

**REPORT ON**  
**TARGET MARKET CONDUCT EXAMINATION**  
**OF**  
**KAISER PERMANENTE INSURANCE COMPANY**  
**AS OF MARCH 31, 2010**

**Conducted from December 7, 2010**

**Through**

**May 16, 2012**

**By**

**Market Conduct Section 1**

**Life and Health Market Regulation  
Division**

**BUREAU OF INSURANCE**

**STATE CORPORATION COMMISSION**

**COMMONWEALTH OF VIRGINIA**

FEIN: 94-3203402  
NAIC: 60053

# COMMONWEALTH OF VIRGINIA

JACQUELINE K. CUNNINGHAM  
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I, Jacqueline K. Cunningham, Commissioner of Insurance of the Commonwealth of Virginia, do hereby certify that the annexed copy of the Market Conduct Examination of Kaiser Permanente Insurance Company, conducted at its Branch Office in Plano, Texas, as of March 31, 2010, is a true copy of the original Report on file with this Bureau, and also includes a true copy of the Company's response to the findings set forth therein, the Bureau's review letter, the Company's offer of settlement, and the State Corporation Commission's Settlement Order in Case No. INS-2012-00262.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of this Bureau at the City of Richmond, Virginia this 21st day of December 2012.



Jacqueline K. Cunningham  
Commissioner of Insurance

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## I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of Kaiser Permanente Insurance Company, (hereinafter referred to as “KPIC”), was conducted at KPIC’s branch office in Plano, Texas under the authority of various sections of the Code of Virginia (hereinafter referred to as “the Code”) and regulations found in the Virginia Administrative Code (hereinafter referred to as “VAC”) including, but not necessarily limited to, the following: §§ 38.2-200, 38.2-515, 38.2-614, 38.2-1317, 38.2-1317.1, 38.2-809, 38.2-3407.15 C, and 38.2-5808 B of the Code.

The period of time covered for the current examination, generally, was October 1, 2009 through March 31, 2010. The examination was initiated on December 7, 2010 at the office of the State Corporation Commission’s Bureau of Insurance in Richmond, VA. The on-site examination was conducted from February 21, 2011, through March 3, 2011, and completed at the office of the State Corporation Commission’s Bureau of Insurance on May 16, 2012. The violations cited and the comments included in this Report are the opinions of the examiners.

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

- |                         |  |
|-------------------------|--|
| 14 VAC 5-400-10 et seq. | Rules Governing Unfair Claim Settlement Practices;   |
| 14 VAC 5-215-10 et seq. | Rules Governing Independent External Review of Final Adverse Utilization Review Decisions. |

The examination included the following areas:

- Managed Care Health Insurance Plans (MCHIPs)
- Ethics & Fairness in Carrier Business Practices
- Premium Notices
- Complaints
- Claim Practices
- Independent External Review of Adverse Utilization Review Decisions

**Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to KPIC during the course of the examination.**

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## II. COMPANY HISTORY

Kaiser Permanente Insurance Company (KPIC) is domiciled in the State of California, having been admitted to write disability insurance on January 1, 1995. Today, KPIC is also admitted in Colorado, Georgia, Hawaii, Kansas, Maryland, Missouri, Ohio, Oregon, South Carolina, Virginia, Washington and the District of Columbia. KPIC is a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP). KPIC's common shares are owned in equal proportions by KFHP and the Permanente Medical Groups.

KPIC was founded by KFHP to offer indemnity-type group accident and health coverage alongside its traditional HMO offerings. KPIC currently underwrites group accident and health plans in 9 jurisdictions where KFHP operates regional health plans. KPIC's group insurance plans include *Point-of-Service*, *Preferred Provider*, *Out-of-Area*, and *Dental*. In 2008, KPIC began serving as a third-party administrator for self-funded accounts seeking to utilize KFHP's integrated health-care delivery system. That same year, KPIC began offering *Stop Loss Insurance* to such self-funded accounts to protect them from unexpected claims experience.

As of March 31, 2010, total assets were \$118,707,719, and total accident and health premiums earned in Virginia were \$4,953,173.

### **III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)**

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

#### **DISCLOSURES AND REPRESENTATIONS TO ENROLLEES**

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

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure, if complaints may be resolved through a specific arbitration agreement.
4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.
5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that KPIC was in substantial compliance.

#### **COMPLAINT SYSTEM**

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

the State Health Commissioner. The examiners reviewed a sample of 25 out of a total population of 64 complaints/appeals received during the examination time frame.

As discussed in the following paragraph, the review revealed 1 instance in which KPIC failed to maintain its established complaint system, in violation of § 38.2-5804 A of the Code.

### **HANDLING**

Sections 5.8.2 through 5.8.4 and Sections 5.10.2 through 5.10.5.1 of KPIC's Coordination and Resolution of Grievances & Appeals set forth the required procedures for handling Level 2 grievances and appeals. As discussed in Review Sheet MC01, the review revealed that the member submitted a third appeal letter, specifically requesting that it be considered "a voluntary Level 2 Appeal," and KPIC's acknowledgement stated that the member's letter was "considered a Level 2 Grievance and Appeal;" however, there was no documentation that KPIC followed its Level 2 response procedures. KPIC agreed with the examiners' observations.

**IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES**

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

**PROVIDER CONTRACTS**

The examiners reviewed a sample of 24 contracts from a total population of 6,631 provider contracts in force during the examination time frame. The provider contracts were reviewed to determine if they contained the 11 provisions required by § 38.2-3407.15 B of the Code.

**OneNet PPO, LLC**

The examiners reviewed 13 contracts that were negotiated with professional and institutional providers through the intermediary OneNet PPO, LLC. The review revealed 86 instances where KPIC's provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheets are referred to in the following table:

<b>Code Section</b>	<b>Number of Violations</b>	<b>Review Sheet</b>
§ 38.2-3407.15 B 1	11	EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 2	11	EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 3	1	EF08
§ 38.2-3407.15 B 4	11	EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 5	11	EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62

§ 38.2-3407.15 B 6	1	EF08
§ 38.2-3407.15 B 7	3	EF01, EF08, EF54
§ 38.2-3407.15 B 8	13	EF01, EF08, EF10, EF11, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 9	11	EF01, EF08, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 10	13	EF01, EF08, EF10, EF11, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62

An example is discussed in Review Sheet EF56, where the provider contract specifically entitled the “Customer submitting the claim” to inspect the record of receipt of a claim maintained by the carrier. As the Code states that the “person submitting the claim” shall be entitled to inspect such record on request, the language included in the provider contract failed to allow the provider this right, in violation of § 38.2-3407.15 B 1 of the Code. KPIC agreed with the examiners’ observations.

**MultiPlan, Inc.**

The examiners reviewed 10 contracts that were negotiated with professional and institutional providers through the intermediary MultiPlan, Inc. The review revealed 80 instances in which KPIC’s provider contracts failed to contain 1 or more of the 11 provisions required by § 38.2-3407.15 B of the Code. The particular provision, number of violations, and corresponding Review Sheets are referred to in the following table:

Code Section	Number of Violations	Review Sheet
§ 38.2-3407.15 B 1	10	EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 2	9	EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 3	10	EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 4	10	EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 5	10	EF02, EF03, EF04, EF05, EF06,

		EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 6	1	EF09
§ 38.2-3407.15 B 7	5	EF02, EF03, EF04, EF07, EF08
§ 38.2-3407.15 B 8	10	EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 9	4	EF02, EF03, EF07, EF09
§ 38.2-3407.15 B 10	10	EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 11	1	EF09

An example is discussed in Review Sheet EF51, where the agreement failed to contain a provision requiring that a provider contract include or attach the fee schedule and all applicable material addenda, schedules and exhibits. KPIC disagreed with the examiners' observations, stating that the reimbursement exhibit was included in the base contract. However, the Code requires a provider contract to contain the language outlined by § 38.2-3407.15 B 8 in addition to including a fee schedule exhibit. Therefore, KPIC's failure to include the provision altogether places the company in violation of this section.

**MedImpact, Inc.**

The examiners reviewed 1 contract that was negotiated with a pharmacy provider through the intermediary MedImpact, Inc. As discussed in Review Sheet EF12, the review revealed the provider contract failed to contain all 11 provisions required by § 38.2-3407.15 B of the Code. KPIC agreed with the examiners' observations.

**SUMMARY**

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. The failure of KPIC to amend its provider contracts to

comply with § 38.2-3407.15 of the Code occurred with such frequency as to indicate a general business practice, placing it in violation of § 38.2-510 A 15 of the Code in 177 instances.

### **PROVIDER CLAIMS**

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain provisions requiring the carrier to adhere to and comply with sections 1 through 11 of these subsections in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

A sample of 212 claims out of a total population of 403 under the contracts was reviewed for compliance with the minimum fair business standards in the processing and payment of claims.

Section 38.2-3407.15 B 3 of the Code requires that any interest due on a claim under § 38.2-3407.1 of the Code shall be paid at the time the claim is paid or within 60 days thereafter. Section 38.2-3407.1 of the Code requires interest to be paid on claim proceeds at the legal rate of interest from the date of 15 working days from the receipt of the proof of loss to the date of claim payment. The review revealed 9 instances in which KPIC failed to pay interest as required by this section, in violation of § 38.2-3407.15 B 3 of the Code. An example is discussed in Review Sheet EFCL12. KPIC agreed with the examiners' observations.

Section 38.2-3407.15 B 6 of the Code requires an insurer to notify a provider 30 days in advance of any retroactive denial of a claim. Section 38.2-3407.15 B 7 of the Code prohibits an insurer from imposing a retroactive denial of payment unless the carrier specifies in writing the specific claim for which retroactive denial is to be imposed. The carrier shall include in this written communication an explanation as to why the claim is being retroactively denied. As discussed in Review Sheet EFCL18, the review revealed 1 instance in which KPIC failed to notify the provider 30 days in advance of the retroactive denial of a claim and failed to provide a written explanation for the retroactive denial of a previously paid claim, in violation of these sections. KPIC agreed with the examiners' observations.

Section 38.2-3407.15 B 4 a ii c of the Code states that every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract to determine the carrier's requirements applicable to the provider for provider-specific payment and reimbursement methodology. Section 38.2-3407.15 B 4 a ii d of the Code states that every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract to determine the carrier's requirements applicable to the provider for other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract. Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis.

The review of the sample claims revealed that KPIC underpaid the fee schedule amount specified for the health care service provided in 1 instance, in violation of §§ 38.2-3407.15 B 4 a ii c, 38.2-3407.15 B 4 a ii d, and 38.2-3407.15 B 8 of the Code. An example is discussed in Review Sheet EFCL23. KPIC agreed with the examiners' observations.

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

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

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## V. PREMIUM NOTICES

KPIC's practices for notifying contract holders of the intent to increase premiums by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code.

Section 38.2-3407.14 A of the Code requires a corporation providing individual or group accident and sickness subscription contracts to provide notice of intent to increase premiums by more than 35%. Section 38.2-3407.14 B of the Code states that the notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under any such contract to the contract holder, or to the designated consultant or other agent of the group contract holder, if requested in writing by the group contract holder.

The examiners reviewed a sample of 15 out of a total population of 41 group contracts for which KPIC intended to increase the premium by more than 35% at renewal during the examination time frame.

As discussed in Review Sheet PB05, the review revealed 1 violation of § 38.2-3407.14 A of the Code. A review of the file indicated that KPIC failed to provide written notice of intent to increase annual premiums by more than 35%, as required. KPIC agreed with the examiners' observations.

The review revealed 2 violations of § 38.2-3407.14 B of the Code. An example is discussed in Review Sheet PB03. KPIC disagreed with the examiners' observations, stating, in part, that the "...group's renewal was mailed on 10.30.09 which is 63 days prior to 1.1.10..." The examiners responded, in part, that "...the FedEx Detailed Results delivery and signature confirmation indicates that the notice was not received until 11/03/09, which resulted in notice of 59 days".

## **VI. COMPLAINTS**

KPIC's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

A sample of 25 from a total population of 64 written complaints received during the examination time frame was reviewed. The review revealed that KPIC was in substantial compliance with this section.

## **VII. CLAIM PRACTICES**

The examination included a review of KPIC's claim practices for compliance with §§ 38.2-510 and 38.2-3407.1 of the Code and 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

### **GENERAL HANDLING STUDY**

The review consisted of a sampling of closed institutional, professional and pharmacy claims. KPIC utilized 2 participating provider networks in Virginia during the examination time frame, OneNet PPO, LLC and MultiPlan, Inc. All institutional and professional claims are processed on behalf of KPIC by Dell Marketing L.P., at its office in Plano, Texas. Pharmacy claims are processed by MedImpact, Inc. in San Diego, California. KPIC provided the examiners with copies of its claims procedures.

### **PAID CLAIM REVIEW**

A sample of 230 was selected from a population of 102,042 claims paid during the examination time frame. The review revealed that the claims were paid in accordance with the policy provisions

### **Interest on Accident and Sickness Claim Proceeds**

Section 38.2-3407.1 B of the Code states that interest upon claim proceeds shall be computed daily at the legal rate of interest from the date of fifteen working days from the insurer's receipt of proof of loss to the date of claim payment.

The review revealed 10 violations of this section. An example is discussed in Review Sheet CL36, where KPIC took 141 calendar days to pay a claim and failed to pay the statutory interest due. KPIC agreed with the examiners' observations.

### **TIME PAYMENT STUDY**

The time payment study was computed by measuring the time it took KPIC, after receiving the properly executed proof of loss, to issue a check for payment. The term "working days" does not include Saturdays, Sundays or holidays. The study was conducted on the total sample of 230 paid accident and sickness claims.

<b>PAID CLAIMS</b>			
<u>Claim Type</u>	<u>Working Days to Settle</u>	<u>Number of Claims</u>	<u>Percentage</u>
Group Accident & Sickness	0 – 15	211	92%
	16 – 20	4	2%
	Over 20	15	6%

Of the 230 claims reviewed for the time study, 8% of claims were not settled within 15 working days. The examiners recommend that KPIC review its procedures to reduce the percentage of claims paid after 15 working days.

### **DENIED CLAIM REVIEW**

A sample of 95 was selected from a population of 10,424 claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the policy provisions.

## **UNFAIR CLAIM SETTLEMENT PRACTICES REVIEW**

The total sample of 230 paid claims and 95 denied claims was also reviewed for compliance with 14 VAC 5-400-10 et seq., Rules Governing Unfair Claim Settlement Practices.

14 VAC 5-400-50 A requires every insurer to acknowledge the receipt of notification of a claim within 10 working days, unless payment is made within that time.

14 VAC 5-400-60 A requires that within 15 working days after receipt of properly executed proofs of loss, the insurer shall advise the claimant of acceptance or denial of the claim by the insurer.

14 VAC 5-400-60 B requires that if the investigation of a claim has not been completed, every insurer shall, within 45 days from the date of the notification of the claim and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

The review was conducted using the date the letter or check was mailed as the settlement date. The areas of non-compliance are discussed in the following paragraphs.

14 VAC 5-400-50 A – in 21 instances, claims were not acknowledged within 10 working days upon receipt of notification. An example is discussed in Review Sheet CL29, where KPIC took 25 working days to acknowledge a claim. KPIC agreed with the examiners' observations.

14 VAC 5-400-60 A – in 20 instances, a claimant was not advised of the acceptance or denial of a claim within 15 working days after proof of loss was received.

An example is discussed in Review Sheet CL06, where KPIC took 33 working days to affirm the claim after receipt of proof of loss. KPIC agreed with the examiners' observations.

14 VAC 5-400-60 B – in 9 instances, KPIC failed, within 45 days from the date of notification of a claim and every 45 days thereafter, to send a letter to the claimant setting forth the reasons additional time was needed for investigation. Review Sheet CL01 provides an example. KPIC agreed with the examiners' observations.

KPIC's failure to comply with certain sections of the above regulations did not occur with such frequency as to indicate a general business practice.

### **THREATENED LITIGATION**

KPIC informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.

## **VIII. INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS**

Chapter 59 of Title 38.2 of the Code requires certain actions to be taken by the Bureau of Insurance on any appeal of a final adverse decision made by a utilization review entity. 14 VAC 5-215-10 et seq. provides a process for appeals to be made to the Bureau of Insurance to obtain an independent external review of final adverse decisions and procedures for expedited consideration of appeals in cases of emergency health care.

There were no appeals of final adverse decisions or independent external reviews that occurred during the examination time frame. KPIC had established procedures in place to maintain compliance with 14 VAC 5-215-10 et seq.

## **IX. CORRECTIVE ACTION PLAN**

Based on the findings stated in this Report, KPIC shall:

1. Establish procedures to ensure that it maintains its complaint system as required by § 38.2-5804 A of the Code;
2. Establish and maintain procedures to ensure that all provider contracts contain the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code;
3. Establish and maintain procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims as required by §§ 38.2-510 A 15, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, and 38.2-3407.15 C of the Code;
4. Establish and maintain procedures for compliance with §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code;
5. Review all renewals of group contracts issued in Virginia for the years 2008, 2009, 2010, 2011, and the current year that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which contract holders were not notified in writing 60 days prior to such increase, as required by §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the group contract holder all premium amounts collected in excess of the 35% increase for the entire policy period for which notice was not provided. Send checks for the required refund along with letters of

explanation stating specifically, “As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission’s Bureau of Insurance, it was revealed that KPIC failed to provide 60 days written notice to the policyholder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount”;

6. Strengthen its procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code;
7. Review all paid claims for the years of 2008, 2009, 2010, 2011, and the current year and make interest payments where necessary as required by § 38.2-3407.1 B of the Code. Send checks for the interest along with a letter of explanation or statement on the EOB that, “As a result of a Target Market Conduct Examination by the Virginia State Corporation Commission’s Bureau of Insurance, it was determined that this interest had not been paid previously.” After which, furnish the examiners with documentation that the required interest has been paid;
8. Review and strengthen its established procedures to ensure that claims are paid within 15 working days;
9. Review its established procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A;
10. Establish and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A;

11. Review its established procedures to ensure that notification of a claim under investigation is sent every 45 days from the date of notification of the claim and every 45 days thereafter, as required by 14 VAC 5-400-60 B; and
12. Within 120 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

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## **X. ACKNOWLEDGMENT**

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

Brant Lyons, Laura Wilson, and Gregory Lee, FLMI, CIE of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Carly Daniel, AIE, AIRC  
Principal Insurance Market Examiner  
Market Conduct Section 1  
Life and Health Market Regulation Division  
Bureau of Insurance

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## XI. REVIEW SHEET SUMMARY BY AREA

<b>MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)</b>
§ 38.2-5804 A, 1 violation, MC01
<b>ETHICS &amp; FAIRNESS IN CARRIER BUSINESS PRACTICES</b>
<i>Provider Contracts (OneNet PPO, LLC)</i>
§ 38.2-3407.15 B 1, 11 violations, EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 2, 11 violations, EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 3, 1 violation, EF08
§ 38.2-3407.15 B 4, 11 violations, EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 5, 11 violations, EF08, EF10, EF11, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 6, 1 violation, EF08
§ 38.2-3407.15 B 7, 3 violations, EF01, EF08, EF54
§ 38.2-3407.15 B 8, 13 violations, EF01, EF08, EF10, EF11, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 9, 11 violations, EF01, EF08, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
§ 38.2-3407.15 B 10, 13 violations, EF01, EF08, EF10, EF11, EF54, EF55, EF56, EF57, EF58, EF59, EF60, EF61, EF62
<i>Provider Contracts (MultiPlan, Inc.)</i>
§ 38.2-3407.15 B 1, 10 violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 2, 9 violations, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52,

EF53
§ 38.2-3407.15 B 3, <b>10</b> violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 4, <b>10</b> violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 5, <b>10</b> violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 6, <b>1</b> violation, EF09
§ 38.2-3407.15 B 7, <b>5</b> violations, EF02, EF03, EF04, EF07, EF08
§ 38.2-3407.15 B 8, <b>10</b> violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 9, <b>4</b> violations, EF02, EF03, EF07, EF09
§ 38.2-3407.15 B 10, <b>10</b> violations, EF02, EF03, EF04, EF05, EF06, EF07, EF09, EF51, EF52, EF53
§ 38.2-3407.15 B 11, <b>1</b> violation, EF09
<i>Provider Contracts (MedImpact, Inc.)</i>
§ 38.2-3407.15 B 1, <b>1</b> violation, EF12
§ 38.2-3407.15 B 2, <b>1</b> violation, EF12
§ 38.2-3407.15 B 3, <b>1</b> violation, EF12
§ 38.2-3407.15 B 4, <b>1</b> violation, EF12
§ 38.2-3407.15 B 5, <b>1</b> violation, EF12
§ 38.2-3407.15 B 6, <b>1</b> violation, EF12
§ 38.2-3407.15 B 7, <b>1</b> violation, EF12
§ 38.2-3407.15 B 8, <b>1</b> violation, EF12
§ 38.2-3407.15 B 9, <b>1</b> violation, EF12

§ 38.2-3407.15 B 10, 1 violation, EF12
§ 38.2-3407.15 B 11, 1 violation, EF12
<i>Provider Claims</i>
§ 38.2-3407.15 B 3, 9 violations, EFCL11, EFCL12, EFCL13, EFCL14, EFCL15, EFCL16, EFCL17, EFCL19, EFCL22
§ 38.2-3407.15 B 4, 1 violation, EFCL23
§ 38.2-3407.15 B 6, 1 violation, EFCL18
§ 38.2-3407.15 B 7, 1 violation, EFCL18
§ 38.2-3407.15 B 8, 1 violation, EFCL23
<b>PREMIUM NOTICES</b>
§ 38.2-3407.14 A, 1 violation, PB05
§ 38.2-3407.14 B, 2 violations, PB03, PB05
<b>CLAIM PRACTICES</b>
§ 38.2-3407.1 B, 10 violations, CL02, CL05, CL06, CL08, CL21, CL24, CL26, CL31, CL35, CL36
14 VAC 5-400-50 A, 21 violations, CL01 CL03, CL04, CL05, CL09, CL10, CL11, CL13, CL14, CL15, CL22, CL23, CL24, CL26, CL29, CL31, CL32, CL33, CL34, CL35, CL36
14 VAC 5-400-60 A, 20 violations, CL01, CL02, CL04, CL05, CL06, CL08, CL09, CL10, CL12, CL21, CL22, CL24, CL26, CL29, CL31, CL32, CL33, CL34, CL35, CL36
14 VAC 5-400-60 B, 9 violations, CL01, CL02, CL06, CL12, CL26, CL31, CL32, CL35, CL36

# COMMONWEALTH OF VIRGINIA

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



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

August 8, 2012

**CERTIFIED MAIL 7011 0110 0001 6085 2014**  
**RETURN RECEIPT REQUESTED**

Jeffery Young  
Kaiser Permanente Insurance Company  
3200 Thornton Ave., 4th Floor  
Burbank, CA 91504

RE: Market Conduct Examination Report  
**Exposure Draft**

Dear Mr. Rambo:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of Kaiser Permanente Insurance Company (KPIC) for the period of October 1, 2009 through March 31, 2010. A preliminary draft of the Report is enclosed for your review.

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

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

Thank you for your prompt attention to this matter.

Yours truly,

Carly B. Daniel, AIE, AIRC  
Principal Insurance Market Examiner  
Market Conduct Section 1  
Life and Health Division  
Bureau of Insurance  
(804) 371-9492

CBD:mhh  
Enclosure  
cc: Althelia Battle

September 7, 2012

Ms. Carly B. Daniel, AIE, AIRC  
Principal Insurance Market Examiner  
Market Conduct Section 1  
Life and Health Market Regulation Division  
Bureau of Insurance  
1300 East Main Street (23219)  
P.O. Box 1157 (23218)  
Richmond, Virginia

**NEXT BUSINESS DAY DELIVERY**

**RE: MARKET CONDUCT EXAM REPORT – EXPOSURE DRAFT**

Dear Ms. Daniel:

This will acknowledge your letter of August 8, 2012, and the above referenced exam report. The following narrative seeks to address the request stated in your letter. Specifically, to specify those items with which KPIC agrees or disagrees, along with the intended method of compliance.

KPIC's comments are set forth on a point-by-point basis following the outline of the exposure draft.

**I. SCOPE OF EXAMINATION**

KPIC accepts the stated scope of the examination.

**II. COMPANY HISTORY**

KPIC wishes to change the second sentence of this section to read as set forth below:

*"Today, KPIC is also admitted in Colorado, Georgia, Hawaii, Kansas, Maryland, Missouri, Ohio, Oregon, South Carolina, Virginia, Washington, and the District of Columbia."*

The intent of the above change is to add clarity as to the states in which KPIC is licensed.

**III. MANAGED CARE HEALTH INSURANCE PLANS (MCHIP)**

**DISCLOSURE AND REPRESENTATIONS TO ENROLLEES**

*"The review revealed that KPIC was in substantial compliance." Page 4*

KPIC agrees with the examiners' observation.

**COMPLAINT SYSTEM**

*"As discussed in the following paragraph, the review revealed 1 instance in which KPIC failed to maintain its established complaint system, in violation of 38.02-5804 A of the Code." Page 5*

KPIC agrees with the examiners' observations. Please see item 1 of section VII, Corrective Action Plan, for KPIC's intended method of compliance.

## HANDLING

***“Section 5.8.4 and Sections 5.10.2 through 5.10.5.1 of KPIC’s Coordination and Resolution of Grievances & Appeals set forth the required procedures for handling Level 2 grievances and appeals. As discussed in Review Sheet MC01, the review revealed that the member submitted a third appeal letter, specifically requesting that it be considered “a voluntary Level 2 Appeal,” and KPIC’s acknowledgement stated that the member’s letter was “considered a Level 2 Grievance and Appeal,” however, there was no documentation that KPIC followed its Level 2 response procedures. KPIC agreed with the examiners’ observations.” Page 5***

KPIC continues to agree with the examiners’ observation. Please see item 1 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

## **IV. ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES**

### **PROVIDER CONTRACTS**

#### **OneNet PPO, LLC**

***“The review revealed 86 instances where KPIC’s provider contacts failed to contain 1 or more of the 11 provisions required by 38.02-3407.15 B of the Code.” Page 6***

KPIC accepts and agrees with the examiners’ observations.

***“An example is discussed in Review Sheet EF56, where the provider contract specifically entitled the “Customer submitting the claim” to inspect the record of receipt of a claim” shall be entitled to inspect such a record on request, the language included in the provider contract failed to allow the provider this right, in violation of 38.2-3407.15 B1 [of] the Code. KPIC agreed with the examiners’ observations.” Page 7***

KPIC continues to agree with the examiners’ observations.

#### **MultiPlan, Inc.**

***“The review revealed 80 instances where KPIC’s provider contacts failed to contain 1 or more of the 11 provisions required by 38.02-3407.15 B of the Code.”***

***“An example is discussed in Review Sheet EF51, where the agreement failed to contain a provision requiring that a provider contract include or attach the fee schedule and all applicable material addenda, schedules and exhibits. KPIC disagreed with the examiners’ observations, stating that the reimbursement exhibit was included in the base contract. However, the Code requires a provider contract to contain the language outlined by 38.2.3407.15 B 8 in addition to including a fee schedule exhibit. Therefore, KPIC’s failure to include the provisions altogether places the company in violation of this section.” Page 8***

KPIC accepts the examiners’ observations.

#### **MedImpact, Inc.**

***“The examiners reviewed 1 contract that was negotiated with a pharmacy provider through the intermediary MedImpact, Inc. As discussed in Review Sheet EF12, the review revealed the provider contact failed to contain all 11 provisions required by 38.02-3407.15 B of the Code. KPIC agreed with the examiners’ observations.” Page 7***

KPIC continues to agree with the examiners’ observations.

## **Summary**

***“Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with 38.2-3407 15 of the Code. The failure of KPIC to amend its provider contracts to comply with 38.2-3407 15 A of the Code occurred with such frequency as to indicate a general business practice, placing it in violation of 38.2-510 A 15 of the Code in 177 instances.” Pages 8 and 9***

KPIC accepts the examiners' observation. Please see item 2 of section VII, Corrective Action Plan, for KPIC's intended method of compliance.

## **PROVIDER CLAIMS**

***“The review revealed 9 instances in which KPIC failed to pay interest as required by this section, in violation of 38.2-3407.15 B 3 of the Code. An example is discussed in Review Sheet EFCL12. KPIC agreed with the examiners' observations.” Page 9***

KPIC continues to agree with the examiners' observations. Please see item 3 of section VII, Corrective Action Plan, for KPIC's intended method of compliance.

***“As discussed in Review Sheet EFCL18, the review revealed 1 instance in which KPIC failed to notify the provider 30 days in advance of the retroactive denial of a claim and failed to provide a written explanation for the retroactive denial of a previously paid claim, in violation of these sections. KPIC agreed with the examiners' observations.” Page 10***

KPIC continues to agree with the examiners' observations. Please see item 3 of section VII, Corrective Action Plan, for KPIC's intended method of compliance.

***“The review of the sample claims revealed that KPIC underpaid the fee schedule amount specified for the health care service provided in 1 instance, in violation of 38.2-3407.15 B 4 a ii c, 38.2-3407.15 B 4 a ii d, and 38.2-3407.15 B 8 of the Code. An example is discussed in Review Sheet EFCL23. KPIC agreed with the examiners' observations.” Page 11***

KPIC continues to agree with the examiners' observations. Please see item 3 of section VII, Corrective Action Plan, for KPIC's intended method of compliance.

***“The review also revealed that KPIC allowed more than the contracted amount in 1 instance. While allowing more than the contracted amount is not considered to be a violation of the Code, this practice may result in an increase in the coinsurance owed by the member on a given claim. KPIC is cautioned to the potential for future violations.” Page 11***

KPIC accepts the examiners' observation; however, we do seek clarification as what is meant by the statement “*KPIC is cautioned to the potential for future violations.*” While KPIC's desire and intent is to process claims in accordance with the contracted amount, we concur with the examiners' observation that allowing more than the contacted amount is not a violation of the Code.

***“KPIC's failure to perform the required provider contract provisions did not occur with such frequency as to indicate a general business practice.” Page 11***

KPIC accepts the examiners' observation.

## V. PREMIUM NOTICES

***“As discussed in Review Sheet PB05, the review revealed 1 violation of 38.2-3407.14 A of the Code. A review of the file indicates that KPIC failed to provide written notice of intent to increase annual premiums by more than the 35%, as required. KPIC agreed with the examiners’ observations.” Page 12***

KPIC continues to agree with the examiners’ observations. Please see item 4 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

***“The review revealed 3 violations of 38.2-3407.14 B of the Code. An example is discussed in Review Sheet PB01. KPIC disagreed with the examiners observations, stating, in part, that “...the renewal information was sent out 10.30.09 which is 63 days prior to 1.1.10...” The examiners responded that the FedEx delivery receipt, with signature confirmation, included in the file indicates that the notice was not received until November 5, 2009 which resulted in notice of only 57 days. In addition, the delivery receipt indicates a pick-up date and shipment date of November 4, 2009. The examiners also noted that the tracking number on the shipment receipt provided with KPIC’s response did not match the tracking number on the delivery receipt in the file.”***

While KPIC accepts the examiners’ observations, it does wish to provide addition context to its original response regarding Review Sheet PB01. Please note that the original premium increase notice was shipped to the employer’s last known address on October 30, 2009, via FedEx 2-Day(Tracking Number 428508035345). That shipment was returned to KPIC due to the fact that the employer had changed locations without notice to KPIC. The employer’s new address was then determined and the notice was again shipped via FedEx overnight delivery (Tracking Number: 428508037705) on November 4, 2009 and was delivered on November 5, 2009. This explains the why two different FedEx tracking numbers were involved in KPIC notification efforts involving this employer.

Please see item 5 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

## VI. COMPLAINTS

***“A sample of 25 from a total population of 64 written complaints received during the examination time frame was reviewed. The review revealed that KPIC was in substantial compliance with this section.” Page 14***

KPIC accepts the examiners’ observation.

## VII. CLAIMS PRACTICES

### GENERAL HANDLING STUDY

KPIC accepts this section as written.

### PREPAID CLAIM REVIEW

***“A sample of 230 was selected from a population of 102,042 claims paid during the examination time frame. The review revealed that the claims were paid in accordance with the policy provisions.” Page 15***

KPIC accepts the examiners’ observation.

### **Interest on Accident and Sickness Proceeds**

***“The review revealed 10 violations of this section. An example is discussed in Review Sheet CL36, where KPIC took 141 calendar days to pay a claim and filed to pay the statutory interest due. KPIC agreed with the examiners’ observations.” Page 15***

KPIC continues to agree with the examiners’ observations. Please see items 6 and 7 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

### **TIME PAYMENT STUDY**

***“Of the 230 claims reviewed for the study, 8% of claims were not settled within 15 working days. The examiners recommend that KPIC review its procedures to reduce the percentage of claims paid after 15 working days.” Page 16***

KPIC accepts the examiners’ recommendation. Please see item 8 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

### **DENIED CLAIMS REVIEW**

***“A sample of 95 was selected for a population of 10, 424 claims denied during the examination time frame. The review revealed that the claims were handled in accordance with the policy provisions.” Page 16***

KPIC accepts the examiners’ observation.

### **UNFAIR CLAIMS SETTLEMENT PRACTICES REVIEW**

***“14 VAC 5 – 400-50 A – in 21 instances, claims were not acknowledged within 10 working days upon receipt of notification. An example is discussed in Review Sheet CL29, where KPIC took 25 working days to acknowledge a claim. KPIC agreed with the examiners’ observations.” Page 15***

KPIC continues to agree with the examiners’ observations. Please see item 9 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

***“14 VAC 5 – 400-60 A – in 20 instances, a claimant was not advised of the acceptance or denial of a claim within 15 working days after proof of loss was received. An example is discussed in Review Sheet CL16, where KPIC took 33 working days to affirm the claim after receipt of proof of loss. KPIC agreed with the examiners’ observations.” Page 17***

KPIC continues to agree with the examiners’ observations. Please see item 10 of section VII, Corrective Action Plan, for KPIC’s intended method of compliance.

### **THREATENED LITIGATION**

***“KPIC informed the examiners that there were no claim files that involved threatened litigation received during the examination time frame.” Page 18***

KPIC reaffirms that there were no claims files that involved threatened litigation received during the examination time frame.

## **VII. INDEPENDENT EXTERNAL REVIEW OF ADVERSE UTILIZATION REVIEW DECISIONS**

***“There were no appeals of final adverse decisions or independent external reviews that occurred during the examination time frame. KPIC had established procedures in place to maintain compliance with 14 VAC 5-215-10 et seq.” Page 20***

KPIC agrees with the examiners’ observations.

## VII. CORRECTIVE ACTION PLAN

1. KPIC agrees to review and update its written procedures so as to ensure that it maintains its complaint system as required by 38.2-5804 A of the Code.
2. While KPIC agrees to review, update and maintain procedures to ensure that all provider contracts contain the provisions required by the Code sections set forth below, KPIC has concerns as to whether or not this action can be accomplished within 120 days following finalization of the Exam Report. For example, the Virginia component of the Multi-Plan contract is comprised of 73 acute care hospitals; 1,463 ancillary facilities; 5,188 primary care providers; and 11,447 specialists. As such, KPIC wishes to better understand the Bureau's expectations of KPIC in regard to this item of the Corrective Action Plan.  
  
38.2-3407.15 B 1; 38.2-3407.15 B 2; 38.2-3407.15 B 3; 38.2-3407.15 B 4; 38.2-3407.15 B 5; 38.2-3407.15 B 6; 38.2-3407.15 B 7; 38.2-3407.15 B 8; 38.2-3407.15 B 9; 38.2-3407.15 B 10; and 38.2-3407.15 B 11 of the Code.
3. KPIC agrees to review, update (and/or establish as necessary) and maintain procedures to ensure adherence to and compliance with the minimum fair business standards in the processing and payment of claims as required by 38.2-520 A 15, 38.2-3407.15 B 3; 38.2-3407.15 B 4; 38.2-3407.15 B 6; 38.2-3407.15 B 7; 38.2-3407.15 B 8; 38.2-3407.15 C of the Code.
4. KPIC agrees to review, update (and/or establish as necessary) and maintain procedures for compliance with 38.2-3407.14 A and 38.2-3407.14 B of the Code.
5. KPIC agrees to review all renewals of group contracts issued in Virginia for the years 2008, 2009, 2010, and 2011, and the current year that resulted in a more than 35% increase in the annual premium charged for the coverage thereunder; determine which contracted holders were not notified in writing 60 days prior to such increase, as required by 38.2-3407.14 A and 38.2-3407.14 B of the Code, and refund to the group contract holder all premium amounts collected in excess of the 35% increase for the entire policy period of which notice was not provided. Additionally, KPIC agrees to send checks for the required refund along with letter of explanation stating specifically, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was revealed that KPIC failed to provide 60 days written notice to the policyholder of intent to increase premium by more than 35%. Please accept the enclosed check for the refund amount."
6. KPIC agrees to strengthen its procedures for the payment of interest on accident and sickness claim proceeds, as required by 38.2-3407.2-3407.1 B of the Code. KPIC has already adjusted its claims systems to correctly calculate interest payments in accordance with 38.2-3407.2-3407.1 B of the Code.
7. KPIC agrees to review and pay for the years 2008, 2009, 2010, 2011, and the current year and make interest payments where necessary as required by 38.2-3407.1 B of the Code. Additionally, KPIC agrees to send checks for the interest along with a letter of explanation or statement on the EOB that, "As a result of a Target Market Conduct Examination initiated by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that interest had not been paid previously." After which, KPIC agrees to furnish the examiners with documentation that the required interest has been paid.
8. KPIC agrees to strengthen its established procedures to ensure that claims are paid within 15 working days. To that end, KPIC has already initiated a change in the hierarchy of claim processing queue to ensure claims are processed within 15 working days.
9. KPIC agrees to review its established procedures to ensure that it acknowledges the receipt of notification of a claim within 10 working days, as required by 14 VAC 5-400-50 A. To this end, KPIC has adjusted the claims system processing threshold from the previous 15 calendar

days, to 12 calendar days to assure compliance with 14 VAC 5-400-50 A.

10. KPIC agrees to review and update (and/or establish as necessary) and maintain procedures to advise a claimant of acceptance or denial of a claim within 15 working days of receipt of proof of loss, as required by 14 VAC 5-400-60 A.
11. KPIC agrees to review its established procedures to ensure that notification of a claim under investigation is sent every 45 days from the date of notification of the claim and every 45 days thereafter, as required by 14 VAC 5-400-60 B.
12. With the exception of the concern noted in item 2 above, KPIC agrees that within 120 days of the exam report being finalized, it will furnish the examiners with documentation that each of the above actions have been completed.

I also want to take this opportunity to extend KPIC's thanks to the examiners involved in this process. Their professionalism, patience, and courtesies extended to our examination team are greatly appreciated.

Sincerely,



Mitchell J. Goodstein  
President  
Kaiser Permanente Insurance Company

COPY



October 24, 2012

**CERTIFIED MAIL 7011 0110 0001 6085 2151  
RETURN RECEIPT REQUESTED**

Jeffrey Young  
Kaiser Permanente Insurance Company  
3200 Thornton Ave., 4th Floor  
Burbank, CA 91504

**RE: Response to Kaiser Permanente Insurance Company for the Target Market  
Conduct Examination Exposure Draft**

Dear Mr. Young:

The examiners have received and reviewed Kaiser Permanente Insurance Company's (KPIC) response to the Draft Report dated September 7, 2012. This response will only address those areas of the response where KPIC disagreed with the findings and corrective actions of the Report, where additional clarification was necessary, or where, upon further review, the examiners decided to modify our findings.

**II. Company History**

The second sentence of this section will be modified as noted in your response. The revised page is enclosed for your review.

**IV. Ethics and Fairness in Carrier Business Practices – Provider Claims**

In regard to the instance where KPIC allowed more than the contracted amount on a claim, the company has requested clarification as to what is meant by the statement that "KPIC is cautioned to the potential for future violations." As stated in the Draft Report, the practice of allowing more than the contracted amount may result in an increase in the coinsurance owed by a member on a given claim. In the event that the overpayment of allowable amounts continues, the examiners may discover instances of incorrect coinsurance calculations during future Claims Practices reviews. While there were no instances discovered during this Examination, this statement was included to caution KPIC of future potential violations.

## V. Premium Notices

Upon review of the additional information provided by KPIC, the examiners have removed the violation of § 38.2-3407.14 B of the Code referenced in Review Sheet PB01. The revised page with a different Review Sheet example is enclosed for your review.

## VII. Corrective Action Plan

**2. Establish and maintain procedures to ensure that all provider contracts contain the provisions required by §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code.**

The examiners acknowledge KPIC's concerns regarding completion of the assigned Corrective Action within the specified time frame. Please be advised that the company should aim to bring each of its contracts into compliance with the required Code sections by this deadline; however, if the process takes longer than 120 days after the Report has been finalized, KPIC can provide an update on the incomplete items and the examiners will consider a request for an extension at that time. The company should note that for any incomplete remediation action, the examiners may request documentation of any portions that have been completed.

**6. Strengthen its procedures for the payment of interest on accident and sickness claim proceeds, as required by § 38.2-3407.1 B of the Code.**

The examiners acknowledge KPIC's agreement to strengthen its procedures for the payment of interest; however, please be advised that the requirements of the Corrective Action Plan pertain only to § 38.2-3407.1 B of the Code.

A copy of the entire Report is attached and these are the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that KPIC has violated the Unfair Trade Practices Act, specifically § 38.2-510 A 15 of the Code.

In addition, there were violations of §§ 38.2-3407.1 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, and 38.2-5804 A of the Code, as well as 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, and 14 VAC 5-400-60 B, Rules Governing Unfair Claim Settlement Practices.

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

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

Very truly yours,

Carly B. Daniel, AIE, AIRC  
Principal Insurance Market Examiner  
Market Conduct Section 1  
Life and Health Market Regulation Division  
Bureau of Insurance

CBD/mhh  
cc: Bob Grissom

COPY

Jeffrey Young  
Kaiser Permanente Insurance Company  
3200 Thornton Ave., 4th Floor  
Burbank, CA 91504

530072

---

Althelia P. Battle, FLMI, HIA, AIE, MHP, AIRC, ACS  
Deputy Commissioner  
Bureau of Insurance  
Post Office Box 1157  
Richmond, VA 23218

RE: Alleged violations the Unfair Trade Practices Act, specifically § 38.2-510 A 15 of the Code as well as violations of §§ 38.2-3407.1 B, 38.2-3407.14 A, 38.2-3407.14 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, 38.2-3407.15 B 11, and 38.2-5804 A of the Code, as well as 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, and 14 VAC 5-400-60 B, Rules Governing Unfair Claim Settlement Practices.

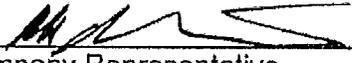
Dear Ms. Battle:

This will acknowledge receipt of your letter dated November 1, 2012, concerning the above-captioned matter.

KPIC wishes to make a settlement offer for the alleged violations cited above. Enclosed with this letter is a check (certified, cashier's or company) in the amount of \$30,000 payable to the Treasurer of Virginia. The Company further understands that as part of the Commission's Order accepting the offer of settlement; it is entitled to a hearing in this matter and waives its right to such a hearing, and agrees to comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report as of March 31, 2010.

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

Yours very truly,

  
Company Representative

Mitchell Goodstein  
President

11/15/12  
Date

Enclosure (check)

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v.

CASE NO. INS-2012-00262

KAISER PERMANENTE INSURANCE  
COMPANY,

Defendant

SETTLEMENT ORDER

Based on a target market conduct examination performed by the Bureau of Insurance ("Bureau"), it is alleged that Kaiser Permanente Insurance Company ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Commonwealth"), in certain instances violated § 38.2-510 A 15 of the Code of Virginia ("Code"), as well as the Commission's Rules Governing Unfair Claim Settlement Practices, 14 VAC 5-400-10 *et seq.*, specifically 14 VAC 5-400-50 A, 14 VAC 5-400-60 A, and 14 VAC 5-400-60 B, by failing to comply with claim settlement practices; violated § 38.2-3407.1 B of the Code by failing to pay interest at the legal rate of interest from the date of fifteen (15) working days from the Defendant's receipt of proof of loss to the date that the claim was paid; violated §§ 38.2-3407.14 A and 38.2-3407.14 B of the Code by failing to comply with the requirements regarding notice of premium increases; violated §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 7, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code by failing to comply with ethics and fairness requirements for business practices; and violated § 38.2-5804 A of the Code by failing to comply with

procedures to establish and maintain a complaint system for each of its Managed Care Health Insurance Plans (MCHIPs).

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

The Defendant has been advised of its right to a hearing in this matter whereupon the Defendant, without admitting any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has tendered to the Commonwealth the sum of Thirty Thousand Dollars (\$30,000), waived its right to a hearing, and agreed to comply with the corrective action plan contained in the Target Market Conduct Examination Report as of March 31, 2010.

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

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

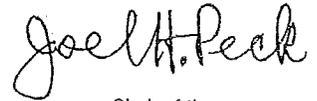
Accordingly, IT IS ORDERED THAT:

(1) The offer of Kaiser Permanente Insurance Company in settlement of the matter set forth herein is hereby accepted.

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

AN ATTESTED COPY hereof shall be sent by the Clerk of the Commission to:  
Jeffrey Young, Kaiser Permanente Insurance Company, 3200 Thornton Avenue, Fourth Floor,  
Burbank, California 91504; and a copy shall be delivered to the Commission's Office of General  
Counsel and the Bureau of Insurance in care of Deputy Commissioner Althelia P. Battle.

A True Copy  
Teste:



Clerk of the  
State Corporation Commission

COPY