Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

320 West 4th Street, Suite 880
Los Angeles, CA 90013-2344
213-576-7618 voice
213-576-7186 fax
jlarsen@dmhc.ca.gov e-mail

August 25, 2006

via UPS Delivery and electronic mail

Amir Neshat, DDS, President, CEO
Liberty Dental Plan of California, Inc.
3200 El Camino Real, Suite 290
Irvine, CA 92602

FINAL REPORT OF ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

Dear Dr. Neshat:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California, Inc. (the "Plan") for the month ended February 28, 2006, conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on June 29, 2006. The Department accepted the Plan's electronically filed response on August 16, 2006.

This Final Report includes a description of the compliance efforts included in the Plan's August 16, 2006 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and electronically file modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its August 16, 2006 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter. Please file this addendum electronically via the Department's eFiling web portal <https://wpso.dmhc.ca.gov/secure/login/>. From the drop-down menu, select "Report/Other: Addendum Response to Final Routine Financial Examination Report-Public (RX005)", and then upload your response. Questions or problems related to the electronic transmission of the response should be directed to Siniva Pedro at (916) 322-5393 or email at spedro@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter

The Executive Summary to the Department's most recent Medical Survey Report is located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

JOAN LARSEN
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Maja Kapic, Chief Financial Officer, Liberty Dental Plan
Mark Wright, Chief, Division of Financial Oversight
Galal Gado, Financial Examiner
Daniele Lopes, Financial Examiner
Amy Krause, Licensing Counsel
Marcy Gallagher, Chief, Division of Plan Surveys

STATE OF CALIFORNIA

DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

FILE NO. 933-0052

DATE OF FINAL REPORT: AUGUST 25, 2006

SUPERVISING EXAMINER: JOAN LARSEN

EXAMINER-IN-CHARGE: GALAL GADO

FINANCIAL EXAMINER: DANIELE LOPES

BACKGROUND INFORMATION FOR
LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

Date Plan Licensed:	Liberty Dental Plan of California, Inc. acquired all the assets of Preferred Health Plans, Inc. d.b.a. Preferred Dental Plan on December 27, 2001. Preferred Health Plans, Inc. was licensed August 3, 1978.
Organizational Structure:	Liberty Dental Plan of California is a sole owner, for-profit company. The Plan began offering a Denti-Cal product in May 2005. In January 2006, the Plan began participation in the In-Home Health Services program in San Francisco.
Type of Plan:	Specialized dental plan that provides a full range of dental services to both commercial and Denti-Cal enrollees.
Provider Network:	The Plan contracts with independent dentists and various specialists. The general dentists are paid on a capitated basis. Noncontracted providers are paid on a fee-for-service basis or discounted Denti-Cal rates. The Plan also provides a commercial referral product.
Plan Enrollment:	A total of 66,220 enrollees were reported at June 30, 2006, with 37,657 commercial enrollees and 28,563 Medi-Cal enrollees.
Service Area:	Major counties throughout California.
Date of Last Public Routine Financial Examination Report:	March 17, 2004

FINAL REPORT OF A ROUTINE EXAMINATION OF LIBERTY DENTAL PLAN OF CALIFORNIA, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of Liberty Dental Plan of California, Inc. (the "Plan") for the month ended February 28, 2006, conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on June 29, 2006. The Department accepted the Plan's electronically filed response on August 16, 2006.

This Final Report includes a description of the compliance efforts included in the Plan's August 16, 2006 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the month ended February 28, 2006, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I.	Financial Report.
Section II.	Calculation of Tangible Equity
Section III.	Compliance Issues
Section IV.	Non-Routine Examination

The Department finds the Plan's compliance efforts are responsive to the deficiency cited and the corrective action required. Therefore, no further response is required.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

Our examination resulted in no adjustments or reclassifications to the Plan's February 28, 2006 monthly financial report filed with the Department. A copy of this financial report can be viewed at the Department's website by typing the link **http://wpso.dmhc.ca.gov/fe/search.asp** and selecting Liberty Dental Plan of California, Inc. on the first drop down menu.

No response required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by Plan at February 28, 2006	$ 440,560
Less: Unsecured Receivables from Officer	50,000
Intangible Assets	245,985
Tangible Net Equity as of February 28, 2006	$ 144,575
REQUIRED TNE as of February 28, 2006	96,993
Excess TNE as of February 28, 2006	$ 47,582

As of February 28, 2006, the Plan was in compliance with the TNE requirements of Section 1376 and Rule 1300.76.

No response required to this Section.

SECTION III. COMPLIANCE ISSUES

A. LATE CLAIM PAYMENTS

Section 1371 requires a specialized plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period. Section 1371 and Rule 1300.71 require that all interest that has accrued shall be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant. Section 1371 also requires that if the claim is contested or denied by the plan, the claimant shall be notified, in writing, that the claim is contested or denied within 30 working days after receipt of the claim by the specialized health care service plan. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

Section 1371.35, which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 30 working days after receipt, the plan shall pay

the greater of $15 per year or interest at the rate of 15 percent per annum, beginning with the first calendar day after the 30 working-day period.

Rule 1300.71 sets forth various definitions and compliance requirements for claim settlement practices.

Interest was not paid on 20% (or 2 out of 10) of the paid claim sample reviewed by the Department for the Plan's new claim payment system for claims paid from January 1, 2006 to March 31, 2006.

The Plan attributed the deficiency to problems with the implementation stage of its new computerized claims system that started on January 1, 2006. The Plan stated these problems were resolved in May 2006.

CORRECTIVE ACTION TAKEN DURING AND AFTER EXAMINATION: During our examination, the Plan corrected the above deficiency by issuing checks for the interest and penalty on the above 2 claims. In addition, on June 19, 2006 the Plan provided evidence that it reviewed delinquent claims paid from January 1, 2006 through March 31, 2006, which resulted in the payment of a total of $2,660 in interest and penalties on 376 claims during the period May 16 through June 13, 2006.

Due to the systematic error in the identification of a late claim and payment of interest, the Plan was required to submit a Corrective Action Plan ("CAP") to substantiate the corrective actions implemented to comply with Section 1371 and Rule 1300.71. The CAP was to include the identification of all claims paid late for the period January 1, 2006 through the date the claim system was corrected. The Plan was to remediate these identified claims and provide evidence of payment of the required interest and penalty amounts.

The CAP was to include the policies and procedures implemented to ensure that late claim payments include the required interest and penalties. The CAP should also state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan responded that it completed the implementation of its new MIS System; which enabled the Plan to process claims promptly in compliance; and, properly and accurately identify late claims and automatically include in its payment of the claim all interest accrued pursuant to Section 1371. The claims processing system was corrected and fully implemented on May 25, 2006.

The Plan's response included a spreadsheet that identified additional claims paid for time period January 1, 2006 – May 25, 2006 for which interest and penalty was disbursed as applicable to the providers. The Plan's response identified additional late claims that resulted in the payment of a total of $415 in interest and penalties on 40 claims paid late during the period April13 through May 23, 2006.

The Plan's response further stated that its Claims Processing function has undergone several changes in addition to the new claims processing system. The Plan implemented Policies and Procedures in order to increase the efficiency in processing and to support the processing goals and guidelines. The Plan provided a copy of its Policy and Procedure in its response that was implemented as of August 1, 2006, which requires a list of all claims aged 30 business days and older to be included on the report of claims run prior to the weekly check-write process. The Plan stated that this process will insure; when necessary, that all delinquent claims will have interest payments paid. Plan's staff received additional training in the past 30 days reinforcing the Plan's strict guidelines that claims must be paid within 30 business days of receipt of the claim and the Plan's new MIS system automatically calculates and includes an interest payment when an interest payment is due on a claim payment.

The Plan's Chief Financial Officer will be responsible for ensuring that the required actions as well as the Policies and Procedures will be implemented.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

B. GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

Section 1384, 1345(s), and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles ("GAAP") and other authoritative pronouncements of the accounting profession. Rule 1300.45(q) indicates that the Accounting Principles Board Opinions, Financial Accounting Standards Board Statements ("FASB"), Accounting Research Bulletins and other authoritative pronouncements of the accounting profession should be applied in determining GAAP.

During our review of administrative expenses for the 8 months ended February 28, 2006, the Department noted reimbursements to some of the Plan's management team for approximately $56,000 in expenses incurred in prior years of 2003 and 2004. The Plan represented that the contractual intent was to recognize these expenses once the Plan became profitable. However, these expenses were not recorded as a liability during fiscal year ended 2004 and 2005 for compliance with GAAP.

The Plan's failure to record these liabilities in the proper time period resulted in misstated financial statements filed with the Department.

The Plan was required to file restated annual/audited financial statements for the year end 2004-2005 with the Department. In addition, the Plan was required to provide the policies and procedures, the date of implementation, the management position responsible for ensuring the corrective action taken, and the controls implemented for ongoing monitoring to assure continued compliance with GAAP.

The Plan provided copies of the restated annual/audited financial statements for the year end 2004-2005in its response. Additionally the Plan provided a copy of the policy and

procedure it implemented as of August 1, 2006 that ensures proper controls and monitoring systems are in place to assure continued compliance with GAAP. This policy states that the Chief Financial Officer is responsible for compliance with GAAP.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

C. MATERIAL MODIFICATIONS AND AMENDMENTS

Section 1352 (a) and (b), and Rules 1300.52 and 1300.52.1 require all plans to file an amendment with the Director within thirty (30) days after any change in the information contained in its application, other than financial and statistical. Material changes to the Plan's operation are required to be filed as a Notice of Material Modification twenty (20) days prior to any changes being implemented as specified in this Section and Rules.

Rule 1300.52.4 sets forth standards for amendment and notices of material modification filings.

Our examination disclosed that the Plan failed to comply with the filing requirements of Section 1352 and Rules 1300.52, 1300.52.1 and 1300.52.4, as follows:

On January 1, 2006, the Plan entered into new subscribers group contracts with an Exclusive Provider Organization ("EPO") line of business that has a material effect on the Plan's operations.

The Plan was required to file the new subscriber group contract as Amendment in accordance with the requirements of Section 1352(a) and (b), and Rules 1300.52 and 1300.52.4 through the electronic filing process with the Department.

The Plan was also required to state the policies and procedures implemented to ensure that amendments/material modifications are filed with the Department; the date of implementation; and, the management position(s) responsible for ensuring that the Plan will comply with the requirements of the above Section and Rules.

The Plan responded that it filed the new subscriber group contract through the electronic filing process with the Department and the cover page for this filing as well as the electronic confirmation was included in its response.

The Plan provided a copy of the Policy and Procedure implemented in July 2006 to ensure that amendments/material modifications are filed with the Department as required by Section 1352(a) and (b), and Rules 1300.52 and 1300.52.4. The Plan's Director of Operations will be responsible for implementation of this required action as well as the aforementioned policy and procedure.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.

D. FIDELITY BOND

Section 1351(q) and Rule 1300.76.3 requires each plan to at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond shall provide for 30 days notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule.

Our review of the Plan's fidelity bond disclosed that the amount of coverage was for $75,000, which was below the minimum required coverage of $600,000. In addition, the Notice of Termination Endorsement to the policy set forth that the company will endeavor to notify the California Department of Insurance. The word "endeavor" is defined as an "earnest attempt" and is to be deleted from the Endorsement in order to comply with the above Rule. The Rule also requires that the fidelity bond "…shall provide for 30 days notice to the Director of the Department of Managed Health Care prior to cancellation", not the Department of Insurance.

CORRECTIVE ACTION TAKEN DURING THE EXAMINATION: The Plan increased the coverage amount to $750,000 as evidenced by a Certificate of Insurance on May 10, 2006.

The Plan was required to file a copy of its fidelity bond that includes revised Endorsements which do not include the language limiting compliance with the above requirement.

The Plan was also required to state the management position responsible for ensuring continued compliance and a description of the controls implemented to ensure compliance.

The Plan's response provided a copy of the fidelity bond that includes the revised and proper Endorsements. The Plan stated that the Chief Financial Officer will be responsible for ensuring continued compliance. The Plan will require the bond carrier to include the required endorsement by the Department.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required.