State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K. Nickel , Commissioner

Wisconsin.gov

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Notice of Adoption and Filing of Examination Report

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

WPS Health Plan, Inc
421 Lawrence Dr Ste 100
DePere WI 54115

dated November 23, 2011, and served upon the company on January 17, 2013, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 30th day of April, 2013.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

WPS HEALTH PLAN, INC.
GREEN BAY, WISCONSIN

NOVEMBER 7, 2011 – NOVEMBER 23, 2011

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November 23, 2011

Honorable Theodore K. Nickel
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted November 7 to November 23, 2011, of:

WPS HEALTH PLAN, INC.
Green Bay, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

WPS Health Plan, Inc. (WPSHP or the company) is a for-profit health maintenance organization (HMO) insurer. The company was incorporated April 19, 2005, and commenced business June 1, 2005. The company is a wholly owned subsidiary of Wisconsin Physicians Service (WPS) Insurance Corporation, a nonprofit service insurance corporation. On June 1, 2005, WPSHP entered into an Asset Purchase Agreement with PHP Insurance Plan, Inc. (PHP), Prevea Health Services, Inc., and Prevea Clinic, Inc. Under this agreement, all of PHP's group and individual health insurance policies and certificates were transferred to WPSHP. PHP also assigned various administrative agreements that were in effect to WPSHP. The company is domiciled in the state of Wisconsin and is licensed to write only in Wisconsin. The company currently operates in 21 counties in northeast and north central Wisconsin. The company offers individual, group and Medicare supplement plans. The company contracts with

more than 2,000 primary care and nearly 10,000 specialty care providers. The company contracts with 18 hospitals to provide inpatient services.

The majority of the premium written by the company in 2009 and 2010 was comprehensive health (group and individual). The company began offering individual health coverage in 2007.

Premium and Loss Ratio Summary

2010				
Line of Business	**Net Premium Income**	**% of Total Premium**	**Net Losses Incurred**	**Medical Loss Ratio**
Comprehensive	$92,973,502	99.3%	$84,062,864	90.4%
Medicare Supplement	639,312	0.7	475,032	74.3
Dental Only	0	0.0	0	0.0
Vision Only	0	0.0	0	0.0
All Other Health	0	0.0	0	0.0
Total	$93,612,814		$84,537,896	90.3%

2009				
Line of Business	**Net Premium Income**	**% of Total Premium**	**Net Losses Incurred**	**Medical Loss Ratio**
Comprehensive	$91,321,722	99.2%	$81,859,005	89.6%
Medicare Supplement	735,340	0.8	554,787	75.4
Dental Only	0	0.0	0	0.0
Vision Only	0	0.0	0	0.0
All Other Health	0	0.0	0	0.0
Total	$92,057,062		$82,413,792	89.5%

The company ranked 47th in 2009 as a writer of individual health and 38th in 2010. In group health insurance business, the company ranked 23rd in 2009 and 24th in 2010. In small employer business, the company ranked 19th in 2009 and 18th in 2010. In Medicare supplement business the company ranked 20th in 2009 and 50th in 2010.

Complaints

The Office of the Commissioner of Insurance (OCI) received 44 complaints against the company between January 9, 2009, and July 31, 2011. A complaint is defined as "a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent." The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint. The number of complaints decreased each year during the period of review. The most common reason for complaints was Claims-related issues, which also decreased each year during the period of review.

Complaints Received

2009

Reason Type	Total		Underwriting		Marketing & Sales		Claims		Plcyhldr Service		Other	
Coverage Type	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
Group A&H	1	4.55%					1	5.26%		%		%
HMO	21	95.45%					18	94.74%	2	100%	1	100%
Total	**22**						**19**		**2**		**1**	

2010

Reason Type	Total		Underwriting		Marketing & Sales		Claims		Plcyhldr Service		Other	
Coverage Type	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
HMO	14	93.33%	2	100%	1	100%	9	90%	1	100%	1	100%
Misc. Health & Life	1	6.67%					1	10%				
Total	**15**		**2**				**10**		**1**		**1**	

2011 (through 7/11/11)

Reason Type	Total		Underwriting		Marketing & Sales		Claims		Plcyhldr Service		Other	
Coverage Type	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total	No.	% Total
HMO	7	100%	1	100%			6	100%				
Total	**7**		**1**				**6**					

Grievances

The company submitted annual grievance experience reports to OCI for 2009 and 2010 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as, "any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan, or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured."

The grievance report for 2009 indicates the company received 135 grievances, of which 21.48% were reversed and 7.4% were compromised. The majority of the grievances filed with the company were related to Prior Authorization and Other. The grievance report for 2010 indicates the company received 124 grievances, of which 29.03% were reversed and 11.16% were compromised. The majority of the grievances filed with the company were related to the category Other.

The following table summarizes the grievances for the company for the years 2009 and 2010:

	2009					2010				
Category	No.	No. Compromise	% Compromise	No. Reversed	% Reversed	No.	No. Compromise	% Compromise	No. Reversed	% Reversed
Access to Care	0					0				
Continuity of Care	1					0				
Drug & Drug Formulary	0					1			1	100.00%
Emergency Service	1					0				
Experimental Treatment	11					3				
Prior Authorization	43	6	13.95%	13	30.23%	27	3	11.11%	10	37.03
Not Covered Benefit	24	3	12.50	4	16.66	23	2	8.69	6	26.08
Not Medically Necessary	15			6	40.00	17	2	11.76	2	11.76
Other	32			5	15.62	49	2	4.08	17	34.69
Plan Administration	5	1	20.00	1	20.00	3				
Plan Providers	0					0				
Request for Referral	3					1				
Total	**135**	**10**	**7.40%**	**29**	**21.48%**	**124**	**9**	**11.16%**	**36**	**29.03%**

Independent Review

Independent review organizations (IROs) certified to do reviews in Wisconsin are required to submit to the OCI annual reports for the prior calendar year's experience indicating the names of the insurance companies and whether the action on the claims was upheld or reversed. Issues eligible for independent review include adverse and experimental treatment determinations. The IRO reports indicate that for 2009 and 2010 the company had a total of eight IRO requests filed involving the company. The following table summarizes the IRO review requests for the company for 2009 and 2010.

Year	Total Review Requests Received	Independent Review Organizations							Number of Decisions that IRO:	
		IPRO	Maximus –CHDR	MCMC	Medical Review Inst. of America	National Medical Reviews	Permedion	Prest	Upheld	Reversed
2010	4	1	1	0	2	0	0	0	3	1
2009	4	0	3	0	1	0	0	0	4	0
Totals	8	1	4	0	3	0	0	0	7	1

II. PURPOSE AND SCOPE

A targeted market conduct examination was conducted to determine compliance with recommendations made in the previous market conduct examination dated August 22, 2002, and to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2009, through July 31, 2011. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination was limited to a review of company operations and management, claims, marketing, sales and advertising, producer licensing, rates and policy forms, new business and underwriting, policyholder services and complaints, grievances and IRO, small employer, managed care, terminations, and 2009 Wisconsin Acts and compliance.

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

III. PRIOR EXAMINATION RECOMMENDATIONS

A previous market conduct examination was conducted of Prevea Health Plan (Prevea). Prevea Health Plan was purchased by WPSHP in June 2005. The examination report of Prevea Health Plan, as adopted July 22, 2002, contained the following 38 recommendations.

Company Management and Operations

1. It is recommended that Prevea use definitions in its provider agreements that comply with s. Ins 9.01 (3) and (5), Wis. Adm. Code.

   Action: Compliance

2. It is recommended that Prevea review existing provider agreements to assure that references to s. Ins 3.50, Wis. Adm. Code, are amended to read s. Ins 9.33 (7) (b), Wis. Adm. Code.

   Action: Compliance

Claims and Claim Processing

3. It is recommended that Prevea rewrite its denial letters for chiropractic claims to include language that is compliant with the requirements of s. 632.875 (2), Wis. Stat.

   Action: Compliance

4. It is recommended that Prevea rewrite its denial of benefits letter to include language informing an enrollee of the right to file a grievance as required by s. Ins 9.33 (2), Wis. Adm. Code.

   Action: Compliance

Marketing, Sales, and Advertisements

5. It is recommended that Prevea ensure that each advertisement in its advertising file include a notation indicating the manner and extent of distribution in order to document compliance with s. Ins 3.27 (28), Wis. Adm. Code.

   Action: Compliance

6. It is recommended that Prevea ensure that each advertisement in its advertising file have a form number in order to document compliance with s. Ins 3.27 (26), Wis. Adm. Code.

   Action: Compliance

7. It is recommended that Prevea ensure that each advertisement in its advertising file identify the company by its full legal company name in order to document compliance with s. Ins 3.27 (12), Wis. Adm. Code.

   Action: Compliance

Electronic Commerce

8. It is recommended that Prevea develop a process to assure that it file with OCI all electronic commerce Medicare supplement advertisements prior to use pursuant to s. Ins 3.39 (15), Wis. Adm. Code.

   Action: Compliance

Producer Licensing

9. It is recommended that Prevea develop and put into use procedures or guidelines regarding producer licensing, accepting business from agents, tracking complaints filed about agents, or maintaining agent files, all of which is governed by s. Ins 6.57, Wis. Adm. Code.

   Action: Noncompliance

10. It is recommended that Prevea procedures for maintaining active, inactive and terminated agent files accurately reflect the manner in which it documents its agent files.

    Action: Compliance

11. It is recommended that Prevea maintain in its agent files a copy of the termination letter sent to an agent in order to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

    Action: Compliance

12. It is recommended that Prevea maintain a copy of a current Wisconsin license as required by its listing procedures in order to verify that all applicants for listing have a current valid Wisconsin license in force in order to document compliance with s. Ins 6.57 (1), Wis. Adm. Code.

    Action: Compliance

Policyholder Service and Complaints

13. It is recommended that Prevea develop and implement procedures or guidelines regarding maintaining company complaint files in order to comply with s. 601.42 (4), Wis. Stat.

    Action: Compliance

14. It is recommended that Prevea identify and process each written dissatisfaction as a grievance pursuant to s. Ins 9.01 (5), Wis. Adm. Code.

    Action: Compliance

Rates and Policy Forms

15. It is recommended that Prevea ensure that all forms contain the exact name and full address of the home office as required by s. 631.20 (2) (c), Wis. Stat.

    Action: Compliance

16. It is recommended that Prevea ensure all forms containing an authorization for disclosure of personal medical information specify the types of persons authorized to disclose this information in order to comply with s. 610.70 (2) (a) 3., Wis. Stat.

    Action: Compliance

17. It is recommended that Prevea ensure that authorization language in an insurance application provide that the authorization will not be valid in excess of 30 months from the date on which the authorization was signed in order to comply with s. 610.70 (2) (b), Wis. Stat.

    Action: Compliance

18. It is recommended that Prevea develop and institute procedures regarding the handling and processing of small employer business in order to document compliance with ch. 635, Wis. Stat., and subch. III Ins 8, Wis. Adm. Code.

    Action: Compliance

Small Employer Business

19. It is recommended that Prevea submit to OCI for approval prior to use all applications and policies, identified by distinct form numbers, in order to comply with s. 631.20, Wis. Stat.

    Action: Compliance

20. It is recommended that Prevea develop a process to assure that all small employer files are complete and contain sufficient documentation to substantiate compliance with ch. 635, Wis. Stats., and subch. III of ch. Ins 8, Wis. Adm. Code.

    Action: Compliance

21. It is recommended that Prevea assure that its small employer files contain complete and accurate supporting documentation of the eligible employees and dependents of eligible employees in order to document compliance with s. Ins 8.65 (1), Wis. Adm. Code.

    Action: Compliance

22. It is recommended that Prevea assure that its small employer files contain complete information regarding number of employees and dependents and corresponding waiver of coverage forms in order to document compliance with s. Ins 6.85 (2), Wis. Adm. Code.

    Action: Compliance

23. It is recommended that Prevea assure that its small employer files contain a disclosure of rating factors and renewability form as required by s. Ins 8.48 (1), Wis. Adm. Code, and that meets the requirements of s. 635.11, Wis. Stat.

    Action: Compliance

24. It is recommended that Prevea draft notification regarding small employer protections and maintain documentation in its small employer files of the fact that notification was given in order to comply with s. Ins 8.44 (2), Wis. Adm. Code.

    Action: Compliance

25. It is recommended Prevea establish a process to assure that intermediaries are listed with the company prior to its accepting business from the intermediary in order to comply with s. Ins 6.57 (2), Wis. Adm. Code.

    Action: Noncompliance

New Business and Underwriting

26. It is recommended that Prevea develop and institute a procedure to audit underwriting in order to document compliance with s. Ins 3.31 (3), Wis. Adm. Code.

    Action: Compliance

27. It is recommended that Prevea develop and institute procedures to assure that large group application files are correct and complete in order to document compliance with s. 628.34, Wis. Stat.

    Action: Compliance

Quality Assurance

28. It is recommended that Prevea develop a compliance and submit the plan to the OCI within 90 days of the adoption of this examination report in order to document compliance with s. Ins 9.42, Wis. Adm. Code.

    Action: Compliance

Access Standards

29. It is recommended that Prevea develop and implement a process to identify those enrollees who are part of an underserved population and to develop an access plan to meet the needs, with respect to covered benefits, of its enrollees who are members of underserved populations as required by s. 609.22 (8), Wis. Stat.

    Action: Compliance

Provider Agreements

30. It is recommended that Prevea include in all provider contracts language that addresses reimbursement to providers for services rendered under continuity of care pursuant to s. 609.24 (1) (e), Wis. Stat.

    Action: Compliance

31. It is recommended that Prevea include in all provider contracts language that addresses reporting disciplinary actions and credentialing pursuant to s. 609.17, Wis. Stat.

    Action: Compliance

32. It is recommended that Prevea include in all provider contracts language that addresses the selection and evaluation of providers pursuant to s. 609.32 (2), Wis. Stat.

    Action: Compliance

33. It is recommended that Prevea rewrite its provider agreements to ensure that the contracts address of the reporting grievances and complaints pursuant to s. Ins 9.33 (7) (b), Wis. Adm. Code.

    Action: Compliance

Grievances

34. It is recommended that Prevea set up controls to ensure that the grievance experience summary filed annually with the commissioner agrees with supporting documents pursuant to s. 628.34 (1), Wis. Stat.

    Action: Noncompliance

35. It is recommended that Prevea develop and institute a procedure whereby the date of the grievance resolution letter is recorded as the date the grievance was resolved as reported to the OCI on the annual grievance report as required by s. Ins 9.33 (7) (b), Wis. Adm. Code.

    Action: Noncompliance

36. It is recommended that Prevea routinely audit its grievance files to assure that its grievance files contain documentation that it complies with its internal grievance procedure and that it is in compliance with s. Ins 9.33, Wis. Adm. Code.

    Action: Compliance

Terminations, Nonrenewal, and Cancellations

37. It is recommended that Prevea develop and institute a written procedure regarding sending HIRSP notification and stating the reason for rejection termination, cancellation or imposition of underwriting restrictions in order to comply with s. 632.785, Wis. Stat.

    Action: Compliance

38. It is recommended that Prevea develop and institute a written procedure regarding informing policyholders of midterm or anniversary cancellation, nonrenewal, other termination, renewal with altered terms, or possible or actual lapses in order to comply with s. 631.36, Wis. Stat.

    Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claims administration processes and procedures, process for paying interest, explanation of benefit (EOB) and remittance advice (RA) forms, claim adjustment (ANSI) codes, preexisting procedure and investigation, claim methodology, coordination of benefits process claim audit reports. The company did not have capitation agreements with providers. All providers were reimbursed on a fee-for-service basis.

The company indicated it used NCQA-related claim processes that involved pre-service decisions, post-service decisions, urgent care, and concurrent review decisions. The company processed all claims for the individual and group health lines of business in its Green Bay office. The company used Amisys as its claims processing system. Approximately 99.7% of the claims were received electronically and loaded to Amisys. The remaining .3% of paper claims were entered manually into its claim process system.

The examiners reviewed a random sample of 25 paid claims, 25 denied claims, 25 paid chiropractic claims, and 25 denied chiropractic claims. As a part of this sample review, the examiners reviewed the company's EOB form and RA form. The EOB included both company internal explanation codes (EX codes) and the standard ANSI codes required by s. Ins 3.651, Wis. Adm. Code. The examiners found that 5 of the paid claims did not include all of the information on the EOB required by s. Ins 3.651 (4), Wis. Adm. Code. The EOBs that disclosed interest paid pursuant to s. 628.46, Wis. Stat., included claim adjustment reason codes (ANSI) JX and 85. However, the ANSI Code List stated that code 85 should only be used when the payment was the responsibility of the patient; which it was not. The examiners also found one EOB that did not include an ANSI claim adjustment reason code.

1. **Recommendation:** It is recommended that the company use the correct claim adjustment reason code on all explanation of benefit (EOB) and remittance advice (RA) forms as required by s. Ins 3.651 (4) (a) 5. f., Wis. Adm. Code.

The examiners also found five denied claims files in which the company did not use the required claims adjustment codes on its EOB. The company stated that it would change the ANSI code 62 to 197 and by December 15, 2011, would conduct an audit to ensure all codes were updated. The company provided its procedure for creation and maintenance of EX codes and ANSI codes that specified within 30 days after publication by the OCI, all of the ANSI codes must be reviewed to identify all new codes, as well as modifications or stop dates.

2. **Recommendation:** It is recommended that the company provide the required claim adjustment reason codes provided by the Office of the Commissioner of Insurance on the remittance advice (RA) or explanation of benefit (EOB) forms as required by s. Ins 3.651 (5), Wis. Adm. Code.

The examiners also found that the RA format was not in compliance with s. Ins 3.651 (3), Wis. Adm. Code., and s. Ins 3.651 (4), Wis. Adm. Code.

3. **Recommendation:** It is recommended that the company develop, document and implement a procedure to ensure that each remittance advice (RA) issued will be formatted correctly as required by s. Ins 3.651 (3), Wis. Adm. Code.

The examiners found that none of the EOBs reviewed in the sample of 100 included a statement as to whether payment accompanied the form and whether payment was made to the health care provider or payment was denied.

4. **Recommendation:** It is recommended that the company update all explanation of benefit (EOB) forms to include a statement as to whether payment accompanies the form, payment was made to the health care provider or payment had been denied as required by s. Ins 3.651 (4) (a) 3., Wis. Adm. Code.

The examiners found during the claims paid sample review that 13 claims were not paid timely, or within 30 days of receipt of proof of loss. Of these 13 files, the examiners found 7 for which the company had not paid interest. Of the 25 chiropractic paid claims reviewed, the

examiners found that 3 claims were not paid timely, or within 30 days of receipt of proof of loss, and the company had not paid interest on any of the 3.

5. **Recommendation:** It is recommended that the company develop, document and implement a process and procedure to ensure it pays interest on claims that are not processed/paid within 30 days of being furnished with written notice of the fact of a covered loss as required by s. 628.46, Wis. Stat.

The examiners reviewed the company's process for identifying claims that required investigation for preexisting conditions and verification of credible coverage. The examiners also reviewed the company's process for preauthorization and precertification. The examiners found that the company sent appropriate approval or denial letters to the member, referred practitioner and referring practitioner. The denial letter for preexisting condition explained the reason for the denial and the member's right to appeal and the right to request an independent review.

The company's claim system was configured to identify most claims for Wisconsin mandated benefits, with the exception of autism spectrum disorder and kidney transplant. These claims were routed to the Medical Management Department for manual processing. The examiners found that the company no longer had a benefit limitation for the kidney disease mandate and for federal mental health parity for large groups of 51 or more employees.

Company Operations and Management

The examiners reviewed the company's response to OCI's company operations and management interrogatory. They also reviewed the Board of Directors minutes, Executive Committee minutes, WPSHP business plan, audit reports and schedules, compliance program and network agreements. The examiners also interviewed the Director of Compliance Quality Services and the WPS Vice President of Regulatory Services.

The company's business affairs were managed by the Board of Directors, which included members of the Executive Committee of WPS. The Board minutes were primarily regarding WPS, but the company was represented at all meetings. The Quality Improvement

Committee reported to the Clinical Quality Management Committee, which reported to the Executive Committee or the Board of Directors. The Clinical Quality Management Committee was responsible for oversight of the company's quality improvement activities. The company's COO reported directly to the President and CEO of WPS.

The company and WPS Corporate Audit Services audited company market conduct functions. As examples, the company audited grievances, company Web site, claims, member services and agent Web sites. WPS Corporate Audit Services performed an Arise Operations audit, which included a review of marketing, agent licensing, compliance, network development, Amysys system configuration, underwriting, billing and enrollment, imaging, claim processing, coordination of benefits, medical management, subrogation and worker's compensation, claims and configuration, member services, grievance, management of the Amisys application software, and building security. All audit results were reported to the Board of Directors.

WPS holds a yearly planning committee in which the vice presidents meet to establish an operating plan. WPSHP was just included in this planning committee in 2011.

The examiners found that the company's compliance program was very comprehensive. WPS had a Compliance Attorney that was the liaison between the company and the WPS Regulatory Services Department. The WPS Regulatory Services Department consulted with the company on compliance matters and together they are responsible for ensuring compliance. The WPS Vice President of Regulatory Services served as the Compliance Officer for WPS commercial business, which includes the company.

The company's network agreements used the same template as provider agreements. It used the list of the Department of Health Services (DHS) approved providers to determine its autism network. For new provider contracting, the Wisconsin Early Autism Project (WEAP) was identified as a key contracting opportunity. The company also queried all of its existing behavioral health providers to verify if any of them provided any type of intensive or non-intensive autism services.

Grievance and IRO

The examiners reviewed the company's response to OCI's grievances and IRO interrogatory. All company departments may participate in the grievance and independent review procedures depending on the nature of the grievance. The company's Quality Department had the primary responsibility for grievance and independent review procedures. The Medical Management, Claims and Member Services Departments played a key role by assisting with the investigation, providing representation on the Grievance Committee and taking applicable follow-up action.

The Grievance Coordinator had the primary responsibility for the grievance procedure and managed the grievance data base. The Director of Quality and Government Programs and the Quality Improvement Specialist were the Grievance Coordinator's back-up.

The company defined a grievance as any dissatisfaction with the administration, claims practices or provision of services by WPSHP that is expressed in writing to WPSHP by, or on behalf of, a member. The company also followed NCQA guidelines that refer to all requests to reverse a decision as appeals. For the purpose of the company's policy and procedure, grievances and appeals were one in the same and stated as grievances.

Grievances were categorized and reported semiannually to the QI Committee. The QI Committee monitored for patterns in grievances and convened an ad-hoc committee to discuss trends, identify opportunities for improvement, and prioritize action items. The Benefits Committee had the authority to take corrective action on benefit-related changes.

The examiners reviewed a random sample of 50 grievances filed during the period of review. The examiners found that 12% or 6 of the 50 grievances involve preexisting condition denials. Of the 6 preexisting claim grievances, 5 claims, or 83.3%, were overturned. Of these 5 claim grievances, 2, or 40%, went to an independent review and were then overturned. The grievance staff indicated during the grievance interview that they analyzed the data in this report.

The examiners focused their review of the company's grievance reports on those grievances categorized as "other." This was to determine if the correct category was used and to determine if there are any patterns. The examination also focused on the grievances that had a decision of overturn and compromise. The examiners found that 50% of the sample of grievances were coded with the reason code "'other," and that 4, or 8%, were coded as "unknown." In total, 58% of grievances did not identify a specific reason. The company responded that it would review these files to determine if a more appropriate code should have been used.

The examiners also found that 5 files, or 10% of the files reviewed, included a grievance resolution date noted on the experience reports that differed from the date of the grievance resolution letter.

6. **Recommendation:** It is recommended that the company develop and institute a procedure whereby the date of the grievance resolution letter is recorded as the date the grievance was resolved as reported to the OCI on the annual grievance report as required by s. Ins 18.06 (2), Wis. Adm. Code.

The examiners reviewed the company's Grievance Experience Reports for 2009 and 2010. In the review of the 2010 report, two issues were noted: 1) The company transposed the "compromised" and "denied" numbers under the "benefit denial" category of the report; and 2) The "plan administration" details were not included. Section 628.34 (1), Wis. Stat., provides that no person on behalf of an insurer may make or cause to be made any communication relating to the insurance business which contains false or misleading information, including information that is misleading because of incompleteness. Filing a report with false entries in the report is a communication within the meaning of this statute.

7. **Recommendation:** It is recommended that the company institute controls to ensure that the grievance experience summary filed annually with the Commissioner agrees with supporting documents as required by s. 628.34 (1), Wis. Stat.

8. **Recommendation:** It is recommended that the company correct and refile with OCI its 2010 grievance experience report as required by s. Ins 18.06 (2), Wis. Adm. Code.

9. **Recommendation:** It is recommended that the company develop, document and implement a process and procedures to accurately report grievance activity to the Commissioner, including information provided in the grievance experience report as required by s. 628.34 (1), Wis. Stat. and ch. 18, subch. II, Wis. Adm. Code.

The examiners reviewed the nine files subject to independent reviews during the period of review. The IRO files contained the following:

- Invoice from IRO organization to company
- Screen shot of file from company's system
- Notification to IRO organization from IRO Coordinator at Arise
- Copy of $25 check to IRO organization (when applicable)
- Letter to Independent Review Coordinator at company from IRO requestor
- Grievance documentation (when applicable)
- IRO determination to IRO requestor
- Other notes applicable to IRO

Of the nine files, one file was overturned, while the remaining were upheld. No exceptions were noted regarding the IRO files reviewed.

Managed Care

The examiners reviewed the company's response to OCI's managed care interrogatory and reviewed a random sample of provider contracts.

The company was a defined network plan and had no health benefit plans that met the definition of a preferred provider plan (PPP) that were not PPPs. The company had its provider directory available on-line, with printed versions available by calling the company. The company provided instructions on obtaining a directory in its member newsletter.

The examiners reviewed the Credentialing Committee minutes and quality improvement minutes. The Medical Management program for WPSHP has been NCQA accredited since 2005. The company provided copies of the program descriptions and procedures for the period of review. No exceptions were noted regarding the review.

The company entered all referral requests into the company's Amisys system where they are kept indefinitely. The company began scanning all of its referrals in January 2011, which included copies of the determinations, clinical records and member correspondence. The company did not require referrals to contracted specialty providers but do require them for tertiary providers.

The company used one template contract for all its providers, hospitals, facilities, and networks contracts. During the provider contract sample review, the examiners found that the contract language indicated recredentialing would be done at 24 months. However, the contract in use, provider manual and compliance plan all indicate 36 months. The company began completing its own credentialing and recredentialing as of January 1, 2007, when its contract with St. Joseph's Hospital ended, and then changed the contract template to read every three years to reflect NCQA's requirement. The examiners found that the company's older contract language had not been updated to reflect the three-year recredentialing cycle.

The company indicated its geographical data showed it had one PCP for every 1,000 members and 90% of its members have two PCPs within 15 minutes of them. Providers were contractually required to provide 24 hours phone access.

The examiners documented that the company filed the annually required certification of access standards, certification of managed care plan types, quality assurance plan and certification of preferred provider plans managed care reports during the period of review.

Marketing, Sales and Advertising

The examiners reviewed the company's response to OCI's marketing, sales and advertising interrogatory, and the WPSHP business plan. The company indicated that the marketing, sales, and advertising functions are split between two departments: Marketing and Sales.

The WPSHP Marketing Department consisted of only the director, who reports directly to the chief operating officer of WPSHP. The director was responsible for marketing and advertising. This included Web site marketing, design of brochures, trade show displays, and other advertising functions.

Both the WPSHP and WPS Sales Departments handled all of the company's sales-related activities. Some of these activities include: developing strategies to advance the sale of products and services; recruit and train independent agents; manage the transition process for new groups; and make presentations to independent agents, prospects, and clients.

The company's marketing strategy was to increase the sales of the individual market. As of January 1, 2009, the company discontinued marketing its individual Medicare Select "65Plus" product.

Newly listed agents were introduced to WPSHP by the WPS agency manager. The training involved products, administrative procedures, technology, internal departments, quoting, underwriting, enrollment, and communications. The training time depended on the agent's experience. The company provided ongoing training and offered continuing education training.

The company did not use internet-based social networking or blogs during the period of review. The examiners reviewed the company's social media policy for employees.

The examiners reviewed 77 advertising files during the period of review. The examiners found that the advertising files contained individual applications filed as advertising.

Policyholder Service and Complaints

The examiner's reviewed the company's response to OCI's policyholder service and complaints interrogatory.

The primary function of the Member Services Department was handling inbound phone calls and in-person and electronic inquiries from members, providers, agents and internal staff. The member services staff provided information regarding benefits, eligibility, claim status, general enrollment and billing, provider participation status, as well as pharmacy benefits and service authorization requirements. The company used Amisys to document their phone calls and handling.

The Member Services Department researched customer issues, and in the event it was unable to resolve the issue within the member services area, it was responsible for directing the situation to the appropriate department for handling. It performed follow-up on referred items to ensure corrective action or resolution had occurred and it followed-up with the customer as appropriate.

The department conducted new group welcome calls within 60 days of a group's effective date in order to assist with any questions or issues the group may have had. The company tracked the survey data and presented it to internal departments on a quarterly basis to identify any opportunities for business process improvement. Other responsibilities of the department included: sending third-party liability questionnaires on claims flagged for potential subrogation, making outbound calls for insurance verification on high-dollar claims, processing drug pre-service authorizations, reviewing and system maintenance of privacy consent forms, creation of member profiles showing claims and their disposition as required, claim remark updates to show correspondence related to a claim has been received, testing customer service system module upgrades and enhancements, and providing ad-hoc support to other departments as required.

The company provided a 60-day notice for all renewal rate changes over 25% and all renewals with altered terms. If altering benefits, the company provided a detailed description of the changes along with the renewal notice.

The company's procedures stated that any voluntary requests for termination of coverage must be received in writing from the policyholder prior to the requested termination date. The reasons policyholders could terminate their coverage included having other coverage, not being able to afford the policy, and/or due to a rate increase. If the request was received after the termination date, coverage would terminate at the end of the next month.

The examiners reviewed 25 complaints from the company complaint log, including documenting compliance with company procedures. The examiners found that 3 files appeared to be incomplete in their handling (no resolution) as no follow-up calls were noted as required by company procedures. The company responded that its procedure was not followed and verified that these complaints were not included in its internal audit of the randomized audit files.

10. **Recommendation:** It is recommended that the company follow its customer call follow-up procedures and follow complaints to completion in order to ensure that insureds receive applicable grievance and/or IRO rights as required by ss. Ins 18.03 (2) and 18.11 (2), Wis. Adm. Code.

The examiners reviewed a random sample of 25 Individual terminations, nonrenewals and cancellations (declined, ridered or rated). The examiners found that the files included the required HIRSP notice when applicable. No exceptions were noted regarding this file review.

Policy Forms

The examiners reviewed the company's response to OCI's policy forms and rates interrogatory, 5 Patient Protection and Affordable Care Act (PPACA) uniform compliance filings, and 24 policy forms filed as file and use for compliance with 2009 Wisconsin Acts 14, 28, 218, 282, and 356. The company Compliance Department was responsible for all form filings and for filing the initial rate filing with new policies.

The examiners found that the company did not have a reinstatement application. The company indicated that any person whose coverage terminated voluntarily or involuntarily must re-apply for coverage using the standard application forms.

The company provided a chart showing when the latest Wisconsin mandates were added to all of its policy forms. The examiners documented that the policies included the mandates in their policy form review. The review included filings that qualified as PPACA eligible.

The examiners found that many of the initial filings were refiled with small revisions within weeks or days of the first filing. The company responded that sometimes after an initial filing was completed, but prior to implementation, WPSHP may make additional revisions to a form because of internal business decisions, recent changes to a statute or regulation, or to correct any typograpgical or formatting errors that were inadvertently missed in the intial form.

Producer Licensing

The examiners reviewed the company's response to OCI's producer licensing interrogatory.

The Sales Support Department was responsible for the management of agent contracts, agent appointments and terminations. The sales assistant was responsible for administrative aspects of agency management including fulfilling OCI administrative requirements, submitting listing forms and monitoring appointments, reviewing and submitting contracts for approval, and communications related to appointments and terminations.

The examiners reviewed the three producer contracts used by the company: agency producer agreement, individual agent listing application and general agency agreement. The company contracted with individual agents by having the agent sign the individual agent listing application. The company contracted with an agency by having the WPS agency manager and the owner or president of the agency collaborate to sign the agency producer agreement

contract. After the agency producer agreement was approved by the company, each agent in the agency completed an individual agent listing application. The examiners found that the company had no direct supervision of the agents. The agency producer agreement gave all supervisory responsibility to the contracting agency.

The contract allowed agencies to recruit and support subagents. The company indicated that it would help the agency train and monitor sales activities of the subagent. The company paid commissions to the agency on behalf of the agent and subagent. The company also paid commissions directly to agents that were appointed with the company with an individual agent listing application.

The examiners reviewed the Arise Health Plan Procedure Agent Licensing and Agent Complaint/Misconduct Report. The examiners found that the procedure and the report did not include how this information was recorded and maintained in the company and agent files. The examiners also found that the company did not have a written procedure or auditing tools to monitor agent sales activity for review and investigation. The company only conducted an annual agency Web site audit.

11. **Recommendation:** It is recommended that the company develop, document and implement a written procedure to ensure complaints against an agent are recorded and maintained in the company and agent files to document compliance with s. Ins 6.57, Wis. Adm. Code.

The company had a process that verified all business accepted, including quotes, was submitted by agents who were appointed by the company. The company also had a process to appoint and terminate agents.

The examiners reviewed the company's termination letter and appointment/termination procedure. The examiners found that the company did not have a procedure when the company was notified by OCI that an agent's license had been revoked or suspended, including suspensions for nonpayment of license renewal fees or failure to meet

continuing education requirements. The company revised the procedure for terminating agents to include a section specific for notifications from the OCI.

12. **Recommendation:** It is recommended that the company develop, document and implement a process and procedure to ensure that it provides prompt notice that a producer is no longer appointed with the company as required by s. Ins 6.57 (2), Wis. Adm. Code.

The examiners reviewed a random sample of 25 appointed agents. The agent file contained the following:

- The appointment letter
- Validation Report From SIRCON, most did not include the date SIRCON received
- Individual Agent Listing Application or Agency Producer Agreement Contract,
- Copy of agent license number

The examiners found that the application did not include a line of authority for the agent or agency as required by s. Ins 6.57 (1), Wis. Adm. Code. The company did not sell other lines of business other than group and individual health insurance and therefore no exceptions were noted.

The examiners reviewed a random sample of 25 terminated agents. The agent file contained the following:

- Agent Termination Letter
- Company Report to SIRCON or OCI Agent Notification to company
- Individual Agent Listing Application or Agency Producer Agreement Contract
- Copy of Agent License Number
- Other notes applicable to agent termination

The examiners found 16 agent files with termination letters sent beyond the 15-day requirement. The examiners also found 10 termination letters which did not clearly state the date of termination. This is the date the insurer effectively severs the agency relationship with

its intermediary agent and withdraws the agent's authority to represent the company in any capacity.

13. **Recommendation:** It is recommended that the company develop, document and implement a process and procedure to ensure that the notice shall clearly state the date of termination. This notice shall also include a formal demand for the return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

The examiners reviewed the company's response to OCI's small employer group interrogatory, application and disclosure forms, standardized letters and underwriting standards.

The company's underwriting for small group business was done by WPS staff in Madison. The company reviewed the final submission to make sure all the paperwork was in the file and complete. The company did not underwrite small employer group new employees, late entrants or their dependents. The company had a number of association plans and followed the small employer group rules for each group within an association that qualified by number of employees. The company required a group size questionnaire to be completed on an annual basis by every group at renewal to verify that they qualify as a small group.

The company provided a written disclosure form to small employers that described its rating methodology, employer's renewability rights and the rights to increase premiums. The company also provided a notice of Wisconsin protections for small employer groups. Both of these forms must be signed by an authorized representative of the small employer and must be submitted with their application for small group insurance. The company provided agents with a checklist that informed them of the required forms for group submission. An internal checklist was also completed during processing of a new group. The examiners found that four small employers groups applying for association group coverage had not signed the disclosure of rating factors and renewability form and that the company's small employer checklist indicated the form did not have to be signed.

14. **Recommendation:** It is recommended that the company develop an audit process to ensure that its procedures are followed and the disclosure of rating and renewability for all small employer groups is provided prior to the sale of a plan as required by s. 635.11 (1m), Wis. Stat.

The examiners found that the company's automated renewal system was designed to ensure compliance with the small employer rating requirements of s. 635.05, Wis. Stat., and s. Ins 8.52, Wis. Adm. Code.

Company agents did not have underwriting authority. Agents were trained on company products using a combination of the field underwriting guide, product brochures and applications, benefit design outlines quoting information and enrollment information. The examiners' review of the field underwriting guide found the guide to be very helpful and detailed.

The examiners reviewed a random sample of 25 issued small employer files. The examiners found one employer application was signed on November 16, 2009, with a January 1, 2010, effective date. The new business check off list indicated that agent's appointment was pending with the company. The OCI database showed that the agent was appointed with the company effective January 14, 2010. The company procedures stated that if an application was received and the agent was not appointed that the new business small employer check would be returned and the group not processed. The company did not provide documentation that the small employer's check was returned and the group processing stopped until the agent was appointed. The company stated that the original application was signed by an appointed agent. During the processing of the group, the company was notified of a change of agents from the same agency and did not check to make sure the new agent was licensed and appointed.

15. **Recommendation:** It is recommended that the company not accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent appointed with the company as required by s. Ins 6.57 (5), Wis. Adm. Code.

The company indicated it provided a notice of the order of benefits determination in the certificate of coverage. Section 632.793, Wis. Stat., provides that if an employee will lose primary coverage upon reaching age 65, the insurer shall provide written notice of the change in coverage status by regular mail to the individual and send a copy of the notice by regular mail to the employer. The company indicated it had developed a procedure of notice of loss of primary coverage at age 65 and began implementing the procedure during the on-site portion of the examination.

New Business and Underwriting

The examiners reviewed the company's response to OCI's new business and underwriting interrogatory.

Company procedures stated that if an agent was not appointed when submitting new business, the underwriting department returned the application and check with a letter explaining that the company can only accept applications from currently appointed agents.

Individual applicants that are declined for coverage were sent a letter which included the reason for the decision, the source of the information used, and HIRSP and appeal information. If a rider or rating was offered, the same information was sent to the applicant along with independent review information.

The application used by the company for individual underwriting asked if the applicant had any other health insurance in force. If the applicant answered yes, the company asked for information to confirm that the applicant intended to end the coverage. The applicant was notified that s/he is not eligible for coverage if currently covered under a group policy or individual health plan. If a person currently had a company individual health plan and wished to change his or her plan to a lesser benefit, no underwriting was required.

At the time of initial underwriting, the Underwriting Department identified all medical conditions that were known in the Amisys system so the Claims Department was aware and did not consider them preexisting. The member file in the Amisys system included a field for the

date span for a preexisting time period. Medical records were reviewed by claims processors and also reviewed by underwriting before the claims were denied as preexisting. If a group enrollee was being investigated, the certificate of creditable coverage was reviewed prior to any action being taken.

The company was a member of the Medical Information Bureau (MIB) but indicated it was not making MIB searches. It was working on procedures to begin the process in the future for individual business.

The company used a third party, eHealthInsurance, to facilitate electronic enrollment. Applicants completed an electronic application online. It was a duplicate of the Wisconsin uniform application for individuals. To process the application, all questions must be answered and the applicant and agent must electronically sign the application. The company did not accept new business applications through telephonic application.

The company provided documentation that it filed cancellation and rescission reports for 2009 and 2010 as required by s. 601.428, Wis. Stat. The reports indicated the company rescinded two policies during 2009 and seven policies during 2010. The examiners reviewed the rescinded applications file. No exceptions were noted.

V. CONCLUSION

This targeted market conduct examination involved a compliance examination of WPS Health Plan, Inc., practices and procedures for the period January 1, 2009, through July 31, 2011. This compliance examination resulted in 15 recommendations in the areas of claims; grievance and IRO; policyholder service and complaints; producer licensing; and small employer.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 14. 1. It is recommended that the company use the correct claim adjustment reason code on all explanation of benefit (EOBs) and remittance advice (RAs) as required by s. Ins 3.651 (4) (a) 5. f., Wis. Adm. Code.

Page 14 2. It is recommended that the company provide the required claim adjustment reason codes provided by the Office of the Commissioner of Insurance on the remittance advice (RA) or explanation of benefit (EOB) forms as required by s. Ins 3.651 (5), Wis. Adm. Code.

Page 14 3. It is recommended that the company develop, document and implement a procedure to ensure that each remittance advice (RA) issued will be formatted correctly as required by s. Ins 3.651 (3), Wis. Adm. Code.

Page 14 4. It is recommended that the company update all explanation of benefit (EOB) forms to include a statement as to whether payment accompanies the form, payment was made to the health care provider or payment had been denied as required by s. Ins 3.651 (4) (a) 3., Wis. Adm. Code.

Page 15 5. It is recommended that the company develop, document and implement a process and procedure to ensure it pays interest on claims that are not processed/paid within 30 days of being furnished with written notice of the fact of a covered loss as required by of s. 628.46, Wis. Stat.

Grievance and IRO

Page 18 6. It is recommended that the company develop and institute a procedure whereby the date of the grievance resolution letter is recorded as the date the grievance was resolved as reported to the OCI on the annual grievance report as required by s. Ins 18.06 (2), Wis. Adm. Code.

Page 18 7. It is recommended that the company institute controls to ensure that the grievance experience summary filed annually with the Commissioner agrees with supporting documents as required by s. 628.34 (1), Wis. Stat.

Page 19 8. It is recommended that the company correct and refile with OCI its 2010 Grievance Experience Report as required by s. Ins 18.06 (2), Wis. Adm. Code.

Page 19 9. It is recommended that the company develop, document and implement a process and procedures to accurately report grievance activity to the Commissioner, including information provided in the grievance experience report as required by s. 628.34 (1), Wis. Stat., and ch. 18, subch II, Wis. Adm. Code.

Policyholder Service and Complaints

Page 23 10. It is recommended that the company follow its customer call follow-up procedures and follow complaints to completion in order to ensure that insureds receive applicable grievance and/or IRO rights as required by ss. Ins 18.03 (2) and 18.11 (2), Wis. Adm. Code..

Producer Licensing

Page 25 11. It is recommended that the company develop, document and implement a written procedure to ensure complaints against an agent are recorded and maintained in the company and agent files to document compliance with s. Ins 6.57, Wis. Adm. Code.

Page 26 12. It is recommended that the company develop, document and implement a process and procedure to ensure that it provides prompt notice that a producer is no longer appointed with the company as required by s. Ins 6.57 (2), Wis. Adm. Code.

Page 27 13. It is recommended that the company develop, document and implement a process and procedure to ensure that the notice shall clearly state the date of termination. This notice shall also include a formal demand for the return of all indicia of agency as required by s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

Page 28 14. It is recommended that the company develop an audit process to ensure that its procedures are followed and the disclosure of rating and renewability for all small employer groups is provided prior to the sale of a plan as required by s. 635.11 (1m), Wis. Stat.

Page 28 15. It is recommended that the company not accept business directly from any intermediary or enter into an agency contract with an intermediary unless that intermediary is a licensed agent appointed with the company as required by s. Ins 6.57 (5), Wis. Adm. Code.

VII. ACKNOWLEDGMENT

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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Moua Yang	Insurance Examiner
Erin Mirza	Insurance Examiner
Alison Fasching	Advanced Insurance Examiner
Stephanie Cook	Advanced Insurance Examiner

Respectfully submitted,

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Examiner-in-Charge