements outlined in s. 632.855 (3), Wis. Stat.
15. It is recommended that the company carefully review and compare the Annual Renewal Billing sent by OCI to the company records and promptly initiate an investigation into the reason(s) an agent appears on the Annual Renewal Billing when that agent does not appear to represent the company.

It is further recommended that, based on the findings of the company investigation, the company take the appropriate action to terminate agents pursuant to s. Ins 6.57 (2), Wis. Adm. Code when the agent does not in fact represent the company.

16. To ensure compliance with ss. Ins 6.57 (1) and (5), Wis. Adm. Code, it is recommended that the company revise its procedures to ensure that follow up on the status of an agent's appointment is made when a validation report confirming the listing is not received within 30 days of being sent to OCI.
17. It is recommended that the company carefully review and compare the Annual Renewal Billing sent by OCI to the company records and promptly initiate an investigation into the reason(s) an agent currently representing the company does not appear on the Annual Renewal Billing. It is further recommended that based on the findings of the company investigation, that the company take the appropriate action to re-appoint agents pursuant to s. Ins 6.57 (1), Wis Adm. Code, or update the company system accordingly to show that the agent no longer represents the company.
18. It is recommended that the company revise its procedures to ensure that termination letters are sent to agents whose license is revoked by OCI for failure to comply with continuing education requirements and that these letters specifically request the return of indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.
19. It is recommended that the company improve its existing procedures to ensure that applications for large group health insurance coverage are completed in their entirety and that the applications are dated and signed by the agent and applicant.
20. It is recommended that the company improve its existing procedures to ensure that applications for small employer health insurance coverage are completed in their entirety.
21. It is recommended that the company revise the enrollment form used for small employer groups to include a statement, in the waiver section of the form, advising the employee of the possible negative consequences of waiving coverage as required by s. Ins 8.65 (2) Wis. Adm. Code.
22. It is recommended that the company develop and use with small employer applications a rating and renewability disclosure form signed by the agent and employer before the application for coverage is taken as required by s. 635.11, Wis. Stat., and s. Ins 8.48 Wis. Adm. Code.
23. It is recommended that the company develop and use with small employer groups a separate disclosure form disclosing to the policyholder the circumstances under which the protections of Ch. 635 Wis. Stat. will cease to apply and that this form be delivered to the policyholder with the policy, as required by s. Ins 8.44 (2), Wis. Adm. Code.
24. It is recommended that the company improve its existing procedures to ensure that applications for individual health insurance coverage are completed in their entirety and that the applications are dated and signed by the agent and applicant.

XV. CONCLUSIONS

The report contains 24 recommendations, with the primary areas of concern being the manner in which the company has been handling grievances and managed care compliance issues.

XVI. ACKNOWLEDGEMENTS

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

Name	Title
Stephanie Cook	Insurance Examiner
Laura Iliff	Actuary
Kristi Jacobson	Insurance Examiner
John Kitslaar	Insurance Examiner
Jo Le Duc	Insurance Examiner
Jamie Sanftleben	Insurance Examiner
Jerry Zimmer	Insurance Examiner

Respectfully Submitted,

Pam Ellefson
Examiner-in-Charge
Bureau of Market Regulation