Wisconsin Office of the
COMMISSIONER
OF INSURANCE

Tony Evers, Governor of Wisconsin
Nathan Houdek, Commissioner of Insurance

August 21, 2026

DELIVERED VIA E-MAIL
BRETT DAVIS
MOLINA HEALTHCARE OF WISCONSIN, INC.
200 S. EXECTUTIVE DR., SUITE 100
BROOKFIELD, WI 53005

Dear Mr. Davis:

On June 1, 2026, a proposed report of examination of your company was served in accordance with the requirements of § 601.44 (6), Wis. Stat. On July 1, 2026, we received notice from Jane Fowler, Molina AVP, Compliance, that the report was not being contested and could be adopted as final. Therefore, we enclose, in accordance with § 601.44 (7), Wis. Stat., the notice of adoption and filing of examination report applicable to your company's recent market conduct examination. The report is now an official public record of the office.

A copy of the examination report as adopted is attached.

Also enclosed is the compliance order issued according to § 601.41 (4), Wis. Stat., and applicable to the report. If you desire a hearing to contest this compliance order, you should make a written request to the Office of the Commissioner of Insurance within 30 calendar days of the date of this letter pursuant to § 601.62 (3), Wis. Stat. It is our office's expectation that the company will comply with the recommendations attached to the compliance order prior to re-entry into the Wisconsin insurance market. Failure to do so will result in administrative action against the company.

Your company is required by § 601.44 (8), Wis. Stat., to furnish a copy of the adopted report to each member of the board of directors. Enclosed is a form that should be executed and filed with our office to confirm that it was done.

Sincerely,

Jamie L. Adams

Jamie Adams
Administrator
Division of Market Regulation & Enforcement
608-267-2305

Notice of Adoption and Filing of Examination Report

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

Molina Healthcare Insurance Company, Inc.
200 S. Executive Dr., Suite 100
Brookfield, WI 53005

Dated August 20, 2026, and to be served upon the company on August 21, 2026, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated August 20, 2026, at Madison, Wisconsin.

Nathan Houdek
Commissioner of Insurance

OFFICE OF THE COMMISSIONER 0F INSURANCE (OCI) STATE OF WISCONSIN

In the Matter of:

COMPLIANCE ORDER

Molina Healthcare of Wisconsin, Inc.,

Respondent.

FINDINGS OF FACT

WHEREAS, an examination of Molina Healthcare Insurance Company, Inc., 200 S. Executive Dr., Suite 100, Brookfield, WI 53005 (the Respondent), was made and a report dated August 20, 2026, has been adopted as the final report by OCI; and

WHEREAS, the report of examination made certain recommendations which are attached to this Order and incorporated by reference; and

WHEREAS, the report of examination has been placed on file as an official public record of OCI.

ORDER

Pursuant to Wis. Stat. § 601.41(4), it is ordered that the Respondent shall comply with the recommendations contained in the report of examination and attached to this Order prior to the company's re-entry to the Wisconsin Marketplace. Compliance with any one or more of the recommendations may be waived in writing by OCI after receiving justifiable written reasons for a waiver.

Dated August 20, 2026, at Madison, Wisconsin.

Nathan Houdek
Commissioner of Insurance

SUMMARY OF RECOMMENDATIONS

Claims

1. It is recommended that the company implement a written process and procedure to fully audit, identify and correct any missing characters (field limit issues) within an EOB before the deployment of new software platforms to ensure compliance with § Ins 3.651(4)(a)7, Wis. Adm. Code.

2. It is recommended that the company implement a written process and procedure that ensures that all check runs are verified for complete generation of required EOBs to ensure compliance with § Ins 6.80(4)(b), Wis. Adm. Code.

Complaint Handling

3. It is recommended that the company develop written policies and procedures to ensure providers are instructed to submit the required clinical information with the initial prior authorization request and to monitor and amend those procedures, as needed, to ensure compliance with § Ins 6.11 (3) (a) 3., Wis. Adm. Code.

Grievances & IRO

4. It is recommended that the company revise the references to federal regulations in its marketplace member appeals and grievance policy to accurately refer to the federal regulations that apply to marketplace plans.

5. It is recommended that the company revise its written procedure and its oversight processes to ensure that a grievance acknowledgment letter is sent to each insured within five business days of receipt of the grievance or appeal to ensure compliance with § Ins 18.03 (4), Wis. Adm. Code.

6. It is recommended that the company revise its procedure and oversight processes to ensure that all records of each grievance be kept and are available to OCI for a period of at least three years, to ensure compliance with § Ins 18.06 (1), Wis. Adm. Code.

7. It is recommended that the company revise its written procedures and its oversight processes to ensure that it sends the grievance meeting notification letter to each insured at least seven calendar days before the date of the meeting to ensure compliance with § Ins 18.03 (3) (b), Wis. Adm. Code.

8. It is recommended that the company revise its written grievance procedure and its oversight processes to ensure that its grievance panel investigates each grievance to ensure compliance with § 632.83 (3) (b), Wis. Stat.

9. It is recommended that the company revise its written procedure and its oversight processes to ensure that the grievance panel's written decision includes a list of the position titles of panel members involved in making the decision, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.

10. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm. Code.

11. It is recommended that the company revise its written appeals procedure and its oversight processes to ensure that its grievance panel investigates each appeal to ensure compliance with § 632.83 (3) (b), Wis. Stat.

12. It is recommended that the company revise its written appeal procedures and its oversight processes to ensure that it sends the grievance meeting notification letter to each insured at least seven calendar days before the date of the meeting to ensure compliance with § Ins 18.03 (3) (b), Wis. Adm. Code.

13. It is recommended that the company revise its appeal procedure and its oversight processes to ensure that all records of each appeal be kept and are available to OCI for a period of at least three years, to ensure compliance with § 632.83 (3) (3) Wis. Stat., and with § Ins 18.06 (1), Wis. Adm. Code.

14. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm Code. (duplicate of #10)

15. It is recommended that the company revise its procedures and its oversight processes to ensure that the Panel Review Document and the appeal resolution letter accurately list the attending panel members and voting panel members, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.

STATE OF WISCONSIN

OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

MOLINA HEALTHCARE OF WISCONSIN, INC.

NAIC COMPANY CODE 12007/GROUP CODE 1531

Brookfield, Wisconsin

AS OF DECEMBER 31, 2024

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The Honorable Nathan Houdek
Commissioner of Insurance
Wisconsin Office of the Commissioner of Insurance
101 East Wilson Street
Madison, WI 53707-7873

Dear Commissioner Houdek:

Pursuant to your instructions and Wis Stat. § 601.43(1) and (5), a targeted market conduct examination was conducted April 14, 2025 to August 18, 2025 of:

MOLINA HEALTHCARE OF WISCONSIN, INC.

NAIC COCODE 12007/GROUP CODE 1531

Brookfield, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Molina Healthcare of Wisconsin, Inc. (MHWI or the company) is a Wisconsin domestic for-profit mixed model Health Maintenance Organization (HMO) insurer. An HMO insurer is defined by § 609.01 (2), Wis. Stat., as a health care plan offered by an organization established under chs. 185 or 193, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrollees, in consideration for predetermined periodic fixed payments, comprehensive health care services performed by providers participating in the plan. Under the mixed model, the company has a delivery system consisting of a combination of staff physicians and/or one or more clinics and/or independent contracting physicians operating out of their separate offices.

The company was incorporated in 2004 and commenced business the same year. It is a wholly owned subsidiary of Molina Healthcare, Inc. (MHC). The company's home office is in Brookfield, WI. MHC is headquartered in California and has a separate subsidiary for each state it markets in. The exam was completed electronically/remotely.

The company provides managed health care services under Medicaid and Medicare programs overseen by the Centers for Medicare and Medicaid Services (CMS), and through the federally facilitated marketplace (Marketplace) created under the Affordable Care Act (ACA). The company's lines of business include Medicare, Medicaid, and individual coverage on the Marketplace. The provider network consists of 105 hospitals and 48,772 providers. It reported membership at 96,635 as of January 10, 2025. In 2025, the company participated in the Marketplace and offered plans in the following Wisconsin counties: Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon,

Marinette, Milwaukee, Oconto, Oneida, Outagamie, Ozaukee, Portage, Racine, Shawano, Sheboygan, Walworth, Waushara, Washington, Waukesha, Waupaca, and Winnebago. In 2026, the company discontinued coverage in all counties except Jefferson to consider a new business strategy in 2027. Recently, the company decided to exit the Marketplace completely in Wisconsin effective January 1, 2027. It will be ineligible to re-enter the market for five years.

As noted in the table below, the company has experienced fluctuation in its market share in the past three years. Prior to the start of the exam, the company also advised that its 2025 market share will be negligible due to the loss of a majority of its Marketplace enrollment. In 2026, it advised that it no longer had any Marketplace members enrolled. The company only reports on market share in the Individual, Accident, and Health market.

Reporting Year	Rank	Market Share	Premiums Written
2024	4 of 314	7.25%	$1,225,413,966
2023	9 of 306	3.8%	$559,479,904
2022	13 of 307	2.5%	$280,417,659
2021	9 of 261	3.2%	$348,736,303
2020	9 of 316	3.4%	$339,653,257

The Office of the Commissioner of Insurance (OCI) received 25 complaints against the company from January 1, 2023 through December 31, 2024.

2024		2023	
3	Claim Handling - Claim Denial	5	Claim Handling - Out-of-Network Benefits
2	Claim Handling – Authorization Dispute	4	Claim Handling – Co-Pay, Deductible, and Co-Insurance Issues
2	Claim Handling – Claim Delay	3	Claim Denial
1	Claim Handling – Co-Pay, Deductible, and Co-Insurance Issues	2	Claim Handling – Claim Delay
1	Claim Handling – Out of Network Benefits	1	Policyholder Service – Unsatisfactory Refund of Premium
1	Marketing and Sales – Agent Handling	1	Claim Handling – Pharmacy Benefits
1	Policyholder Service – Delays/No Response	1	Claim Handling – Unsatisfactory Settlement/Offer

Note: A complaint may have more than one reason code assigned to it.

The company position was overturned on 40% of complaints. The examiners reviewed the complaints and found no evident patterns or issues that needed to be addressed during the exam.

II. PURPOSE AND SCOPE

A targeted examination was conducted pursuant to Wis. Stat. § 601.43(1). The examination focused on the period from January 1, 2023 through December 31, 2024.

The examination was a targeted examination involving the following lines of business and business functions: Company Operations and Management, Claims, Complaint Handling, Grievance and IRO, Managed Care, Network Adequacy, Policyholder Services, and Prescription Drug Formulary.

The report is prepared on an exception basis and comments are provided on those areas of the company's operations where adverse findings were noted. However, the absence of an adverse finding does not mean approval by OCI of any specific practice or procedure. The examiners' review was limited to selected practices, procedures, products, and files of the company. As a result, other practices, procedures, products, or files that are noncompliant may exist but were not identified during the examination. Therefore, this report may not reflect all the company's practices and procedures.

III. PRIOR DESK AUDIT RECOMMENDATIONS

The previous desk audit of the company dated January 12, 2024, contained the following recommendations. The company was asked to provide documentation of actions taken to ensure compliance. The company provided attestations from management of each relevant area of review that the recommendation had been addressed. These attestations outlined changes, along with updated procedures where applicable. The examiners independently determined compliance or noncompliance based on the attestations and supporting documentation or lack thereof.

System Issues & Process Issues

1. It is recommended that the company review its Change Management Process with employees to ensure it is followed, and changes are reviewed by all stakeholders prior to implementation.

   Action: Compliance

2. It is recommended that the company develop a process to ensure the effectuation of fair and equitable settlement of claims submitted to ensure compliance with § Ins 6.11 (3), Wis. Adm. Code.

   Action: Compliance

Complaint Handling & Resolution Issues

3. It is recommended that the company develop and provide training to all employees handling complaints, to review and research with the same rigor as those employees handling grievances and OCI complaints to ensure compliance with § Ins 6.11, Wis. Adm. Code.

Action: Compliance

Additional Recommendations

4. It is recommended that the company respond to all interrogatory questions with an adequate, thorough response to ensure compliance with § 601.42, Wis. Stat.

   Action: Compliance

5. As board minutes are the official written record of decisions and actions taken at a meeting and are a critical form of communication, concise and well-structured minutes are essential to the governance process. As a best practice, board meetings should describe all motions, decisions and resolutions made. The minutes should also provide for a general capture (or narrative) of topics discussed during the meeting.

   Action: Compliance

6. For Company-defined Appeals: It is recommended that the company develop a policy and procedure that ensures all members that file a grievance are invited to meet with the grievance committee to ensure compliance with § Ins 18.03 (3), Wis. Adm. Code; § 632.83, Wis. Stat.

   Action: Non-Compliance – see Recommendation 12.

7. For Company-defined Grievances: It is recommended that the company develop a policy and procedure that ensures all members that file a grievance are invited to meet with the grievance committee to ensure compliance with § Ins 18.03 (3), Wis. Adm. Code; § 632.83, Wis. Stat.

   Action: Non-Compliance – see Recommendation 7

8. It is recommended that the company develop a process to ensure that an offer of coverage is provided for the services of a provider that the plan represented as a participating provider to ensure compliance with § 609.24, Wis. Stat.

   Action: Compliance

9. It is recommended that the company revise their Continuity of Care policies and procedures, so they are consistent and ensure compliance with § 609.24, Wis. Stat.

   Action: Compliance

10. It is recommended that the company follow its own policies and procedures and perform regular audits to ensure compliance with §§ Ins 9.42 (3), (4) (f), and (5) (a), Wis. Adm. Code

    Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

A. Company Operations and Management

The examiners reviewed the company's response to the Company Operations and Management Interrogatory including the company history and overview, members of the board of directors (BOD) and those members' relationships to the company, BOD bylaws, BOD policies and responsibilities, third party contracts, audits, examinations and/or lawsuits filed, and compliance.

The company provided organizational charts for the following areas: Compliance; Finance & Analytics; Government Contracts & Member Engagement/Government Contracts and Growth and Community Engagement; Healthcare Services; Quality, Medical Affairs, and Pharmacy; Network Management and Operations; Infrastructure and Security; and the Cybersecurity Services Department that included Risk Management, Architecture, and Information Governance.

The company has a BOD and a Regulatory Compliance Committee (RCC) that consists of BOD and health plan leadership. It also had a Compliance Committee (CC) in 2023, but that was absorbed into the RCC in 2024. Bylaws, policies, and rules were submitted for the BOD and RCC. The BOD and CC/RCC agendas and minutes indicated oversight and vertical communication. A list of officers with positions held during the reporting period was also provided. According to the company, BOD met with senior leadership and was briefed on all significant operational/compliance issues.

The examiners reviewed copies of vendor contracts with Geozoning, Inc. (HealthSherpa), Firstsource Health Plans and Healthcare Services, LLC (Firstsource), Quest Analytics, LLC (Quest), and Change Healthcare Technologies, LLC (Change).

The company reported that it meets with Healthcare Solutions (now Optum) weekly to discuss projects. It provided performance metrics for 2023 and 2024 to demonstrate oversight.

Molina delegated pharmacy claim adjudication and pharmacy network management to their Pharmacy Benefit Manager (PBM), CVS CareMark. The company's procedures detailed oversight and monitoring of the PBM. In addition, the company required that each vendor sign a contract with Molina.

The company stated that it audited each vendor annually, at a minimum, which includes reviews of policies and procedures, files, Quality and Compliance Committee minutes and reports, performance monitoring tools/dashboards, and operating procedures. Those findings were then presented to and reviewed with the vendor during meetings. The company's Delegation Oversight Department used corrective action plans (CAPs) to correct and remediate vendor non-compliance.

Internal audit reports or summaries were shared with the RCC of the BOD. The company stated that, if a CAP was needed, a validation audit was scheduled after the CAP completion to verify implementation of the plan and resolution of the problem. The Compliance Monitoring team reviewed and compiled monthly the key performance indicator (KPI) data. KPI Outlier reports were sent to the compliance officers and applicable compliance leadership. Ten internal audits were performed from 2023 to 2024 in these functional areas: Configuration (2), Healthcare Services (2), Member & Provider Contact Center (4), Care Connections (1), and Claims (1).

As a result of internal audits, the company initiated a CAP based on interest being applied incorrectly on clean claims. Validation of the prior CAP was unsuccessful due to persistent

issues including deficiencies in training and education. The company initiated another CAP to address the absence of standardized processes related to Mental Health Parity. Key action items included establishing a dedicated parity team, enhancing the parity dashboard, and communicating interim workflow.

The company reported six external audits that were completed by OCI, CMS, and the federal Department of Health & Human Services (HHS) during the period of review.

Since the company only markets in Wisconsin, no market conduct exams were performed by any other state department of insurance, and no lawsuits were filed in Wisconsin during the period of review.

The company proposed discontinuing all on-exchange products for plan year 2026 and keeping a Gold plan off-exchange only in Jefferson County, with no marketing of the plan and no expected enrollment, while focusing on restructuring their network to offer a plan again in 2027.

The company had detailed record retention processes and maintained a list of records with the corresponding retention duration. The company also had a comprehensive business continuity management plan in the event of an emergency or crisis.

Question eight of the interrogatory asked for copies of contracts for management services, data management and processing, marketing, general agency, administrative services, and case management. The Geozoning Inc. (DBA HealthSherpa) Risk Report generated November 24, 2023, suggested prioritization in the following areas: data storage control, data transfer control, event or incident detection, third party management, systems development, and risk management. The report stated, "Level of Engagement in Process as High: The vendor has been

highly responsive with minimal chasing required and completed actions within the required deadline."

The report labeled all risks as mitigated and indicated none needed further tracking and/or ongoing management. However, the company also submitted a second report, dated March 6, 2025, that noted many of the same risks and recommendations as listed in the 2023 report: data storage control, data transfer control, third party management, systems development, event or incident detection, and risk management and response domains. Because the 2025 report was generated after the review period, it did not result in a Finding and is included as a reference only.

Question 13 of the interrogatory asked for copies of all internal audits involving Wisconsin business scheduled, commenced, or completed during the period of review. The examiners found that the company's *2023-AUDIT-4072 of Wisconsin Marketplace Claims* pertaining to interest paid on clean claims identified a coding issue and deficient internal controls in training, procedures, and self-monitoring. Four successive Corrective Action Plans (CAPs) were implemented, with *2023-CAP-3501* initiated due to deficiencies in training and education.

The examiners found no violations in the materials reviewed.

B. Claims

The examiners reviewed the company's response to the Claims Interrogatory including their organizational charts, the policies and procedures for claim handling, personnel training program, complaints and appeals, audit procedures, medical necessity and experimental treatment determinations, and coordination of benefits (COB).

The examiners also reviewed documents that contained claims workflow charts, KPIs of claims processed, Explanations of Benefits (EOBs) and Remittance Advices (RAs), prior authorization benefit determination matrix, the company's process for establishing provider fee schedules, and the *Marketplace Handbook* for information on copays and coinsurance, contracts for third party administrators (TPAs) used in claim processing functions, and any letters used by the company in claim processing.

The company provided organizational charts for the Claims area for the period of review. There were significant changes between 2023 and 2024. It appears there was a reorganization of the area, as several titles and position names changed and new positions were added. In addition, only one employee name appears on both the 2023 and 2024 charts.

The company stated there were no changes in the Claims Processes and Procedures (P&P) during the period of review.

The company's internal training program provided monthly and new hire claim fundamentals training that incorporated state-specific claim processing criteria. On-demand virtual eLearning/Self-Paced training was also available.

Providers could submit claims in three ways; Paper, Availity Portal and Electronic Data Interchange (EDI) Clearinghouse. The company provided samples of their EOBs and RAs. All samples were compliant with §§ Ins 3.651(4), and 3.651, Wis. Adm. Code. The company provided copies of Evidence of Coverage (EOC) and Provider Manuals for 2023 and 2024. The documents described how an insured and/or a provider could submit proof of loss.

To manage the claim count of receipts, the company utilized KPIs. The KPIs assisted the company with managing various metrics including claims processing timelines. According to

the company's *KPI Claims Report*, the percentage of claims paid within 30 calendar days was nearly 99% during the period of review.

The company performed pre- and post-payment audits on (1) 100% of claims with paid amounts equal to or greater than $50,000.00 and (2) a statistically valid sample size of a random selection of system and manually adjudicated claims. The company stated that, if non-compliance was detected over a three-month period, Operational Oversight would have requested a CAP.

During the period of review, the company contracted with two TPAs; FirstSource Health Plans and Health Care Services (FirstSource) and Availity, LLC (Availity) for claims processing. Oversight activities outlined in both TPA contracts were thorough and comprehensive. The company also utilized the technology platforms of QNXT, FirstSource, and Availity (provider portal) to manage benefits, process claims, and maintain provider networks.

The examiners reviewed the company's claims processes for preauthorization/ precertification, medical necessity, and experimental treatment. All materials reviewed adhered to specific State and federal requirements.

The examiners reviewed the company's payment methodology. It used Fee For Service (FFS) payment methodology, leveraging federal and/or state published fee schedules to determine payment rates and to ensure those rates satisfied payment obligations included in its provider contracts. For procedure codes that were not priced by CMS, the company developed its own proprietary pricing system using a blend of market research and Medicaid pricing to calculate "Gap-filling" in fee schedules. The company's fee schedules and pricing data were sorted into geographical areas. The company was asked when its fee database is updated, and how it ensures

that the data, at the time of an update, is never older than 18 months. It responded that its pricing data has effective and term dates to ensure that the price appropriate for the date of service is always assigned.

The company provided members with a *Marketplace Member Handbook*. This handbook included a Schedule of Benefits (SOB) that allowed members to see what their deductible(s), copay(s) and/or coinsurance would be for a service. The company also provided a *MyMolina* mobile application with an *Engage Cost Estimator Tool* (ECE). If the member knew the procedure code(s) that would be billed, the ECE could be used to determine allowed amounts before receiving medical care from both in- and out-of-network providers. For those without internet access, the company's contact center agents could mail the ECE cost data to the members.

Sample Review

The examiners reviewed a sample of 50 unpaid claims and 50 paid claims. Two claims resulted in findings.

The examiners found that sample #31 of the denied claim sample contained an EOB with a Reason Code Description that was cut off, and key words were missing from the description. The company determined that the missing words were due to a "field limit issue". This issue impacted 254 members in 2023 and 163 members in 2024. The field limit issue is in violation of § Ins 3.651(4)(a)7, Wis. Adm. Code that states an insurer shall provide all insureds with a narrative explanation of each claim adjustment reason code.

Recommendation

1. It is recommended that the company implement a written process and procedure to fully audit, identify, and correct any missing characters (field limit issues) within an EOB

before the deployment of new software platforms to ensure compliance with § Ins 3.651(4)(a)7, Wis. Adm. Code.

The examiners found that sample #50 of the paid claim sample contained an EOB that had a paid date of 12/23/2024, but no EOB generation/sent date. When the examiner inquired about this sample, the company replied that it was related to one check run. The company stated 382 members were affected by this event and the company further represented that no members suffered any negative consequences. The company then generated an EOB on 5/15/2025 due to OCI's identification of this issue. The missing EOB was in violation of § Ins 3.651, Wis. Adm. Code that requires an insurer to furnish a standardized EOB to insureds.

Recommendation

2. It is recommended that the company implement a written process and procedure that ensures that all check runs are verified for complete generation of required to ensure compliance with § Ins 3.651, Wis. Adm. Code.

C. Complaint Handling

The examiners reviewed the company's response to the Complaint Handling Interrogatory including their Member Appeals & Grievances organizational chart, complaint handling procedures and processes, training, reports, and complaint ratios.

In response to Question 11 of the Complaint Handling Interrogatory, the company reported an increase in its ratio of complaints (from 6.4 complaints per 1,000 members in 2023 to 10.23 complaints per 1,000 members in 2024) was due to the decrease in Marketplace membership. Since the ratio is based on the number of members, the examiner asked for

clarification. In response to the follow-up inquiry, the company then acknowledged that the Change Healthcare data breach in 2024 also resulted in increased complaints activity.

The examiners reviewed the company's response to the Complaint Handling interrogatory. Question 3 asked the company to identify any process in place to review complaint trends within the business area and/or company. The examiners found an increase in pharmacy-related complaints primarily pertaining to insufficient clinical information submitted with the initial prior authorization requests. Section Ins 6.11 (3) (a) 3., Wis. Adm. Code provides that it is an unfair claim settlement practice, when done without just cause and with such frequency as to indicate a general business practice, to fail to promptly provide insureds and claimants with the necessary claim forms, instructions, and reasonable assistance.

Recommendation

3. It is recommended that the company develop written policies and procedures to ensure providers are instructed to submit the required clinical information with the initial prior authorization request and to monitor and amend those procedures, as needed, to ensure compliance with § Ins 6.11 (3) (a) 3., Wis. Adm. Code.

D. Grievance and IRO

The examiners reviewed the company's response to the Grievance and IRO interrogatory, the Marketplace member appeals and grievance policy, the Marketplace member appeals and grievances procedure, the maximus-external review procedure, the member appeal and grievance committee policy, a copy of the company's final resolution letter template, the internal appeals and external appeals provisions and the filing an external review provisions in the

company's 2023 and 2024 evidence of coverage, and the grievance (internal appeals) and external appeals section of the company's website.

The examiners also interviewed the compliance officer, the director of appeals and grievances, and other company staff.

The company separates grievances as defined in § Ins 18.01 (4), Wis. Adm. Code, into grievances and appeals. According to the company's policy titled *Marketplace Member Appeals and Grievance Policy*, company defines an appeal as "a member's, or authorized representative's, written request for review of an adverse benefit determination." The same document defines a grievance as "any dissatisfaction with MHWI that is expressed in writing to MHWI by a member or their authorized representative that does not relate to an adverse benefit determination."

The examiners found that the company has written policies and procedures for review and resolution of grievances and expedited grievances.

The examiners found that the company's policy titled M*arketplace member appeals and grievance policy* incorrectly included references to the federal Medicaid regulation rather than the federal Marketplace regulation. The examiner reached out to the company regarding the incorrect reference, and upon this notification the incorrect reference was updated.

The examiners found that the company has elected to utilize the HHS-administered external review process. Under this process, members are directed to submit an external review request directly to the independent review organization selected by the federal HHS to administer the external review program. The company reported receiving two independent external review requests in 2023 and receiving no requests in 2024.

Sample Review

The examiners reviewed a sample of 53 files the company identified as grievances and 47 files the company identified as appeals. Of the files reviewed, 14% of the grievances and 37% of the appeals were overturned. The company's reasons for overturning its original grievance decision varied and the examiner did not identify any specific pattern.

Grievance files

Of the 53 grievance files reviewed, the examiners found four files in which the company did not provide written acknowledgement of receipt within five business days. Section Ins 18.03 (4), Wis. Adm. Code states an insurer offering a health benefit plan shall, within five business days of receipt of a grievance, deliver or deposit in the mail a written acknowledgment to the insured or the insured's authorized representative confirming receipt of the grievance.

The examiners found seven grievance files that did not include a complete copy of the grievance, including copies of any applicable emails. Section 632.83 (3) (e), Wis. Stat., requires an insurer to retain records pertaining to each grievance. Section Ins 18.06 (1), Wis. Adm. Code, provides that each record of each grievance submitted to the insurer shall be kept and retained for a period of at least three years. It is OCI's position that a complete record includes, but is not limited to, emails that pertain to the handling of the grievance/appeal.

The examiners found 26 grievance files that did not include a written notice that the grievant has the right to participate in the grievance panel meeting. Sections Ins 18.03 (3) (a) and (b), Wis. Adm. Code, provides that the grievance procedure utilized by an insurer offering a health benefit plan includes a method whereby the insured has the right to appear or participate in the

grievance meeting and that the written notification include the time and place of the grievance meeting at least seven calendar days before the meeting.

The examiners found 25 grievance files in which the resolution letters stated the grievances were reviewed by a grievance/claims specialist or other individual instead of the grievance panel. Section 632.83 (3) (b), Wis. Stat., requires that an insurer's grievance procedure includes the establishment of a grievance panel for the investigation of each grievance submitted, consisting of at least one individual authorized to take corrective action on the grievance and at least one insured other than the grievant, if an insured is available to serve on the grievance panel. Even if a grievance is resolved in the insured's favor, the grievant still has the right to appear before the grievance panel per Wisconsin regulations.

The examiners found eight grievance files in which the grievance resolution letter indicated that the grievance panel had reviewed the grievance but did not include a list of the titles of the panel members. Section Ins 18.03 (3) (g), Wis. Adm. Code, provides that the grievance panel's written decision shall be signed by one voting member of the panel and include a written description of the position titles of panel members involved in making the decision.

The examiners found four grievance files in which the issue of the grievance did not match the grievance category listed on the grievance log submitted to OCI. Section Ins 18.06 (2), Wis. Adm. Code, provides an insurer offering a health benefit plan shall submit a grievance experience report to the commissioner by March 1 of each year in a form prescribed by the commissioner.

Appeals Files

Of the 47 appeal files reviewed, the examiners found 12 appeals that did not appear to be reviewed by the company's grievance panel. Section 632.83 (3) (b), Wis. Stat., requires that an insurer's grievance procedure includes the establishment of a grievance panel for the investigation of each grievance submitted, consisting of at least one individual authorized to take corrective action on the grievance and at least one insured other than the grievant, if an insured is available to service on the grievance panel.

The examiners found 12 appeals in which the grievant had not been invited to meet with the panel. Section Ins 18.03 (3) (b), Wis. Adm. Code, provides that the grievance procedure utilized by an insurer offering a health benefit plan includes a method whereby the insured has the right to appear or participate in the grievance meeting and that the written notification include the time and place of the grievance meeting at least seven calendar days before the meeting.

The examiners found 11 appeals files in which the appeal was received by phone. However, the files did not appear to be complete as they did not include the phone notes or other documentation of the call. Section 632.83 (3) (e), Wis. Stat., requires an insurer to retain records pertaining to each grievance. Section Ins 18.06 (1), Wis. Adm. Code, requires an insurer to keep and retain records of each grievance and make the records available during exams and upon request. It is OCI's interpretation that a complete record includes, but is not limited to, phone notes that pertain to the handling of the grievance/appeal.

The examiners found 14 appeals files in which the issue of the appeal did not match the category listed on the log submitted to OCI with the Grievance Experience Report. Section Ins 18.06 (2), Wis. Adm. Code, provides an insurer offering a health benefit plan shall submit a

grievance experience report to the commissioner by March 1 of each year in a form prescribed by the commissioner.

The examiners found 17 files in which the number of panel members listed as attendees on the Panel Review Document (minutes) did not match the number of voters and also did not match the number listed on the appeal resolution letter. Section Ins 18.03 (3) (g), Wis. Adm. Code, provides that the grievance panel's written decision shall be signed by one voting member of the panel and includes a written description of the position titles of panel members involved in making the decision.

Recommendations

4. It is recommended that the company revise the references to federal regulations in its Marketplace member appeals and grievance policy to accurately refer to the federal regulations that apply to Marketplace plans.
5. It is recommended that the company follow its written procedure and its oversight processes to ensure that a grievance acknowledgment letter is sent to each insured within five business days of receipt of the grievance or appeal to ensure compliance with § Ins 18.03 (4), Wis. Adm. Code.
6. It is recommended that the company revise its procedure and oversight processes to ensure that all records of each grievance be kept and are available to OCI for a period of at least three years, to ensure compliance with § Ins 18.06 (1), Wis. Adm. Code.
7. It is recommended that the company revise its written procedures and its oversight processes to ensure that it sends the grievance meeting notification letter to each

insured at least seven calendar days before the date of the meeting to ensure compliance with § Ins 18.03 (3) (b), Wis. Adm. Code.

8. It is recommended that the company revise its written grievance procedure and its oversight processes to ensure that its grievance panel investigates each grievance to ensure compliance with § 632.83 (3) (b), Wis. Stat.
9. It is recommended that the company revise its written procedure and its oversight processes to ensure that the grievance panel's written decision includes a list of the position titles of panel members involved in making the decision, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.
10. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm. Code.
11. It is recommended that the company revise its written appeals procedure and its oversight processes to ensure that its grievance panel investigates each appeal to ensure compliance with § 632.83 (3) (b), Wis. Stat.
12. It is recommended that the company revise its written appeal procedures and its oversight processes to ensure that it sends the grievance meeting notification letter to each insured at least seven calendar days before the date of the meeting to ensure compliance with § Ins 18.03 (3) (b), Wis. Adm. Code.
13. It is recommended that the company revise its appeal procedure and its oversight processes to ensure that all records of each appeal be kept and are available to OCI

for a period of at least three years, to ensure compliance with § 632.83 (3) (3) Wis. Stat., and with § Ins 18.06 (1), Wis. Adm. Code.

14. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm Code.
15. It is recommended that the company revise its procedures and its oversight processes to ensure that the Panel Review Document and the appeal resolution letter accurately list the attending panel members and voting panel members, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.

E. Managed Care

The examiners reviewed the company's response to the Managed Care interrogatory, its policies and procedures regarding plan administration, compliance program, quality assurance and improvement, access standards, and credentialing and recredentialing. The examiners also reviewed the company organization, committee meeting documents, provider directories, and provider agreements. The company is National Committee for Quality Assurance (NCQA) certified.

The examiners reviewed the company's 2023 and 2024 provider manuals and member handbooks. The *2023 Marketplace Provider Manual* stated that when a Marketplace subscriber or their spouse gives birth, the newborn is automatically covered under the subscriber's policy with Molina for the first 31 days of life. For the newborn to continue with Molina coverage past this time, the infant must be enrolled through the Marketplace with Molina on or before 60 days from the date of birth. This is not compliant with § 632.895(5), Wis. Stat., which states the insurer may refuse to continue coverage beyond the 60-day period if such notification is not received, unless

within one year after the birth of the child the insured makes all past-due payments. The *2024 Marketplace Provider Manual* did not include the noncompliant language. The *2024 Marketplace Provider Manual* refers the provider to Availity Essentials (Availity) portal for eligibility issues.

The examiners found no violations in the materials reviewed.

F. Network Adequacy

The examiners reviewed the company's response to the Network Adequacy interrogatory, its policies and procedures regarding its access plan, and network accessibility and adequacy. The examiners also reviewed the company organization, monitoring reports, provider directories, and provider agreements.

The examiners reviewed the provider network titled "Molina Healthcare of WI", for 2023 and 2024 in the required CMS Network template for Qualified Health Plan (QHP) filings.

The examiners reviewed the member population by provider network and geographic rating area, the number and type of physicians, the number and type of referral specialists, and the number of hospitals for each provider network. The company provided detailed network information as reported to CMS for Marketplace plans.

The examiners reviewed the provider network spreadsheet which included mental health providers located in Denton County with zip code 75057. This county and zip code is located in Texas. The company advised that these providers are Teladoc Physicians that provide virtual mental health services.

The company used Quest software which has map capabilities. The company follows the CMS standards for Marketplace when reporting provider types for network adequacy. The company reports running a network adequacy check at least monthly.

The examiners reviewed documents covering the following areas: Access to Care, Availability of Health Care, Marketplace Member Handbook, Network Adequacy Standard, Network Adequacy Certification Criteria, DHS Member Choice Report, Provider Online Directory, 24 Hour Nurse Line 7 Days a Week, Network Accessibility and Adequacy, Non-Par Provider Emergency and Post Stabilization Services, and Second Opinions. The examiners found the company monitors the sufficiency of its networks to meet the health care needs of the population enrolled.

The company adopted geo-access standards and may adjust according to local network or regulatory requirements for primary care providers such as internal medicine, family practice/general and pediatricians, as well as high-volume and high-impact specialists such as OB/GYN, oncology and behavioral health.

The examiners reviewed a sample provider contract that is used for all provider types for compliance with the following regulations:

1. § Ins 9.35, Wis. Adm. Code, Continuity of Care, and with § 609.24, Wis. Stat., Continuity of Care
2. § Ins 9.36 Wis. Adm. Code, Gag Clauses, and § 609.30, Provider Disclosures
3. § 609.94, Wis. Stat., 1989 Wisconsin Act 23, Hold Harmless
4. Federal laws necessary to reflect compliance of the Molina Marketplace Product

The sample provider contract was deemed compliant.

Molina Healthcare attests compliance with 45 CFR 156.230(a)(2), stating that each Molina licensed QHP will include a provider network that is sufficient in number and types of

providers, including providers that specialize in mental health and substance use disorder services, to assure that all services will be accessible to enrollees without unreasonable delay.

The examiners reviewed the company's response regarding the ratio of primary care, OB/GYN, and pediatrics providers to enrollees. The company applies the CMS standards for Marketplace within the Quest Desktop and Cloud platforms utilizing the QHP Sample File and Marketplace network providers. Quest calculates ratios based on the CMS standards. Each month, the company meets with business stakeholders to review network adequacy for this line of business and address any network gaps. Network gaps and market options are provided to the contracting team, which then reaches out to relevant providers and offers to contract. The same provider network was in place throughout the entire review period.

The examiners reviewed the following reports and found them to be a source for monitoring provider and facility patterns and to determine any outliers: *Hospital Inpatient Trends*; *Hospital Outpatient Trends*; *Hospital Performance; Hospital Summary; Hospital Trend Performance*; and *Physician Profiles and Provider Utilization*.

The examiners reviewed the procedures for updating the provider directories for terminated providers and providers accepting new patients. There is a daily refresh of provider information which ensures timely updates.

The examiners reviewed the policy and procedure related to § Ins 9.32 (1), Wis. Adm. Code, defined network plan requirements, and did not identify a violation.

Molina Marketplace members and providers can access the Contact Center support team Monday through Friday from 8:00 a.m. to 6:00 p.m. Central Time. Other needs, such as

verifying enrollment and ordering ID cards, are also available via the company's self-service Interactive Voice Response (IVR) system.

The examiners found no violations in the materials reviewed.

G. Policyholder Service

The examiners reviewed the company's response to the Policyholder Service Interrogatory including the organizational chart, hiring and training manual, rights & responsibilities of insureds, processes & procedures for determining premiums and reviewing/changing Marketplace policies.

The company provided policyholder service organizational charts including that of their vendor, WIPRO, who supported their Wisconsin Marketplace Call Center. Job descriptions were also submitted.

According to the company's *Customer Experience Representative Training policy*, customer experience representatives received training for general customer service, phone and computer systems, eligibility, grievances, enrollment/disenrollment, demographic changes, premium billing/payments, grace periods, cost-sharing, benefits, providers, referrals, authorizations, and pharmacy. According to the company's *Customer Experience Representative Training procedure*, quality assurance monitoring was performed on customer experience representatives, call tracking was in place to prevent improper validation of callers, and performance metrics were used. According to the company's *WI Marketplace Member & Provider Contact Center Dashboard Reports*, the company states it reviews monthly metrics regarding the number of calls offered, calls handled, time to answer, hold times, and abandoned calls and calculated percentages for service level and abandoned calls on a dashboard.

According to the company's *Inbound Call Type Dashboard*, the company leadership reviewed their Contact Center trends on a weekly basis and identified demographic change, eligibility/enrollment, medical benefits, and network inquiry as the top inquiries in both 2023 and 2024. Calls decreased in each of these categories from 2023 to 2024, but membership also decreased.

Policyholder service rights and responsibilities were listed in the policy. The company asserted that they followed regulations when processing renewals from the Marketplace and sent monthly premium invoices to members. Renewal, nonpayment warning, and termination template letters were submitted for review, along with the enrollment policy and procedures.

The company indicated they have a process in place to submit any unclaimed properties to the Wisconsin Department of Revenue annually.

The examiners found no violations in the materials reviewed.

H. Prescription Drug Formulary

The examiners reviewed the company's response to the Pharmacy interrogatory. The company uses CVS CareMark for their PBM. The PBM is delegated to claims adjudication and pharmacy network management.

The company has policies and procedures for PBM oversight and compliance with regulatory and contractual requirements. The majority of PBM audits are completed by an independent third-party auditor. However, the company does perform a small number of audits. The third-party auditor reviews the PBM contract and performs audits on PBM contract pricing, the rebate program, formulary adherence, PBM pass-through pricing, and retail pharmacy network agreements.

The company's Pharmacy and Therapeutics (P&T) Committee is made up of non-voting and voting members. The voting members consist of seven independent physicians and four independent pharmacists from various clinical specialties. According to the company's *National Pharmacy and therapeutics Committee Charter*, members are approved and appointed to the Committee by the Corporate Chief Medical Officer based on the following: expertise/national recognition in a clinical specialty that best represents the needs of the plan enrollees, active professional license to practice in at least one state of the US, and expertise in clinically appropriate prescribing, dispensing, and monitoring of outpatient prescription drugs (drug use review, evaluation, intervention). The company's P&T Committee meets on a quarterly basis.

Formulary changes happen on a quarterly basis. The last quarter in 2023 had negative changes that would go into effect on Jan 1, 2024, which required change notifications going out to members. The change notifications went out on Nov 7, 2023, meeting the requirement of a 30-day notice. The remainder of the quarterly changes were positive and did not require change notifications being sent out.

The company has a retail pharmacy network that covers the state and has pharmacies in every county.

The examiners found no violations in the materials reviewed.

V. CONCLUSION

The examiners noted several violations in the area of Grievances and IRO. It should be noted that, because the company treats "Grievances" and "Appeals" with separate definitions, there were cases where an exception was duplicated to address them separately. The examiners found repeat compliance issues in this area that were first addressed with the company during the prior desk audit.

The findings from the Claims area highlight the recommendation from the prior desk audit that potential changes need to be thoroughly reviewed by affected staff before implementation.

The company is (and has been) going through significant management changes. Prior to the period of review (2017), president and CEO of MHC, Dr. J. Mario Molina, stepped down from the board of directors. The examiners also noted that there was almost complete turnover in its Organizational Charts, and during this exam we received notice from the company that Brian Maddy, the president during the period of review, had left the company. The appointed interim president was Joe Dietlin. In October 2025, the company announced the appointment of Brett Davis as the new plan president.

As the examiners were preparing to start the exam, the company requested a meeting with OCI. In the meeting, the company announced that, in 2026, it planned to pause marketing on the Marketplace, offering only one off-exchange plan in one Wisconsin county (Jefferson County). It stated that its intention was to regroup in 2026 and possibly re-enter the Marketplace with a revamped plan for the 2027 plan year. This leaves the company with only Medicare and Medicaid business in Wisconsin.

OCI staff and management discussed the implications of this change and its possible impact on the exam. We decided to proceed with the exam, as the period of review was prior to this change. Recently the company notified the OCI that it would be exiting the Marketplace completely effective January 1, 2027, and was aware that it would not be eligible to re-enter the market for five years. Any recommendations made will apply if the company re-enters the Marketplace in Wisconsin.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 17 1. It is recommended that the company implement a written process and procedure to fully audit, identify and correct any missing characters (field limit issues) within an EOB before the deployment of new software platforms to ensure compliance with § Ins 3.651(4)(a)7, Wis. Adm. Code.

Page 18 2. It is recommended that the company implement a written process and procedure that ensures that all check runs are verified for complete generation of required EOBs to ensure compliance with § Ins 6.80(4)(b), Wis. Adm. Code.

Complaint Handling

Page 19 3. It is recommended that the company develop written policies and procedures to ensure providers are instructed to submit the required clinical information with the initial prior authorization request and to monitor and amend those procedures, as needed, to ensure compliance with § Ins 6.11 (3) (a) 3., Wis. Adm. Code.

Grievances & IRO

Page 24 4. It is recommended that the company revise the references to federal regulations in its *marketplace member appeals and grievance policy* to accurately refer to the federal regulations that apply to marketplace plans.

Page 24 5. It is recommended that the company revise its written procedure and its oversight processes to ensure that a grievance acknowledgment letter is sent

to each insured within five business days of receipt of the grievance or appeal to ensure compliance with § Ins 18.03 (4), Wis. Adm. Code.

Page 24 6. It is recommended that the company revise its procedure and oversight processes to ensure that all records of each grievance be kept and are available to OCI for a period of at least three years, to ensure compliance with § Ins 18.06 (1), Wis. Adm. Code.

Page 24 7. It is recommended that the company revise its written procedures and its oversight processes to ensure that it sends the grievance meeting notification letter to each insured at least seven calendar days before the date of the meeting to ensure compliance with § Ins 18.03 (3) (b), Wis. Adm. Code.

Page 25 8. It is recommended that the company revise its written grievance procedure and its oversight processes to ensure that its grievance panel investigates each grievance to ensure compliance with § 632.83 (3) (b), Wis. Stat.

Page 25 9. It is recommended that the company revise its written procedure and its oversight processes to ensure that the grievance panel's written decision includes a list of the position titles of panel members involved in making the decision, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.

Page 25 10. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm. Code.

Page 25 11. It is recommended that the company revise its written appeals procedure and its oversight processes to ensure that its grievance panel investigates each appeal to ensure compliance with § 632.83 (3) (b), Wis. Stat.

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Page 25 13. It is recommended that the company revise its appeal procedure and its oversight processes to ensure that all records of each appeal be kept and are available to OCI for a period of at least three years, to ensure compliance with § 632.83 (3) (3) Wis. Stat., and with § Ins 18.06 (1), Wis. Adm. Code.

Page 26 14. It is recommended that the company develop and implement a process to code the grievance category according to category definitions provided by OCI, to ensure compliance with § Ins 18.06 (2), Wis. Adm Code.

Page 26 15. It is recommended that the company revise its procedures and its oversight processes to ensure that the Panel Review Document and the appeal resolution letter accurately list the attending panel members and voting panel members, to ensure compliance with § Ins 18.03 (3) (g), Wis. Adm. Code.

VII. ACKNOWLEDGEMENT

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

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

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Mary Kay Rodriguez	Insurance Examiner - Advanced

Respectfully submitted,

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Examiner-in-Charge