State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Scott Walker, Governor
Theodore K Nickel, Commissioner

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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

GUNDERSEN HEALTH PLAN INC
1836 SOUTH AVE
LA CROSSE WI 54601

dated September 27, 2013, and served upon the company on May 28, 2014, 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 2nd day of July, 2014.

Theodore K. Nickel
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

GUNDERSEN HEALTH PLAN, INC.
LA CROSSE, WISCONSIN

SEPTEMBER 9–27, 2013

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May 22, 2014

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

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted September 9 to September 27, 2013, of:

GUNDERSEN HEALTH PLAN, INC.
La Crosse, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Gundersen Health Plan, Inc. (GHP or the company) is a not-for-profit network model Health Maintenance organization (HMO) insurer. The company was incorporated in Wisconsin on March 13, 1995, as a non-stock service insurance corporation under ch. 613, Wis. Stat., and commenced business September 1, 1995. Initially, GHP was controlled by Gundersen Clinic, Ltd. (the Clinic) and Gundersen Center, Inc. (the Hospital), the HMO's primary clinic and founder. Effective June 10, 1996, the Clinic and the Hospital became formally affiliated through the creation of a common parent corporation, Gundersen Lutheran, Inc. Effective January 1, 2000, GHP became a wholly owned subsidiary of Gundersen Lutheran replacing the Clinic and the Hospital. In August 2006 GHP expanded its territory by obtaining a certificate of authority in the state of Iowa to transact business as an HMO in five northern counties. Effective June 30, 2008, the legal name of the common parent corporation, Gundersen Lutheran, Inc., was changed to Gundersen Lutheran Health System (Health System). The company was licensed to write business in Iowa effective 2011. Effective February 15, 2012, a wholly owned

subsidiary, Gundersen Lutheran Health Plan Minnesota, was licensed to sell health insurance in Minnesota. Effective May 1, 2013, the Health System officially eliminated the word Lutheran from its and its affiliates' names due to a rebranding initiative.

In addition to the comprehensive (hospital and medical) product, the company also had third-party administrator (TPA) business, Medicare Advantage (Medicare) and Medicaid products.

The company wrote commercial HMO coverage and point of service (POS) products in Wisconsin and the northeast region of the state of Iowa. The company began offering a Medicare supplement product in Wisconsin effective January 1, 2013.

At the time of this examination, the company had filed forms and rates for individual and small group products, which will be marketed both on and off the federally facilitated marketplace (FFM) for effective dates beginning January 1, 2014. The company did not offer an individual product previously.

At the time of the examination, the company offered insurance to employer groups and serviced southeastern Minnesota, northeastern Iowa and 11 counties located in western Wisconsin. It is important to note that both insured and self-insured business is reported in the comprehensive line of business noted below.

Premium and Loss Ratio Summary

	2012			
Line of Business	**Net Premium Income**	**% of Total Premium**	**Net Losses Incurred**	**Medical Loss Ratio**
Comprehensive	$123,068,615	43.9%	$115,129,536	93.5%
Medicare Supplement	0	0.0	0	0.0
Dental Only	0	0.0	0	0.0
Vision Only	0	0.0	0	0.0
Title XVII Medicare	123,473,976	44.0	115,790,180	93.7
Title XIX Medicaid	33,858,734	12.1	31,361,984	92.6
Total	**$280,401,325**		**$262,281,700**	**93.5%**

2011				
Line of Business	Net Premium Income	% of Total Premium	Net Losses Incurred	Medical Loss Ratio
Comprehensive	$112,713,812	43.7%	$104,584,434	92.8%
Medicare Supplement	0	0.0	0	0.0
Dental Only	0	0.0	0	0.0
Vision Only	0	0.0	0	0.0
Title XVII Medicare	119,058,690	46.2	111,945,206	94.0
Title XIX	25,947,391	10.01	23,541,605	90.7
Total	**$257,719,893**		**$240,071,245**	**93.2%**

The company ranked 4th in 2011 as a writer of individual health and 3rd in 2012. In group health insurance business, the company ranked 5th in both 2011 and 2012.

Complaints

The Office of the Commissioner of Insurance (OCI) received 16 complaints against the company between January 1, 2011, through May 31, 2013. A complaint is defined as a written communication received by the OCI that indicates dissatisfaction with an insurance company or agent. The following table categorizes the complaints received against the company by complaint reason.

Group Accident & Health						
Year	Total	Underwriting	Marketing and Sales	Claims	Policyholder Service	Other
2011	12	0	0	11	1	0
2012	3	0	0	3	0	0
2013	1	0	0	1	0	0
Total	**16**	**0**	**0**	**15**	**1**	**0**

Grievances

The company submitted annual grievance reports to OCI for 2011 and 2012 as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined as any dissatisfaction with the provision of services or claim practices of an insurer offering a health benefit plan or administration of a health benefit plan by an insurer that is expressed in writing to the insurer by, or behalf of, an insured.

The grievance report for 2011 indicated the company received 101 grievances, of which 37 were reversed and 64 decisions were upheld. The categories of Prior Authorization and Not a Covered Benefit accounted for 52% of the grievances filed.

The grievance report for 2012 indicated the company received 59 grievances, of which 29 were reversed and 30 decisions were upheld. The categories of Prior Authorization and Not a Covered Benefit accounted for 66% of the grievances filed.

The following table summarizes reported grievances for the last two years.

	2011	2012
Category	**No.**	**No.**
Access to Care	0	0
Continuity of Care	0	0
Drug & Drug Formulary	1	1
Emergency Services	0	0
Experimental Treatment	0	0
Prior Authorization	27	22
Not Covered Benefit	26	17
Not Medically Necessary	10	3
Other	4	0
Plan Administration	13	9
Plan Providers	0	1
Request for Referral	20	6
Total	**101**	**59**

Independent Review

The company had five independent review requests during the period of review. The company used the Department of Labor (DOL) external review process to comply with the federal external review requirements. The company had contracted with three independent review organizations (IRO). All review requests were processed according to the federal external review process. The company had no grandfathered plans and a small number of Medicare supplements.

The following table summarizes reported IROs for the exam period.

Year	Total Review Requests	IPRO	Maximus	MCMC	National Medical Reviews	Upheld	Reversed
2011	4	1	2	0	1	2	2
2012	1	0	0	1	0	1	0

II. PURPOSE AND SCOPE

A targeted examination was conducted to determine compliance with recommendations made in the previous market conduct examination adopted May 2006 and whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2011, through May 31, 2013. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The examination included, but was not limited to, a review of group HMO and group POS business. Functional areas that were reviewed included company operations and management; claims; grievances and IROs; marketing, sales and advertising; policyholder services and complaints; producer licensing; policy forms; and underwriting and rating.

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

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted May 26, 2006, contained 22 recommendations. Following are the recommendations and the examiner's findings regarding the company's compliance with each recommendation.

Claims

1. It is recommended that the company revise its RA form to ensure that it conforms to the correct order of the format in Appendix A as required by s. Ins 3.651 (3) (a), Wis. Adm. Code.

   Action: Compliance

2. It is recommended that the company revise its EOB to include each patient's name printed with the last name first followed by the first name and middle initial in order to comply with s. Ins 3.651 (4) (a) 4, Wis. Adm. Code.

   Action: Compliance

Grievance and IRO

3. It is recommended that the company modify its written independent review procedures to allow members to bypass its internal grievance procedure as required by s. 632.835 (2) (d), Wis. Stat.

   Action: Compliance

4. It is recommended the company develop, document and implement a procedure to ensure that it sends extension letters to grievant when it is unable to resolve a grievance within 30 calendar days of receipt as required by s. Ins 18.03 (6), Wis. Adm. Code.

   Action: Compliance

5. It is recommended that the company develop, document and implement a process and procedure to acknowledge an expedited grievance within 72 hours of receipt of the grievance in order to comply with s. Ins 18.05, Wis. Adm. Code.

   Action: Compliance

Marketing, Sales and Advertising

6. It is recommended that the company develop, document and implement a process and procedure providing oversight of agent Internet advertisements referencing the company in order to document compliance with s. 628.34, Wis. Stat., and s. Ins 3.27 (27), Wis. Adm. Code.

   Action: Compliance

7. It is recommended that the company develop, document and implement a procedure to ensure all mass produced advertisements are identified with a form number in order to comply with s. Ins 3.27 (26), Wis. Adm. Code.

   Action: Compliance

8. It is recommended that the company develop, document and implement a procedure for ensuring that a notation be attached to each advertisement in the file indicating the manner and extent of distribution and the form number of any policy amendment, rider, or endorsement form advertised as required by s. Ins 3.27 (28), Wis. Adm. Code.

   Action: Compliance

9. It is recommended that the company develop, document and implement a procedure for maintaining its written advertising file in order to comply with s. Ins 3.27 (28), Wis. Adm. Code.

   Action: Compliance

Policyholder Service and Complaints

10. It is recommended that the company develop, document and implement a process to ensure that it send acknowledgement letters on OCI complaints that it handles as grievances in order to comply with its own internal procedure and with s. Ins 18.03 (4), Wis. Adm. Code.

    Action: Compliance

Producer Licensing

11. It is recommended that the company develop, document, and implement a procedure to track the termination of appointments of its agents in order to document compliance with s. Ins 6.57 (2), Wis. Adm. Code.

    Action: Compliance

12. It is recommended that the company develop, document and implement a procedure for handling and tracking agent complaints in order to document compliance with s. Ins 6.57 (2) (b), Wis. Adm. Code.

    Action: Compliance

13. It is recommended that the company update its vendor contracts to require that background checks be conducted on new agents pursuant to s. Ins 6.59 (5), Wis. Adm. Code.

    Action: Compliance

14. It is recommended that the company develop, document and implement an audit process for monitoring whether its vendors perform background checks of new agents to assess trustworthiness and competence in order to document compliance with s. Ins 6.59 (5), Wis. Adm. Code.

    Action: Compliance

15. It is recommended that the company develop, document and implement a procedure for auditing contracted agencies to ensure termination letters are sent to agents who are no longer listed as a representative, and to ensure that all termination letters include a formal demand for return of all indicia of the company in order to comply with s. Ins 6.57 (2), Wis. Adm. Code.

    Action: Compliance

16. It is recommended that the company institute a process to ensure the licensing and appointment status of employees and management staff writing business and/or paid compensation, including review by company management other than employees or management staff writing business and paid compensation, in order to document compliance with s. 628.11, Wis. Stat., and s. Ins 6.57 (5), Wis. Adm. Code.

    Action: Compliance

Small Employer

17. It is recommended that the company develop, document and implement a procedure to ensure agent signatures and dates are not omitted on employer group applications or disclosure statements, and that agents do not sign and date employer applications prior to completion in order to comply with s. 628.34 (1), Wis. Stat.

    Action: Compliance

18. It is recommended that the company revise, document and implement its procedure for issuing small employer group policies to ensure that official documentation showing complete lists of eligible employees and dependents of eligible employees of small employers is included in the file in order to comply with s. Ins 8.65 (1), Wis. Adm. Code.

    Action: Compliance

19. It is recommended that the company develop, document and implement procedures to ensure small employer rating errors are identified and corrected, and that refunds are issued to groups when issued rates above those permitted in order to comply with s. 635.05, Wis. Stat., and s. Ins 8.52, Wis. Adm. Code.

    Action: Compliance

20. It is recommended that the company revise its small employer rating procedures to include a process that automatically reviews the rates calculated and includes automatic system edits to ensure compliance with the rate restrictions of s. 635.05, Wis. Stat., and s. Ins 8.52, Wis. Adm. Code.

    Action: Compliance

Underwriting & Rating

21. It is recommended that the company develop, document and institute policies and procedures to maintain company records of operations for a period of 3 years as required by s. Ins 6.80 (4), Wis. Adm. Code.

    Action: Compliance

22. It is recommended that the company develop, document and implement a procedure for processing and auditing employer applications that ensures applications are handled correctly as a small or a large group in order to comply with s. 635.02 (7), Wis. Stat.

    Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to OCI's claims interrogatory, claims processes and procedures, explanation of benefits (EOB) and remittance advice (RA) forms, claim adjustment (ANSI) codes, and claims methodology.

The company indicated that it internally processed all institutional, professional and dental claims. The company received 90.3% of all claims electronically, and an average of 74.43% were auto-adjudicated.

The company contracted with pharmacy benefit manager (PBM) ClearScript to administer pharmacy claims, provide the pharmacy network and provide mail order drug providers. The company also contracted with Chiropractic Care of Wisconsin, which provided a network of chiropractors and performed utilization management functions for chiropractic services, including pre-certification of services, urgent concurrent review, adoption of medical criteria, post service review, claim approvals and denials and evaluation of new technology. Other than the services provided by ClearScript and Chiropractic Care of Wisconsin, all determinations of medical necessity, experimental services, preauthorization of services and referral authorizations were performed by the company's medical management department.

The company paid the Health System on a capitation basis. The company contracted with Multiplan, Inc., and Stratose (formerly Coalition America, Inc.) for repricing of nonparticipating provider claims for available discounts or fee negotiation. For nonparticipating provider claims the company applied the repricing discount and then application of UCR, only if no discount was available.

The examiners found that the company requested additional information for potential third-party liability claims. The company would also deny these types of claims if the requested additional information was not received, if no-fault insurance was primary, and if excess medical payments or liability coverage was primary. Section 632.845 (2), Wis. Stat., provides that an

insurer that provides coverage under a health care plan may not refuse to cover health care services that are provided to an insured under the plan and for which there is coverage under the plan on the basis that there may be coverage for the services under a liability insurance policy.

1. **Recommendation**: It is recommended that the company develop, document, and implement a procedure for processing potential third-party liability claims as required by s. 632.845 (2), Wis. Stat.

The examiners found that the company calculated interest due on late claim payments based on the date of the decision to allow payment for processing errors rather than the original date proof of claim was received by the company. Section 628.46 (1), Wis. Stat., provides that unless otherwise provided by law, an insurer shall promptly pay every insurance claim. A claim shall be overdue if not paid within 30 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of the loss.

2. **Recommendation**: It is recommended that the company develop, document, and implement a procedure when processing company claim errors to use the actual date proof of loss was received to calculate interest as required by s. 628.46 (1), Wis. Stat.

The examiners reviewed the company's "financial responsibility estimate – commercial members" form letter that it used to provide information regarding the amount allowable for a specific medical procedure. The examiners found that the company's form letter did not advise the member that the policy benefits are available only to individuals who are eligible for benefits at the time a health care procedure or service is provided, that policy provisions including, but not limited to, preexisting condition and contestable clauses and medical requirements may cause the insurer to deny a claim, that policy limitations including, but not limited to, copayments and deductibles may reduce the amount the insurer will pay for a health care procedure or service, and that a policy may contain exclusions from coverage for specified health care procedures or services pursuant to s. Ins 3.60 (6) (a) 2., Wis. Adm. Code.

The company stated that it was taking corrective action to include the missing information on the form letter.

3. **Recommendation:** It is recommended that the company include all information required by s. Ins 3.60 (6) (a) 2., Wis. Adm. Code, in letters sent to its members regarding requested allowable amounts for specific procedures.

The examiners reviewed a random sample of 50 preventive service claims paid and 50 claims not paid. The examiners found that the company had applied cost-sharing to 7 claims for preventive services. The company agreed that cost-sharing was applied to 6 of the 7 identified claims in error. However, cost-sharing was applied to CPT code 90746 (Hepatitis B vaccine) because the treatment was provided to a member who was 28 years old. The examiners found that CPT code 90746 was included as a USPSTF Grade A preventive service for individuals that was non-age specific. The Public Health Service (PHS) Act section 2713 required all plans to cover preventive services and immunizations recommended by the USPSTF and the CDC with cost-sharing waived.

4. **Recommendation:** It is recommended that the company develop, document, and implement a procedure to ensure that all preventive claims are processed in compliance with the Public Health Service (PHS) Act section 2713 with cost-sharing waived.

Grievance and IRO

The examiners reviewed the company's response to OCI's grievance and independent review interrogatory; grievance and appeal policy and procedures for 2011, 2012 and 2013; the complaints and grievance language in certificates of coverage; notice of appeal rights on explanation of benefits forms and benefit denial letters; grievance and external review rights information on the company's Web site; grievance committee minutes; and the annual grievance experience report for 2011 and 2012. The examiners also interviewed the company's director of compliance, manager of customer service, manager of audit and training, director of business operations and compliance specialist regarding grievance and independent review procedures.

The company defined a grievance as any written expression of dissatisfaction in any form. If the grievance included a quality of care issue, it was referred to a nurse in the quality management department and also processed as a grievance.

The company delegated preauthorization of chiropractic services to ChiroCare, which was responsible for attaching the company's grievance and independent review notice to any denial letter.

The company forwarded all grievances to its member advocate who verified coverage information, obtained all relevant documents, and forwarded the documents and information to the medical director, or other appropriate staff. The medical director, or other appropriate staff, reviewed the file and provided a written response, which was included in the grievance file. If the denial was reversed based on the initial review, the grievance meeting would be cancelled and the file identified as denial overturned.

The grievance committee included an associate medical director, a medical ethicist, a clinical member, and the compliance director. The company's grievance committee included a member advocate, a director of clinical services, a manager of claims administration and a non-employee member of the plan who had been on the grievance committee for several years and was an administrator for a large employer group.

The examiners found that the company had policies and procedures in place to allow a member to file a grievance and request an independent review. It used the DOL external review process to comply with the federal external review requirements as there were no grandfathered plans and a small number of a closed block of Medicare supplements. The company had contracted with three IROs. All review requests were processed according to the federal external review process.

The examiners found that the company's annual grievance experience reports indicated that its grievances had decreased by 41% from 2011 to 2012. The company attributed the decrease in grievances to departmental leadership's monitoring of weekly

complaint reports that identified trends and opportunities for educating members that would help them better understand their benefits.

The examiners reviewed a random sample of 50 grievances. The examiners found that two grievances included grievance resolution letters that did not notify the insured of the right to request an independent review. Section Ins 18.11 (2), Wis. Adm. Code, provides that each time an insurer makes a coverage denial determination the insurer shall provide a notice of the right to request an independent review.

5. **Recommendation:** It is recommended that the company include in its grievance resolution letters a notice of the right to request an independent review each time it makes a coverage denial determination as required by s. Ins 18.11 (2), Wis. Adm. Code.

Marketing, Sales and Advertising

The examiners reviewed the company's response to OCI's marketing, sales and advertising interrogatory; advertising files; and business plans. The examiners also interviewed the company's director of sales and marketing and the department's support specialist.

The company's sales and marketing director reported directly to its chief executive officer (CEO). Three marketing representatives and one support specialist reported to its sales and marketing director. The sales and marketing team was responsible for promotion of GHP products and services, to sell and renew commercial business and to manage the agent distribution channel.

The company promoted itself to be local, not-for-profit, flexible and accessible for its customers. The company was owned by the major health system in the region, so having its name tied to a health system known for quality was also an advantage. GHP positioned itself to be a good fit for groups that had the majority of its employees in the immediate service area. GHP offered a POS product and a rental network that could be used for groups with employees that resided outside of its service area.

The company reported, as of June 2013, based on number of members, its business was approximately 15% Medicare Advantage, 19% Medicaid and 65% commercial. The commercial business was made up of self-insured (57%), fully insured large (32%) and fully insured small group (11%). GHP's Medicare Advantage had approximately 14,000 members. The company relied on an agent distribution model to sell most of its commercial and Medicare supplement business. The company indicated that when a new agency requested appointment, it reviewed the agency's marketing plan, appointed the agents affiliated with the agency, and provided product training. The examiners reviewed examples of the packets of materials used by company sales representatives as part of agent training; copies of agency and/or agent newsletters; bulletins and memos. The company exercised oversight over the agencies and agents by providing information in person, e-mail or letter regarding changes in products and processes.

The company did not advertise directly to consumers and relied on the internal sales force to work with the agencies and agents to drive new sales and retain customers. The company indicated that it marketed its Medicare Advantage products directly to Medicare beneficiaries using its in-house sales team. The company launched a new Medicare supplement product, Senior Choice, in early 2013. The company indicated it had also developed a new individual product, GundersenOne, and was planning on entering the individual health market starting January 1, 2014.

The company's Web site included information on the plans the company offered. The company indicated it was revising its Web site October 1, 2013, to coincide with PPACA enrollment and the beginning of sales of its individual product. The company did not use social media.

The examiners reviewed the 13 advertisements in the company's advertising file to ensure they were complaint with Wisconsin's advertising rule.

No exceptions were noted involving the marketing, sales and advertising review.

Policyholder Service and Complaints

The examiners reviewed the company's response to OCI's policyholder service and complaints interrogatory and its complaint reports. The examiners also interviewed its manager of customer service.

The company's customer service department was part of GHP's business operations department. It responded to all inquiries including telephone calls, correspondence and e-mail notes. It assisted with GHP member retention efforts, provided timely follow-up and problem resolution.

The company defined a complaint as any expression of dissatisfaction expressed to the Health Plan by an insured, or an insured's authorized representative, about GHP or GHP providers with whom GHP had a direct or indirect contract. A complaint could be expressed orally or in writing. The company ensured that complaints were identified, recorded, investigated, processed, resolved, and communicated back to the member; then, analyzed and reported to the appropriate company committees. The company indicated that complaints could be received through any department within the company. All complaints were handled as priority with a standard timeframe to resolve within ten business days. Members would be notified of the complaint resolution either by phone, writing, e-mail or facsimile. If the complaint was not resolved to the member's satisfaction, the member would be advised of their right to submit an appeal or grievance regarding their concern in writing.

The company reviewed its complaint logs weekly, quarterly and annually. If at any time during the year it identified a trend in complaints or it determined that a complaint required analysis and possible action, company staff submitted a formal plan to the compliance department for analysis.

During the compliance interview, the manager of customer service indicated that a group of customer service representatives had obtained Wisconsin Accident and Health intermediary licenses and would be acting as an enrollment group for the company's new

individual product. The policyholder service department had completed additional training for PPACA.

The company had 147 complaints in 2011, 93 complaints in 2012, and 44 complaints January 1, 2013, through May 31, 2013. The examiners reviewed all OCI complaint files and 50 company complaint files. The examiners found that the files provided satisfactory documentation and were compliant with any applicable Wisconsin laws and rules.

No exceptions were noted involving the policyholder service and complaints review.

Producer Licensing

The examiners reviewed the company's response to OCI's producer licensing interrogatory, appointment procedures, and oversight of agencies and agents.

The company did not have an agency department. All contracting, appointments, and terminations were processed in its sales and marketing department.

When the company considered a new agency, the compliance department would complete a background check on the agency and then the sales and marketing department completed the agency contracting process, which consisted of an agency information sheet, a request for a copy of errors and omissions (E&O) coverage, an agency contract and a business associate agreement. When the company received the signed contracts, the company collected a release for a background check and a copy of the Wisconsin accident and health insurance license for all agents employed by the agency.

The company contracted with Cumberland Licensing Corporation (Cumberland Licensing) to provide agent licensing services. Cumberland Licensing processes included background checks, agent Producer Database (PDB) inquiries, agent appointment and terminations, and the company appointment process.

The examiners found that the company's compliance department had performed annual audits of all active appointed agent files for calendar years 2010 and 2011.

The examiners reviewed a random sample of 25 active agent files to document that the company timely and accurately reported to the commissioner agent appointments. No exceptions were noted regarding the active agent file review.

The examiners reviewed a random sample of 25 terminated agent licensing files. The examiners found that the company provided written notice of termination to 4 agents that were not dated prior to or within 15 days of termination. The examiners also found that the company failed to file termination of appointment for 1 agent prior to or within 30 days of termination with OCI. Section Ins 6.57 (2), Wis. Adm. Code, states notice of termination of appointment of individual intermediary in accordance with s. 628.11, Wis. Stat., shall be filed prior to or within 30 calendar days of the termination date with the Office of the Commissioner of Insurance. Prior to or within 15 days of filing this termination notice, the insurer shall provide the agent written notice that the agent is no longer to be appointed as a representative of the company and that he or she may not act as its representative. This notice shall also include a formal demand for the return of all indicia of agency. Section 628.11, Wis. Stat., states an insurer shall report to the Commissioner at such intervals as the Commissioner establishes by rule all appointments, including renewals of appointments, and all terminations of appointments of insurance agents to do business in this state, and shall pay the fees prescribed under s. 601.31 (1) (n), Wis. Stat.

6. **Recommendation**: It is recommended that the company develop a procedure to ensure that written notice of termination of appointment is provided timely to its agents and filed within 30 days with OCI in order to comply with s. Ins 6.57 (2), Wis. Adm. Code, and s. 628.11, Wis. Stat.

New Business and Underwriting

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

The company's sales and marketing department was responsible for receipt of its new business. The company's underwriting department reviewed application materials for

groups of 2 to 100 enrolled employees. The company's group administration manager and underwriter determined the final rate assignment. Groups of over 100 enrolled employees were experience rated by the company's actuarial department. The company's renewal process began 90 days in advance of the renewal. The company provided renewal rates to its groups 60 days in advance of the renewal date.

The examiners reviewed a random sample of 25 large employer groups new business files to document that policy forms were filed with and approved by OCI, that appropriate forms were signed and that the writing agents were appointed with the company.

No exceptions were noted involving the new business and underwriting review.

Small Employer

The examiners reviewed the company's response to OCI's small employer group underwriting and rating interrogatory and its underwriting and rating policies and procedures for small employer business.

The company's sales and marketing department received small employer applications and enrollment. All small employer groups, as defined in s. 635.02 (7) (a), Wis. Stat., were reviewed in underwriting and were offered coverage. The company's group administration manager and underwriter determined the final rate assignment. All small employer groups were renewed annually on the group's anniversary date. The renewal process was started 90 days in advance of the renewal. Renewal rates were provided to the group 60 days in advance of the renewal date. The company monitored its small employer group rates for both new business and renewals through the use of an internally developed quoting application developed by GHP's actuarial and information systems. The applications' rates were updated quarterly by the actuarial department.

The examiners reviewed 25 small employer group new business files to document compliance with small group reform, that the policy forms were filed with and approved for use

and that the writing agents were listed with the company. No exceptions were noted regarding the small employer file review.

The examiners found that a company document, PP2.013 Employer Group Underwriting, stated that employer groups would be allowed to elect to offer only single coverage to their employees. Section 632.746 (10), Wis. Stat., provides that if an insurer offers a group health benefit plan to an employer, the insurer shall offer coverage to all of the eligible employees of the employer and their dependents. The company advised that the process would be modified and the company would not allow employer groups to exclude spouses or other dependents. The company stated that it had not issued a group policy in violation of s. 632.746 (10), Wis. Stat.

7. **Recommendation**: It is recommended that the company ensure that all of the eligible employees of the employer and their dependents are allowed to elect coverage in compliance with s. 632.746 (10), Wis. Stat.

Policy Forms

The examiners reviewed the company's response to OCI's policy forms interrogatory and the policy form filings it made in SERFF during the period of review.

The company's compliance department was responsible for form filings submitted to OCI and utilized OCI bulletins, health plan listservs, and GHP's membership in the American Health Insurance Plans (AHIP) to monitor legislation as well as new laws and regulations. The company's compliance department communicated changes in insurance laws to health plan stakeholders by means of a literature distribution form that described the change to the law, the effective date, and the lines of business affected.

The company's conversion policy was underwritten by Celtic Insurance Company. The examiners reviewed the conversion policy and found it to be compliant.

The examiners reviewed 33 policy form filings the company submitted to OCI. The examiners found that 5 certificates contained contradictory language in regard to defining a benefit year and benefit calculations. A benefit year was defined as a 12-month period of health

insurance coverage and could be the same as a calendar year starting over each January 1 or based on the group's renewal date. The certificate stated "If you are an inpatient in a covered facility on December 31, then your benefit calculations and payment obligations for the services received will start over as of January 1. Benefit calculations and payments will be based on the benefit plan in force on the day you receive your services." The company advised the examiners that its claims system would correctly determine the benefit based on the benefit year. However, the examiners found the certificate language could be confusing for consumers. The company stated that it had revised the language for all 2014 certificates.

The examiners found that 5 of the company's certificate of coverage form filings did not contain language regarding the right to obtain an exception for coverage of a device not routinely covered by the plan. Section 632.853, Wis. Stat., states a health care plan that provides coverage of only certain specified prescription drugs or devices shall develop a process through which a physician may present medical evidence to obtain an individual patient exception for coverage of a prescription drug or device not routinely covered by the plan. The process shall include timelines for both urgent and non-urgent review.

8. **Recommendation**: It is recommended that the company develop a process through which a physician may present medical evidence to obtain an individual patient exception for coverage of a device not routinely covered by the plan to comply with s. 632.853, Wis. Stat.

The examiners found 5 of the company's certificates of coverage form filings did not contain accurate language defining a qualifying event. Section 632.897 (2) (b) 2., Wis. Stat., provides that a group member who would otherwise terminate eligibility for coverage under the group policy other than a group member who terminates eligibility for coverage due to discharge for misconduct shown in connection with his or her employment. The company indicated that the PPACA compliant certificates it filed for January 1, 2014, included voluntary and involuntary loss of coverage in the definition of a qualifying event.

9. **Recommendation**: It is recommended that the company implement a revision of certificate language to include involuntary loss of coverage when defining a qualifying event as required by s. 632.897 (2) (b) 2., Wis. Stat.

Company Operations and Management

The examiners reviewed the company's response to OCI's company operations and management interrogatory; board of directors meeting minutes; provider services agreements; strategic business plans; GHP's compliance plan and its compliance department's responsibilities; external audits conducted by Centers for Medicare & Medicaid Services (CMS) and Department of Health Services (DHS); its disaster recovery plan; and contracts for management services, data management and processing, marketing, general agency, administrative services, and case management. The examiners also interviewed the chief compliance officer for the Health System and the company's director of compliance.

The examiners found that the company's compliance program was well documented and organized. The company indicated that all entities under the Health System reported to the chief compliance officer. The company's director of compliance reported directly to the chief compliance officer, attended all GHP's board of directors' meetings and had dotted line reporting to the board of directors and CEO of GHP. The board of directors' bylaws required two compliance oversight committee meetings per year that would include members of the board of directors. The company also had a compliance operations committee that met at least quarterly to advise and assist the compliance department.

No exceptions were noted involving the company operations and management review.

V. CONCLUSION

The examiners found that the company had complied with the 22 recommendations from the previous targeted examination that was adopted May 2006. This examination resulted in 9 new recommendations in the areas of underwriting, claims, policy forms, grievance and IRO, and producer licensing.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 12 1. It is recommended that the company develop, document, and implement a procedure for processing potential third-party liability claims as required by s. 632.845 (2), Wis. Stat.

Page 12 2. It is recommended that the company develop, document, and implement a procedure when processing company claim errors to use the actual date proof of loss was received to calculate interest as required by s. 628.46 (1), Wis. Stat.

Page 13 3. It is recommended that the company include all information required by s. Ins 3.60 (6) (a) 2., Wis. Adm. Code, in letters sent to its members regarding requested allowable amounts for specific procedures.

Page 13 4. It is recommended that the company develop, document, and implement a procedure to ensure that all preventive claims are processed in compliance with the Public Health Service (PHS) Act section 2713 with cost-sharing waived.

Grievance and IRO

Page 15 5. It is recommended that the company include in its grievance resolution letters a notice of the right to request an independent review each time it makes a coverage denial determination as required by s. Ins 18.11 (2), Wis. Adm. Code.

Producer Licensing

Page 19 6. It is recommended that the company develop a procedure to ensure that written notice of termination of appointment is provided timely to its agents and filed within 30 days with OCI in order to comply with s. Ins 6.57 (2), Wis. Adm. Code, and s. 628.11, Wis. Stat.

Small Employer

Page 21 7. It is recommended that the company ensure that all of the eligible employees of the employer and their dependents are allowed to elect coverage in compliance with s. 632.746 (10), Wis. Stat.

Policy Forms

Page 22 8. It is recommended that the company develop a process through which a physician may present medical evidence to obtain an individual patient exception for coverage of a device not routinely covered by the plan to comply with s. 632.853, Wis. Stat.

Page 23 9. It is recommended that the company implement a revision of certificate language to include involuntary loss of coverage when defining a qualifying event as required by s. 632.897 (2) (b) 2., Wis. Stat.

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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Respectfully submitted,

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