



Arnold Schwarzenegger, Governor
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Business, Transportation and Housing Agency

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In reply refer to file No. 933 0055
Via Federal Express and E-Mail

April 30, 2010

George Halvorson, Chairman of the Board & Chief Executive Officer
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

**RE: FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF KAISER
FOUNDATION HEALTH PLAN, INC.**

Dear Mr. Halvorson:

Enclosed is the Final Report of the Non-Routine Examination of Kaiser Foundation Health Plan, Inc. (the "Plan") conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").¹ The Department issued a Preliminary Report to the Plan on January 14, 2010. The Plan filed responses with the Department on March 10, 2010 and April 13, 2010.

The examination was conducted for good cause based on complaints received by the Department from several members of the Plan. On April 15, 2009, the Department held a meeting with Plan representatives to express the Department's concerns with the billing and collection practices of the Plan's contracted providers for services provided to the Plan's members.

The examination involved reviewing the billing and collection practices for deductible health plan products and end-stage renal disease ("ESRD") coverage for the period October 1, 2008 through March 31, 2009.

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 provide 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."

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 Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

Please indicate within ten (10) days whether the Plan requests the Department to append its March 10, 2010 and April 13, 2010 responses to the Final Report. If so, please indicate which portions of the Plan's responses shall be appended and provide a copy (electronically) of those portions of the Plan's responses 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.

If the Plan requests the Department to append a brief statement summarizing the Plan's March 10, 2010 and April 13, 2010 responses to the report or wishes to modify any information provided to the Department in its responses, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal.

Please file this addendum electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
 - 1) File Type; select "Amendment to prior filing";
 - 2) Original Filing, select the Department's assigned "Filing No. 20091297" by clicking on the down arrow; and
 - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select "Complete Amendment",
- Select a "Signatory,"
- Complete "Execution" and then click "complete filing".

As noted in the attached Final Report, the Plan's March 10, 2010 and April 13, 2010 responses do not fully resolve the deficiencies cited and the corrective actions required in the Preliminary Report issued by the Department on January 14, 2010. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for these unresolved issues, within thirty (30) days of receipt of this report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please file the Plan's response to the Final Report electronically via the Department's eFiling web portal <https://wpsso.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
 - 1) File Type; select "Amendment to prior filing";
 - 2) Original Filing, select the Department's assigned "Filing No. 20091297" by clicking on the down arrow; and

- 3) Click “create filing”.
- From the Original Filing Details Menu, click “Upload Amendments”; select # of documents; select document type: " Plan’s Response to Final Report (FE10)"; then “Select File” and click “Upload”.
 - Upload all documents then upload a cover letter as Exhibit E-1 that references to your response. After upload, then select “Complete Amendment”,
 - Select a “Signatory,”
 - Complete “Execution” and then click “complete filing”.

Questions or problems related to the electronic transmission of the response should be directed to Rita Ultreras at (916) 255-2443 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wpsso@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 report will be located at the Department’s web site at www.dmhc.ca.gov.

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

Sincerely,

[Original Signed By](#)

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

ng:jn

cc: Maureen McKennan, Assistant Deputy Director, Office of Health Plan Oversight
Amy Dobberteen, Assistant Deputy Director, Office of Enforcement
Andrew George, Assistant Deputy Director, HMO Help Center
Michael McClelland, Assistant Deputy Director, Office of Provider Oversight
Michael Cleary, Chief, Division of Financial Oversight
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DIVISION OF FINANCIAL OVERSIGHT

**FINAL REPORT OF
THE NON-ROUTINE EXAMINATION OF
KAISER FOUNDATION HEALTH PLAN, INC.**

FILE NO. 933 0055

DATE OF FINAL REPORT: APRIL 30, 2010

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: NED GENNAOUI

FINANCIAL EXAMINERS:

**STEVEN ALSETH
JAMEY MATALKA
SUSAN MILLER
GALAL GADO**

BACKGROUND INFORMATION FOR KAISER FOUNDATION HEALTH PLAN, INC.

Date Plan Licensed:	October 27, 1977
Organizational Structure:	Kaiser Foundation Health Plan, Inc. (“Plan”) is a nonprofit, public benefit corporation, licensed as a Knox-Keene plan and as a federally qualified HMO. The Plan is one of the organizations that comprise the Kaiser Permanente Medical Care Program. The other organizations are Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group.
Type of Plan:	A health care service plan providing the full range of health benefits, including hospital, medical and pharmacy, to commercial, Medicare and Medi-Cal members.
Provider Network:	Integrated care model offering health care services through a network of hospitals and physician practices operating under the Kaiser Permanente name. Compensation arrangements include capitation, discounted fee for service, per diem and case rate basis.
Plan Enrollment:	6,792,650 as of March 31, 2009
Service Area:	Major counties within California.
Date of Last Final Routine Financial Examination Report:	November 26, 2007

**FINAL REPORT OF THE NON-ROUTINE EXAMINATION OF
KAISER FOUNDATION HEALTH PLAN, INC.**

This is the Final Report of the Non-Routine Examination of Kaiser Foundation Health Plan, Inc. (the "Plan") conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 (b) of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").¹ The Department issued a Preliminary Report to the Plan on January 14, 2010. The Plan filed responses with the Department on March 10, 2010 and April 13, 2010.

This Final Report includes a description of the compliance efforts included in the Plan's responses in accordance with Section 1382 (c). The Plan's responses are noted in *italics*.

The examination was conducted for good cause based on complaints received by the Department from several members of the Plan. On April 15, 2009, the Department held a meeting with Plan representatives to express the Department's concerns with the billing and collection practices of the Plan's contracted providers for services provided to the Plan's members.

The examination involved reviewing the billing and collection practices for deductible health plan products and end-stage renal disease ("ESRD") coverage for the period October 1, 2008 through March 31, 2009.

Our findings are presented in the accompanying attachment as follows:

Section I.	Compliance Issues
Section II.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for the corrective actions requested in this report, within 30 days after receipt of this report.

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 Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

SECTION I. COMPLIANCE ISSUES

A. LACK OF ADMINISTRATIVE CAPACITY OVER DEDUCTIBLE PRODUCTS

Section 1367 (g) requires each plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. It also requires that the obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

Rule 1300.67.3 (a)(2) requires each plan to provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include, among other things, staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

The Plan is responsible for the effective and efficient administration of the deductible products it markets and issues to its members. The Plan is obligated to ensure that its contracted providers have the administrative capacity to promptly submit claims to the Plan so that out-of-pocket costs and deductibles can be accumulated to administer these products correctly.

The Department's examination disclosed the following deficiencies related to the administration of the Plan's deductible products caused by its contracted providers' lack of administrative capacity:

1. Untimely Claim Submission

The examination found that claims were not promptly submitted by Kaiser Foundation Hospitals, The Permanente Medical Group and Southern California Permanente Medical Group (hereafter referred to as "Kaiser internal providers") to the Plan for accumulation of out-of-pocket costs and deductibles. An analysis of the claim data submitted by the Plan for receipt dates of October 1, 2008 through March 31, 2009 are presented below:

Southern California Region ("SCA")

- For SCA professional claims, 8 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended December 31, 2008.
- For SCA professional claims, 3 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended March 31, 2009.
- For SCA institutional claims, 37 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended December 31, 2008.

- For SCA institutional claims, 15 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended March 31, 2009.

Northern California Region (“NCA”)

- For NCA professional claims, 16 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended December 31, 2008.
- For NCA professional claims, 5 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended March 31, 2009.
- For NCA institutional claims, 23 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month period ended December 31, 2008.
- For NCA institutional claims, 7 percent of claims were not submitted by providers to the Plan within 90 calendar days of service date for the three-month ended March 31, 2009.

A delay in claims submissions means that the Summary of Accumulation (“SOA”) statement does not timely reflect charges to member/guarantor’s individual or family accounts. A SOA that timely captures charges is needed to determine when a member/guarantor’s annual out-of-pocket maximum, individual and/or family annual deductible limits have been reached. This delay also caused billings for services to be sent to the member/guarantor several months after services were rendered.

The Plan’s contracts with Kaiser internal providers do not require timely filing of claims. Timely billing is important to members so that they can effectively manage their medical costs and obtain the independent third party statements needed to obtain reimbursements from flexible spending accounts pursuant to IRS Publication 969.

The Plan was required to amend all Kaiser internal provider contracts to include filing requirements for claims submission to ensure timely accumulation of the member/guarantor’s annual out-of-pocket maximums, individual and/or family annual deductibles. The claim filing requirements was to state a specific time frame to ensure that members covered by the Plan’s deductible products are able to receive timely information to meet the IRS filing requirements for flexible spending accounts reimbursements. The Plan was required to submit evidence of the filing of amended provider contracts with its response to this report.

The Plan responded that it respectfully disagrees with the Department’s position that the cited law supports the identified deficiency. California Health and Safety Code Section

1367(g) states, in pertinent part, as follows: "The Plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees." California Code of Regulations, Title 28, Section 1300.67.3(a) (2) states, in pertinent part, as follows: "The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include: . . . staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business." The Department's finding does not suggest that the Plan failed to arrange for the provision of medical and hospital services consistent with the relevant benefit contracts. Rather, the Department suggests that requiring a 90 day submission deadline is necessary for a Plan to comply with Section 1367(g) and Title 28 Section 1300.67.3 and construes its sample of provider claims as evidence of a Plan deficiency. The Plan contends that the Knox-Keene Act does not support a 90 day deadline, as a claims practice or as a standard for a plan's administrative capacity. Further, the Plan contends that while TPMG, SCPMG, and KFH claims submissions have and are subject to improvement, they have not been contrary to the Knox-Keene Act and certainly not an indication that the Plan's administrative capacity has been lacking. The Plan however, shares the Department's interest in expediting claims submission, processing, and accounting for the benefit of our Members. Accordingly, as described further below, the Plan has and will implement responsive measures. Indeed, a full and fair review of the recent claims submission record of TPMG, SCPMG, and KFH substantiates the Plan's successful oversight and attention. The vast majority of claims are submitted on a very timely basis even against the Department's disputed timely submission standards.

State law prohibits a plan from requiring a provider to submit claims in less than 90 days from the date of service when the plan is the primary payer. (28 Cal. Code Regs. § 1300.71(b)(1)) The law does not, however, mandate any requirement for provider claims submission. The standard practice in the industry is for commercial health plans to negotiate a timeframe for claims submission with providers, and 12 months is a common timeframe used in the industry. In addition, the Medicare program regulations provide well over a year for providers to submit claims for payment. (42 C.F.R. Section 424.44.) Consistent with industry practice, the Plan applies a 12 month time limit for all claims submission by external providers to the Plan.

The data referenced by the Department includes claims submitted by outside providers, which are submitted later than internal provider claims are submitted to the Plan. In the vast majority of cases, internal providers' claims for professional services are currently submitted to the health plan within 30 days of the date of service. The following graphic for Q4 2009 evidences that by the end of the year the time from date of service to submission of claim to the health plan was 90 days or less for 95% + of all claims.

Claims Produced Within 90 Days

North		Oct-09	Nov-09	Dec-09
0-90 Days	%	96%	98%	96%
	#	381,354	363,003	334,598
91+	%	4%	2%	4%
	#	15,175	8,074	12,220
Total	#	396,529	371,077	346,818

South		Oct-09	Nov-09	Dec-09
0-90 Days	%	92%	95%	95%
	#	206,118	182,193	184,060
91+	%	8%	5%	5%
	#	17,768	10,134	8,711
Total	#	223,886	192,327	192,771

The Plan recognizes that timely claims processing is particularly important to our deductible members. Our data reflects that the Plan is improving substantially in this area. As noted above, in the vast majority of cases, claims have been produced in a timely manner and this will only continue to improve. There are several reasons why there will always be a certain number of cases that fall outside the median timelines for submission of a claim to the Plan, and the eventual production of the billing statement.

For example, there are critical quality assurance requirements that must be met before the claim passes scrutiny within the internal provider's established processes to be submitted to the Plan. In addition, the internal provider's ability to submit a claim and to eventually produce a billing statement is hampered by retroactive enrollment processes, which are both unavoidable and frequent due to the Plan's large enrollment. The Plan provided examples of large groups affected by retroactive enrollment, which accounts for the reason why some bills will always take longer to process.

These examples support the Plan's conclusion that it is neither possible nor beneficial for any of the concerned parties for the Plan to apply a strict timeline for internal providers to submit claims to the Plan, or for the production of the billing statement to the patient.

The Department has requested that the Plan amend its provider contracts to include a specific timeframe for the submission of claims to the Plan. The Plan respectfully disagrees with this request because, as noted above, the Knox-Keene Act does not require a 90 day submission deadline. Moreover, a far more effective method of improving claims submission time is regular engagement with the providers, setting goals and targets, establishing policies and procedures, monitoring performance, and focusing on continuous quality improvement. In the course of its business, the Plan works regularly with the providers in the course of monitoring its customer satisfaction and on numerous activities that require coordination between the plan and the provider. The Plan has determined that it can better ensure appropriate oversight of the timeliness of claims

submission and production of billing statements through the active, ongoing governance functions of the Health Plan Oversight Committee, which meets monthly. Members of this committee include:

- *Executive Director, CA Claims and Encounter Strategy*
- *SVP, Product Management and Benefits Administration*
- *VP, NCAL Revenue Cycle*
- *VP, Benefits Administration*
- *VP, Actuarial Services*
- *VP, Marketing Communications*
- *Director, National Revenue Cycle*
- *Product Performance Leader*
- *VP, SCAL Revenue Cycle*
- *Executive Director, Benefit Strategy Administration*
- *VP, Compliance*
- *Managing Director, Strategy and Program Management*
- *Director, SCAL Claims*
- *VP, Systems Solutions and Development*
- *Executive Director, Products & Benefits and Deductible Health Plans*
- *Executive Director, Claims Performance and Strategy*
- *VP, Member Service Call Centers.*

A higher level of executive oversight is provided by the Health Plan Revenue Cycle Executive Committee, which meets quarterly. Members of the committee include:

- *SVP, National Product Development and Benefits Administration*
- *CFO*
- *Director, Business Management, SCPMG*
- *SVP, Customer Service*
- *SVP, National Health Plan Manager*
- *SVP, Finance Operations*
- *VP, Systems & Solutions Development*
- *SVP, Finance*
- *VP, Health Plan Service Administration*
- *Assistant Medical Director, TPMG*

In relationship to this Health Plan governance structure, a Health Plan Oversight of DHMO Member Claims Submissions Policy and a related Service Level Agreement have been formulated.

The Health Plan Oversight of DHMO Member Claims Submissions Policy requires claims for services rendered for deductible members to be submitted to the Health Plan within 12 months from the date of service. The Policy will specify that the Plan and the internal provider(s) will waive any member liability if the billing statement is sent out

beyond 12 months from the date of service. The Policy will make clear that as part of its oversight activities, the Plan will be routinely monitoring claims submission timeliness. This Policy is consistent with the industry standard, and with the Plan's requirements of its external providers. The Plan submitted this policy with its April 13, 2010 response.

The Plan also drafted a Service Level Agreement between the Plan and the Internal Providers. This Agreement will specify a performance level metric that 90 percent of all billing statements, if balance due, will be sent out to the deductible member within 125 days of the date of service. The Health Plan Revenue Cycle Oversight Policy provides for monitoring of performance under the metric set forth in the Service Level Agreement. The Plan submitted the signed agreement with its April 13, 2010 response.

The Plan strongly believes that the governance structure detailed above and both the Health Plan Revenue Cycle Oversight Policy and the Service Level Agreement, along with the data demonstrating the Health Plan's proactive improvement in this area, are a comprehensive and appropriate response to the Department's findings in A1.

Based on the foregoing, the Plan respectfully requests that this deficiency be changed to a survey "recommendation."

The Department acknowledges the improvement in the timeframe for submission of claims by Kaiser internal providers and the Plan's belief that its oversight governance structure will improve member's satisfaction with its deductible products. The Department also acknowledges the Plan's disagreement with the legal citations for this finding.

The Plan states that 12 months is a common timeframe for providers in the industry to submit claims. Based on the Department's examination of other health care service plans, we find that contracted providers generally bill within 90 days and non-contracted providers generally bill within 180 days to insure adequate cash flow to fund their operations. In examining the Plan's integrated care model, we found that Kaiser internal providers have difficulties generating claims within the norms experienced by other health plans with their external providers who don't have the benefit of Kaiser integrated computer system connectivity.

The Plan provided examples of large groups affected by retroactive enrollment, which accounts for the reason why some bills will always take longer to process. The Department has not seen this issue preventing providers of other health care service plans from timely billing for services rendered.

The Department declines the Plan's request to change the deficiency to a "recommendation" and finds that the corrective actions of the Plan do not fully insure that Summary of Accumulation Statement will timely reflect charges to member/guarantor's individual or family accounts. In addition, the Plan's corrective actions do not provide timely billings of services to a member/guarantor after services are rendered in up to 10 percent of billing statements.

The above deficiency will be referred to the Office of Enforcement for administrative actions.

2. Failure to Provide Timely Independent Third Party Statements for Flexible Spending Account Reimbursements

IRS Publication 969 requires an independent third party statement of medical services received and the medical expenses incurred during the period of coverage for reimbursements from flexible spending accounts.

IRS Publication 929 also states, "Flexible spending accounts are "use-it-or-lose-it" plans. This means that amounts in the account at the end of the plan year cannot be carried over to the next year. However, the plan can provide for a grace period of up to 2½ months after the end of the plan year. If there is a grace period, any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year."

The Department received a complaint from a member who was unable to obtain an independent third party statement from a Kaiser internal provider so that the member could obtain reimbursement from his health savings account before the grace period expired. The Department found that the delay in claims submission and the billing practices of Kaiser internal providers contributed to the delay in providing the member with an itemized statement of services received and charges incurred to comply with the IRS requirements. This issue was noted in sample SF-46.

The Plan was required to establish and submit its policy for remediating a member/ guarantor who has forfeited distribution(s) because the member was unable to meet the IRS independent third party statement requirement; as well as, remediate a member/ guarantor for any penalties and taxes incurred because of the Plan's contracted provider's failure to provide the statement timely.

The Plan responded that this deficiency should apply only to health flexible spending arrangements (FSAs) and not health savings accounts (HSAs), because HSAs are not subject to time limitations for reimbursement or to a "use-it-or-lose-it" requirement. Flexible spending arrangements (FSAs) are employer-established benefit plans. For members with FSAs, the Plan has no way of knowing which members have funded accounts at their disposal and which do not because the financial relationship is between the member and an administrator of the employer-established benefit plan, not the Plan. Therefore, it is the responsibility of the members to contact the Plan if they need certain documentation that they wish to submit for FSA reimbursement.

IRS Publication 969 states that, in order to receive reimbursement, a participant must provide the health FSA with "a written statement from an independent third party stating that the medical expense has been incurred and the amount of the expense." In this regard, all Plan members receive a receipt and service description/visit summary at the time of service that could contain information on the out-of-pocket expenses incurred by

the member; this receipt could be utilized for purposes of the above-described "written statement." In addition, all members (including members with FSAs and HSAs) are able to call the Plan's customer service center to receive bills on demand if they require a duplicate or if they are waiting for a bill. However, these demand bills are available only for services for which the Plan has received claims from Plan or Contracted providers.

If the member contacts the Plan for a statement of services that has not yet been delivered due to billing cycle timing, the Plan will produce a demand bill for the member. In addition, the member will receive the standard bill when it is released from the billing cycle.

If the member contacts the Plan for a statement of services that has not yet been produced because the Plan has not yet received a claim from a Plan or contracted provider, the Plan will excuse the member liability for services that cannot be substantiated with a bill for services within the 2 1/2 month grace period allowed by IRS guidelines. This describes the current practice of the Plan. The Administrative Adjustments Policy was revised to specifically address this issue, and a copy of the revised policy was submitted with the Plan's April 13, 2010 response.

A participant in a HSA is not subject to any penalties or taxes for failure to timely provide documentation for reimbursement to the HSA. Therefore, the Plan's response does not encompass this issue

The Department acknowledges that the deficiency should only apply to flexible spending accounts. Therefore, the reference to health saving accounts has been removed from the deficiency cited. The Department finds that the Plan's corrective actions do not fully resolve the deficiency cited. The Plan's policy needs to include a provision to address reimbursement of penalties or additional taxes that are imposed by the IRS for billing(s) not provided to member/guarantor during the grace period.

B. UNJUST BILLING PATTERN

Section 1371.39 (b)(1) states that an "unfair billing pattern" means engaging in a demonstrable and unjust pattern of unbundling of claims, up-coding of claims, or other demonstrable and unjustified billing patterns, as defined by the Department.

The Plan is responsible for the effective and efficient administration of the deductible products it markets and issues to its members. The Plan is obligated to ensure that its contracted providers have the administrative capacity to promptly provide members with a clear and concise itemization of services received and charges incurred so that members can effectively manage their medical costs. This means that the Plan is ultimately responsible for overseeing its contracted provider's billing practices when services are provided to a member covered by the Plan's deductible products.

The Department's examination disclosed the following unjust billing patterns:

1. Unjust Time Lag for Posting Billed Charges

The posting of charges to the Summary of Accumulation (“SOA”) and to the member/guarantor’s billing statement, after posting of the claim to the accumulation system (accumulator), were unjustly long for several claims. This practice makes it difficult for the member/guarantor to determine when annual out-of-pocket maximums, individual and/or family deductible limits have been reached. Some examples of unjust time lag were noted on claim samples:

Sample No.	Date of Receipt of Claim	Posting Date to Accumulator (PDA)	Date of SOA	Date of Billing (DOB)	Number of Days from PDA to DOB
SF-9	12-11-08	12-12-08	1-11-09	7-8-09	209
SF-15	11-1-08	11-11-08	1-15-09	1-18-09	67
SP-25	11-13-08	11-14-08	11-15-08	6-16-09	214
SP-46	12-20-08	12-22-08	1-13-09	5-12-09	141
NF-11	10-21-08	10-22-08	11-8-08	12-25-08	64
NP-3	11-29-08	12-1-08	12-14-08	2-12-09	73
NP-10	11-20-08	11-21-08	None	1-25-09	65

The Plan was required to submit the corrective action plan that will be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan responded that it respectfully disagrees with the Department’s position that the cited law supports the identified deficiency. California Health and Safety Code Section 1371.39 addresses unfair billing patterns. “Unfair billing patterns” is defined as “engaging in a demonstrable and unjust pattern of unbundling of claims, up-coding of claims, or other demonstrable and unjustified billing patterns...” The statute is drafted to apply to billing patterns that result in inappropriate reimbursement to the provider through unjustly unbundling or upcoding billing practices.

The Department’s findings are limited to the delayed posting of charges, which is not an unfair billing pattern within the meaning of Section 1371.39.

The Plan, however, shares the Department’s concern about timeliness of posting of charges, as reflected in its response below and its respond to Deficiency A1.

The provider/hospital will strive for no more than 45 days from the date of remittance receipt for statement generation. It is important to note that patient statements run on a monthly cycle so in the worst case a statement would be produced 30 days after remittance processing. Thus, it’s reasonable to expect all statements to generate within 45 days of remittance processing.

This metric is reviewed by the Health Plan Revenue Cycle Oversight Committee as referenced in A1 in accordance with the 90%-125 day expectation as contained in the Service Level Agreement.

The Department acknowledges the Plan disagreement with the legal citation for this finding. However, it is unclear to the Department why the SOA statement cannot be sent to the member/guarantor at the end of the month that a claim is posted to the Accumulator. Therefore, the Plan is requested to justify the reasons why the SOA statement cannot be generated at month end to notify the members/guarantors of their accumulation status regarding their deductibles and out of pocket maximums.

2. Dual Kaiser Coverage Not Considered for Proper Billing

Kaiser internal providers are waiting for members with dual coverage (subscriber and spouse have coverage through Kaiser from different sources) to call before making adjustments to their billed charges. This practice makes it difficult for the member/guarantor to determine when annual out-of-pocket maximums, individual and/or family deductible limits have been reached, and may result in overpayments of out-of-pocket expenses and deductibles. The Department incorrectly referred to sample NF-49 as an example of this deficiency in the preliminary report; the Department should have referred to sample SF-49.

The Plan was required to submit the corrective action plan that will be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan responded that in its Foundation System membership database, dual Plan coverage is captured. The membership database currently articulates with the point of service front-end clinic workstations and displays the proper co-pay. If there is dual Plan coverage, the system will reflect that there is no co-pay at the point of registration.

The Department cited Sample NF-49 in support of this deficiency. The Plan believes the correct sample citation should be NF-1. In this case, it appears that there was a human error which resulted in the co-pay not being properly manually written-off. However, the member did not receive a bill for the co-pay and that, indeed, the co-pay was subsequently adjusted off of the account on June 19, 2009. This was done without the member having contacted us in this regard.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

C. UNFAIR DISCLOSURE

Section 1363 (a) states, "The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract."

The Plan did not fully communicate the benefits, terms and conditions for its deductible products to its members as follows:

1. Unclear Totals on Billing Statements

The member/guarantor's billing statement presents two different total amounts owed, one on an aged and another on an un-aged basis. For example, a statement can show an aged total amount of \$120 (based on the number of days outstanding) and an un-aged total amount owed of \$100. The reason for the difference is that the Kaiser internal provider applied a \$20 payment received to the un-aged total amount owed but not to the aged total amount owed. The Department finds this presentation to be confusing and not a fair disclosure of the total amount owed. This issue was noted in Samples NF-17 and SF-48.

The Plan was required to submit the corrective action plan that would be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan responded that it respectfully disagrees with the Department's position that the cited law supports the deficiencies identified under Section C1. California Health and Safety Code Section 1363(a) falls under the Knox-Keene Act, Article 4, which is entitled, "Solicitation and Enrollment." As set forth in this section, the term disclosure is intended to address plan forms or materials that allow a consumer to make an informed choice about plan options prior to enrollment. For example, section 1363(a) specifically refers to materials "to facilitate comparisons between plan contracts of the same or other types of plans." In short, this section addresses disclosures for purposes of solicitation and enrollment; unclear billing statements that an enrollee may receive post-enrollment are not contemplated under the language of the statute. The Plan, however, shares the Department's interest in providing clear and comprehensible information to our Members. Accordingly, as described further below, the Plan has and will implement responsive measures.

The Plan published and launched the distribution of the "Paying for Care" brochure on October 14, 2009. The content of this brochure provides information on how professional and facility billing works. This brochure is available to members during open enrollment, in the medical centers at the point of service, upon request, through the Member Services Call Center and at KP.org in both English and Spanish.

In order to ensure that members who may be affected by the processes detailed within the brochure remain confident in their understanding and expectations surrounding the Plan's billing process, the Plan will be undertaking the following measures within the indicated timelines:

- *February through April, 2010 – establish and engage a focus group with both, northern and southern California members, in which currently identified deficiencies with guarantor statements are reviewed and provider system upgrades and member communications needs are defined.*

- *May through October, 2010 – analyzing the focus group findings, gaps will be identified, solutions will be proposed, and business requirements for any system changes will be formulated, including determination of the necessary IT resources.*
- *October 31, 2010 – Requirements for the business plan will be completed and an implementation time line will be created.*

The goals of this process are expected to explore the following:

- *A reformatting of the guarantor statement (Deficiency C1)*
- *Possible modification of aging buckets for guarantor dollars (Deficiency C2)*
- *Determine if transactions shall be listed either in transaction posting date order or date of service and whether both the posting date and service date should be displayed (Deficiency C3)*

Based on the foregoing, the Plan respectfully requests that this deficiency, and all deficiencies under Section C, be changed to a survey “recommendation.”

The Department acknowledges the Plan’s disagreement with the legal citation for this finding, and the Plan’s future plan to reformat the guarantor statement.

The Department declines the Plan’s request to change the deficiency to a “recommendation” and finds that the Plan’s corrective actions do not resolve the deficiency cited.

The Plan’s response does not indicate the changes that will be implemented to guarantor statements to produce fair and clear disclosure of the guarantor’s financial responsibility on current billing statements. The Plan is requested to identify the changes to the guarantor statements that will be made based on analyses of focus group results, which is anticipated to be completed by October 31, 2010. In addition, the Plan is requested to indicate when the changes will be implemented and file a sample of guarantor statements for physician and hospital services. The implemented changes, the date of implementation and a sample of guarantor statements are required to be filed with the Department within 15 days of the completion of the analyses of October 31, 2010. The Plan is requested to provide a written assurance with its response to this Final Report that the requested documents will be filed by November 15, 2010.

2. Incorrect Aging of Member/Guarantor’s Balance Due

Kaiser internal providers are aging the total amount owed on the member/guarantor’s billing statement based on service date and not the date that the service was billed. Therefore, the total amount owed is being presented as outstanding longer than when it

was actually billed. The Department finds this presentation to be confusing and not a fair disclosure of the true aging of the total amount owed. This issue was noted in Samples SF-42 and SF-44.

The Plan was required to submit the corrective action plan that would be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan's response is provided under Deficiency C1 above.

The Department's finding is provided under Deficiency C1 above.

3. Service Rendered Not Listed Chronologically

Kaiser internal providers do not list services rendered in chronological date order on Member/guarantor's billing statements. The services are listed by the date that the claim was finally processed which can be several months later. This presentation makes it difficult for the member/guarantor to determine when annual out-of-pocket maximums, individual and/or family deductible limits have been reached. This issue was noted in Sample SF-48.

The Plan was required to submit the corrective action plan that will be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan's response is provided under Deficiency C1 above.

The Department's finding is provided under Deficiency C1 above.

4. No Fair Disclosure about Expected Timeframe for Accumulation and Billing

The Plan's member kit does not fairly disclose to the member/guarantor when charges will be reflected in a statement of accumulation ("SOA") and a bill for services will be provided to the member/guarantor. The member kit states the following:

"Because of the time it takes for items to show up in your account, your SOA and bill may not always reflect the most recent charges that apply to your deductible. These charges may appear on your next statement or bill."

Furthermore, Kaiser internal providers do not fairly disclose to the member/guarantor at time of service that an excessive time lag may occur between the date services are rendered and charges are reflected in a SOA. They also do not fairly disclose that an excessive time lag may occur between the date services are rendered and the date charges are billed to the member/guarantor.

This lack of disclosure makes it difficult for the member/guarantor to determine when annual out-of-pocket maximums, individual and/or family deductible limits have been reached.

The Plan was required to submit the corrective action plan that will be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan responded that subsequent to the initial findings of this survey, the Plan has substantially reduced the timeframe in which member billing and the accumulation to their account may occur. That fact notwithstanding, the Plan has proactively provided for member education insofar as billing and accumulation is concerned, as evidenced in the October 14, 2009 Kaiser Permanente Deductible HMO Plan brochure, "Paying for Care", a copy of which was provided to the Department.

Specifically, the section "More About Your Bill" of the brochure, alerts members to the process whereby charges may be posted to their accounts, and also the possibility that more than one bill may be issued for a single service.

"Services and related payments may take several months to appear on your bill. So your current bill may not always reflect your most recent charges or payments. This information may appear on a future bill.

Sometimes, you may see a payment but not the related charges for a service. That could be because your payment was recorded before the charges for a service were processed. If so, the charges should appear on a future bill. Also, remember that you may receive more than one bill for a single service—a "physician bill" and a "hospital bill." If you don't see all the charges for a service on one bill, they may appear on a future bill."

The Department finds that the Plan's corrective actions do not resolve the deficiency cited and the corrective actions required. The revised disclosure does not add clarity about when annual out-of-pocket maximums, individual and/or family deductible limits have been met.

The above deficiency will be referred to the Office of Enforcement for administrative actions.

5. No Fair Disclosure to Member or Guarantor about Professional and Institutional Billing Processes

Kaiser internal providers do not fairly disclose to the member/guarantor that separate bills will be sent for institutional services and for professional services based on different billing cycles. This practice makes it difficult for the member/guarantor to determine when annual out-of-pocket maximums, individual and/or family deductible limits have been reached.

The Plan was required to submit the corrective action plan that will be implemented by Kaiser internal providers to correct the above deficiency with its response to this report.

The Plan responded that it published and launched the distribution of the attached financial brochure ("Paying for Care") on Oct 14, 2009.

The content of this brochure was developed to respond to issues identified by Members during focus groups held in Q2 2009. Among the issues that Members identified were:

- *What to expect during their visits*
- *How professional and facility billing works*
- *How to read their Billing Statements and their Statements of Accumulation*
- *How their liability is calculated*

Members also identified during the focus groups that they wanted to receive information when it was the most meaningful to them but that they also did not expect Physicians to engage in billing discussions. To balance these two needs, the "Paying for Care" brochure is available to members through the following channels:

- *During Open Enrollment to help them know what to expect from a deductible plan*
- *In medical centers at the point of service (available through frontline clerks, not physicians), Local Member Services or Financial Counselors*
- *Upon request through a call to the Member Services Call Center*
- *On KP.org where the brochure is available in PDF format*

The "Paying for Care" brochure is available in both English and Spanish.

The Plan has very clearly detailed the professional and institutional billing processes, as evidenced on Pages 2 and 3 of the Kaiser Permanente Deductible HMO Plan brochure, "Paying For Care." Expectations and potential concerns with the process of the posting of claims for covered services to the member account are addressed utilizing easily understood diagrams with accompanying descriptions. This brochure is readily available to new and existing members through a variety of Plan sources.

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required.

D. OPERATING AT VARIANCE WITH FILED DOCUMENTS

Section 1386 (b)(1) states that the following acts or omissions constitute grounds for disciplinary action by the director:

- (1) The plan is operating at variance with the basic organizational documents as filed pursuant to Section 1351 or 1352, or with its published plan, or in any manner contrary to that described in, and reasonably inferred from, the plan as contained in its application for licensure and annual report, or any modification thereof, unless amendments allowing the variation have been submitted to, and approved by, the director.

The Plan's Evidence of Coverage ("EOC") constitutes a "published plan," under the meaning of 1386 (b). Therefore, by not mailing the accumulation and billing statements, and not refunding member overpayments promptly, the Plan is operating at variance with its published plan as follows:

1. Not Refunding Overpayments Promptly

The Cost Sharing (Deductible, Copayments, and Coinsurance) section of the Plan's EOC states, among other things, "...After you [member] receive the Services, we [the Plan] will compare the Charges for the Services subject to the Deductible that you actually received against what you paid when you checked in for an appointment or procedure. If you overpaid, we will send you a refund promptly..."

Section 1.5 of the Plan's Credit Balance Resolution Policy states, "The Regional Patient Business Services (PBS) Collections Assistant Director/Director and the Department Manager review system generated reports on a weekly/monthly basis to ensure credits and undistributed credits are processed with the established goal of 90 days..."

The Department's examination disclosed that overpayments are not refunded to members consistently within 90 days. This is not in compliance with the Plan's Credit Balance Resolution Policy and the Plan's EOC, which requires refunding overpayments promptly. This failure was found in samples SP-34 and 39; NP-2, 6, 15, 38 and 42; SF-28 and 35; and NF-13, 26, 35 and 44.

The Plan stated that a refund is not issued if the member/guarantor has a balance due on the other billing system. As previously mentioned, the Plan's contracted providers have two billing systems: one for institutional claims and one for professional claims. The Plan stated that a request has to be made by the member/guarantor to transfer overpayment from one billing system and apply it to a balance due in the other billing system. The Plan's contracted providers do not notify the member/guarantor of the overpayment in one system if there is a balance due on the other billing system.

The Plan was required to submit a corrective action plan ("CAP") that details the specific steps being taken by Kaiser internal providers to resolve these credit balances and promptly refund overpayments to members.

- a. The CAP was to include a submission of electronic data files (Excel or dBase) that identifies each credit balance account as of December 31, 2009 and the following information:
 - Member/Guarantor Billing Account Number
 - Credit Balance Amount
 - Date of Last Activity
 - Determination (Refund or No Refund)
 - Reason for No Refund
 - Amount of Refund
 - Refund Check Number
 - Date Refund Check Mailed

- b. Procedures implemented by Kaiser internal providers to ensure that overpayments are refunded within 90 calendar days of collection.
- c. Training conducted by Kaiser internal providers to inform staff of the refund policy and procedures implemented.
- d. Audit procedures to ensure that the Plan is monitoring the refund policy and procedures of its Kaiser internal providers.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If Kaiser internal providers or the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP is completed.

The Plan responded as follows:

- a. *As per conversations with Department representatives on March 2 and 9, 2010, the first report will be submitted by the Plan on April 26, 2010 based upon the 2009 DHMO Potential Liability Credits report. The following elements will be in the report:*
 - *Guarantor account number*
 - *Credit balance amount*
 - *Status: refund, resolved, open*
 - *Amount of refund*
 - *Refund check number*
 - *Date of refund check (mail date being within 5 days)*
- b. *Revenue Cycle will amend the Plan's Credit Balance Resolution Policy to clarify that, in accordance with current practice, a refund determination will be made within 90 days of issuance and receipt of the Remittance Advice, and the actual refund check (when applicable) will be issued within 6-8 weeks of the determination that a refund is due. The Policy was amended and a copy of the revised policy was submitted with the Plan's April 13, 2010 response.*
- c. *This procedure has been the Plan's practice. Refresher training to ensure clarity will be conducted to applicable staff by June 30, 2010.*
- d. *Monitoring of compliance with the SOX policy will be conducted by the Regional Revenue Cycle Audit Teams for Southern California and Northern California. Monitoring of compliance with the policy will also be conducted at the national level to ensure SOX compliance.*

The Plan identified the Vice President, Revenue Cycle, SCAL and the Vice President, Revenue Cycle, NCAL as the individuals responsible for overseeing the CAP.

The Department finds that the Plan's compliance efforts are not fully responsive to the deficiency cited and the corrective actions required. The Plan is requested to file a report detailing the resolution of credit balances reported on the physician and hospital reports as of December 31, 2009.

In addition, the Plan is required to implement a policy and procedures to notify guarantors when there is a balance owed on one billing system and an overpayment on the other billing system, and to file the implemented policy and procedures with the Department.

Finally, the Plan is required to justify the 90 days from the issuance of the remittance advice and to justify the reason it takes 6-8 weeks to issue a refund check.

2. Not Mailing Summary of Accumulation Statements

The Cost Sharing (Deductible, Copayments, and Coinsurance) section of the Plan's evidence of coverage ("EOC") states, in the Keeping Track of the Deductible section, "When you [member] pay an amount toward your Deductible, we [the Plan] will give you a receipt and will send you a statement. The statement will include the total amount you have paid toward your Deductible..."

The Department's examination disclosed that the Plan failed to issue summary of accumulation statements for several claims. They included Samples NP-36; SF-4, 28 and 35; and NF-4, 15, and 17. The Plan found that accumulation statements are not generated by its system for claims posted on the same day as the accumulation statement date.

For example, an accumulation statement dated July 27, 2008 lists all claims posted from July 26, 2008 back to at least June 27, 2008. The subsequent Accumulation Statement dated August 27, 2008 lists all claims from July 28, 2008 through August 26, 2008. As a result, claims posted to the accumulator on July 27, 2008 were not listed on any accumulation statements.

The Plan was required to submit the corrective action plan that was implemented to correct the above deficiency with its response to this report. The corrective action plan was to include a describe of system changes implemented to ensure accumulation statements are issued for all service charges applied toward deductible and out-of-pocket expenses.

The Plan responded that during the audit, a defect was uncovered in that when a member had claims finalized in the claim system on the same day as their regularly scheduled SOA run date, the charges were not picked up and reported on the SOA for that cycle, nor were the charges reported on any subsequent SOA cycle. A code change was made

to the program that sweeps for charges eligible for reporting on the SOA to ensure that no charges will be missed going forward. After system testing of the code change in a test environment and confirmation that the defect was eliminated, the SOA program was implemented in the production claim system on September 11, 2009.

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

3. Not Mailing Guarantor's Billing Statements

As previously indicated, the Cost Sharing section of the EOC states, in the Keeping Track of the Deductible section, "When you [member] pay an amount toward your Deductible, we [the Plan] will give you a receipt and will send you a statement. The statement will include the total amount you have paid toward your Deductible..."

The Department's examination disclosed that a member/guarantor's billing statement is not sent if there is no balance due or there is an overpayment by the member/guarantor. Pursuant to the Plan's EOC, the Plan is responsible for ensuring that Kaiser internal providers send a statement to the member or guarantor regarding a payment applied to a service even if no balance is due or if there is an overpayment, to document the member/guarantor's current account balance. The service date for the payment also needs to be identified, so the member/guarantor can obtain reimbursement from a Health Saving Account or flexible spending account, if applicable. This issue was noted in Samples NF-44, SF-9, SF-28 and SF-35.

The Plan was required to submit the corrective action plan that was implemented by Kaiser internal providers to correct the above deficiency with its response to this report. The corrective action plan was to include a copy of the policy and procedures implemented by Kaiser internal providers to ensure that guarantor's billing statements are sent monthly to document payments received from guarantors, and notify guarantors of overpayments.

The Plan responded that monthly statements are sent if there is money due. The Plan does not send statements if there is a zero balance due on the account. This is consistent with the industry standard, and with the design of the Plan's national billing system, which was designed based on industry standard provider billing practices.

However, the Plan's current practice is to provide the member with a demand statement with the entire payment history (including any zero balance status) upon request. In addition, the member is provided with a receipt at the time of check-in, and the member will receive information on all transactions when the cost-share is due.

The Department finds that the Plan's current practice does not resolve the deficiency cited and the corrective actions required.

The above deficiency will be referred to the Office of Enforcement for administrative actions.

E. EVIDENCE OF COVERAGE FOR END-STAGE RENAL DISEASE

Section 1363 (a) states, “The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The director may require that the materials be presented in a reasonably uniform manner so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.”

Rule 1300.63.1(b)(9) requires the evidence of coverage to include, among other things, a complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, co-payments, and deductibles.

The Plan did not fully communicate to members the terms and conditions for its end-stage renal disease (“ESRD”) coverage as follows:

Southern California Region

The ESRD Welcome Packet under the Coordination of Benefits Period section states, “...If you [member] have Kaiser Permanente coverage through an employer group health plan, Kaiser Permanente pays for all your medical care before you receive Medicare entitlement and for thirty days after your date of Medicare entitlement. Then Medicare becomes primary payer and Kaiser Permanente becomes supplementary payer. Kaiser Permanente will pay all co-payment and deductible amounts that Medicare does not pay.”

The EOC does not disclose that the Plan will pay all copayment and deductible amounts that Medicare does not pay.

The Plan was required to file with the Department a revised EOC that describes the coordination of benefits with Medicare and the waiver of copayment for members enrolled in Medicare. The Plan was required to submit evidence of the filing of the revised EOC with its response to this report.

The Plan responded that a majority of Kaiser Permanente members will get their Medicare coverage through the Plan’s Senior Advantage plan. These members will receive the Senior Advantage EOC which indicates that there is no co-pay for dialysis treatments. For the small number of members who have not assigned their Medicare coverage to the Plan, the Plan coordinates with that coverage. The Plan will file revised EOC language as follows:

Under the Coordination of Benefits section, the following paragraph will be added:

If you are enrolled in original Medicare or have Medicare coverage with another health plan or insurance company, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Call Center to find out which Medicare rules apply to your situation, and how payment will be handled.

In that the rules for coordination are very complex and are affected by many different individual circumstances, this proposed language is general in nature.

Since this will affect only a small number of people, the Plan proposes to file this addition with its annual EOC filing, which will take place in mid-April, 2010.

The Department finds that the Plan's corrective action is responsive to the deficiency cited and the corrective action required. However, the Plan is requested to provide evidence of this filing with its response to this Final Report.

F. CLEAR ESRD EXPLANATION OF BENEFIT

Rule 1300.71(d)(1) requires that the Plan shall not improperly deny, adjust, or contest a claim. For each claim that is denied, adjusted or contested, the Plan shall provide an accurate and clear written explanation of the specific reasons for the action taken.

Southern California Region

The following deficiencies were noted from a review of member explanation of benefit ("EOB") or provider remittance advices ("RA"):

1. The copayment amount on the EOB or RA did not agree with the copayment amount in the EOC for seven (7) out of the fifty (50) claims reviewed. They included claim samples ESRD S-10, 21, 23, 24, 32, 35, and 37.
2. The Plan failed to issue an EOB to member notifying him/her of the copayment amount due to provider for eight (8) out of the fifty (50) claims reviewed. They included claim samples ESRD S-1, 2, 3, 7, 21, 35, 37, and 40.
3. The explanation for claim adjustments on RAs was either missing or incorrect on fourteen (14) out of the fifty (50) claims reviewed. They included claim samples ESRD S-2, 3, 7, 8, 15, 18, 24, 27, 28, 29, 32, 33, 34, and 39.

Northern California Region

The EOB sent to ESRD members does not indicate the copayment amount that the member is responsible for paying. The EOB states, "...If your Kaiser Health Plan benefits require you to pay co-pays and other fees, you will be billed for these types of fees by Kaiser Permanente."

The EOB was required to indicate the copayment amount that the member is responsible for paying.

The Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP shall include the following:

- a. Procedures implemented in the Southern California Region to ensure that copayment amount on the EOB and RA agrees with the EOC.
- b. Procedures implemented in the Southern California Region to ensure that EOBs are sent to ESRD members.
- c. Procedures implemented in the Northern California Region to ensure that EOBs state the copayment amount that the member is responsible for paying.
- d. Procedures implemented in the Southern California Region to ensure that adjustment reasons are described on RAs.
- e. Training conducted to inform staff of the new procedures implemented.
- f. Audit procedures established to ensure that the Plan is monitoring the implementation of the new procedures.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

The Plan’s responded as follows:

Southern California Region

1. *Initially, the EOCs provided during the audit were incorrect. Thus the co-payment amount on the EOB or RA did not match the EOC. Upon further investigation, the correct EOCs were provided and added to the claim file at the time of the audit. The correct EOCs contained co-payment amounts that matched the EOBs and RAs for all claims sampled.*
 - a. *The Plan submitted Training Update # 2. It states that the co-payment amount in Foundations Systems reflects the co-payment amount in the member’s Evidence of Coverage (EOC). Foundations Systems is the system of record for claims adjustors to access benefits information, including co-payments.*
 - b. *SCCA is creating controls and criteria around the confidential provider designation process. These controls and criteria will address which types of providers should be considered providers of sensitive services. This will ensure that providers of ESRD services are not inadvertently included on the confidential providers list so that members*

receiving ESRD services will continue to receive their EOBs. SCCA submitted documentation of the process with its April 13, 2010 response.

- c. N/A*
 - d. The Plan submitted Training Update # 2. It outlines the steps claims adjusters must take to ensure that the explanations described on the RA and EOBs are not missing or incorrect.*
 - e. Training is not necessary because this was not a claims adjuster error. Initially, the wrong EOCs were provided at the time of the audit. The error was discovered and the correct EOCs were provided.*
 - f. SCCA will compare the benefits on the member ESRD EOCs with the Foundations Systems screens in the audit file to ensure that the correct ESRD EOCs are provided at the time of the audit.*
- 2. Prior to September 1, 2009, some ESRD providers were included on a list of “confidential” providers of sensitive services. As a result, EOBs to members for claims submitted by those ESRD providers were suppressed.*
- a. The Plan submitted Training Update # 2. It states that the co-payment amount in Foundations Systems reflects the co-payment amount in the member’s Evidence of Coverage (EOC). Foundations Systems is the system of record for claims adjusters to access benefits information, including co-payments.*
 - b. SCCA is creating controls and criteria around the confidential provider designation process. These controls and criteria will address which types of providers should be considered providers of sensitive services. This will ensure that providers of ESRD services are not inadvertently included on the confidential providers list so that members receiving ESRD services will continue to receive their EOBs. SCCA submitted documentation of the process with its April 13, 2010 response.*
 - c. N/A*
 - d. The Plan submitted Training Update # 2. It outlines the steps claims adjusters must take to ensure that the explanations described on the RA and EOBs are not missing or incorrect.*
 - e. Staff training was not necessary as this was a programming error. On September 1, 2009, SCCA completed a project to remove the confidential flag on ESRD providers, if present.*
 - f. SCCA will run a control report semi-annually to ensure that members receive EOBs when ESRD claims are adjudicated. The first such report was run for ESRD claims with*

dates of service from September 2, 2009 through January 13, 2010. Using a statistical sampling, it was determined that all members were sent their EOBs.

3. *The explanations on the RAs were either missing or incorrect.*
 - a. *The Plan submitted Training Update # 2. It states that the co-payment amount in Foundations Systems reflects the co-payment amount in the member's Evidence of Coverage (EOC). Foundations Systems is the system of record for claims adjusters to access benefits information, including co-payments.*
 - b. *SCCA is creating controls and criteria around the confidential providers designation process. These controls and criteria will address which types of providers should be considered providers of sensitive services. This will ensure that providers of ESRD services are not inadvertently included on the confidential providers list so that members receiving ESRD services will continue to receive their EOBs. SCCA submitted documentation of the process with its April 13, 2010 response.*
 - c. *N/A*
 - d. *The Plan submitted Training Update # 2. It outlines the steps claims adjusters must take to ensure that the explanations described on the RA and EOBs are not missing or incorrect.*
 - e. *The ESRD team received informal refresher training on September 23, 2009 to ensure that they are entering the correct explanation code in the claims system on all lines to ensure the appropriate message will be displayed on each line. Of the thirteen (13) claims attributed to claims adjuster error, six (6) were adjudicated by one adjuster. In addition to attending the ESRD team training on September 23, 2009, this claims adjuster received one-on-one refresher training with the supervisor on September 16, 2009 where the steps to ensure the correct explanations on the RAs and EOBs were reviewed.*
 - f. *SCCA will run a control report semi-annually to ensure that the explanations on the RAs and EOBs for ESRD claims are reviewed and applied appropriately.*

The Plan identified the Director, Southern California Claims, and the Compliance Director, California Claims as the individuals responsible for the CAP.

Northern California Region

- a. *N/A*
- b. *N/A*

- c. *The Authorized Outside Medical System (AOMS) has built in interfaces to Foundation Systems to appropriately determine the member's benefits, which includes copayment amounts from EOCs.*
- *Currently, AOMS generates an Explanation of Benefits (EOB) to ESRD members when a claim is paid. However, for cases where a copayment must be collected from the member, the EOB does not include information regarding member copayment responsibility.*
 - *Therefore, the system logic will be modified to (1) include the member copayment amounts and, (2) the letter language will be changed to inform the member that the Plan will send a bill requesting payment of any applicable copayment amounts.*
 - *The completion date of the changes to the system logic is July 31, 2010.*
- d. *N/A*
- e. *Once the system changes are implemented, the system will automatically make the changes in the EOBs. Staff training is not required for implementation to occur.*
- f. *A post implementation review will be performed to ensure accuracy of EOBs and letter language. A quarterly review of a sample of member EOBs will be performed to ensure compliance to requirements. Additionally, the Plan will conduct periodic internal audits, by Health Plan Regulatory Services, to ensure the inclusion of this information.*

The Plan identified the VP, California Claims and Member Services, and the TPMG AOMS Associate Director as the individuals responsible for the CAP.

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

G. REIMBURSEMENT OF ESRD COPAYMENT TO CALPERS MEMBERS

Section 1371 requires a health care service plan to reimburse uncontested claims no later than 45 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 45 working day period.

Southern California Region

The Department's examination disclosed that the Plan deducted copayments from payments to providers who rendered dialysis services to California Public Employees Retirement System ("CALPERS") members. However, the members should not have been assessed any copayments based on CALPERS subscriber contract. They included claim samples ESRD S-21 and 37.

The Plan was required to submit a Corrective Action Plan (“CAP”) to address the deficiency cited above. The CAP was to include the following:

- a. Implementing system changes to reflect no copayment for ESRD services to CALPERS members.
- b. Identification of all CALPERS claims for ESRS services where the member was assessed copayments from June 1, 2008 through the date corrective action has been implemented by the Plan.
- c. Evidence that copayment, interest and penalties, as appropriate, were paid retroactively to members for the claims identified in the paragraph immediately above. This evidence was to include an electronic data file (Excel or Access) or schedule that identifies the following:
 - Claim number
 - Date of service
 - Date of receipt
 - Total additional amount paid
 - Date of payment
 - Number of days used to calculate interest
 - Amount of interest paid
 - Amount of penalty paid
 - Interest and penalty paid date

The data file was to include the total number of claims and the total additional copayment, interest and penalty paid, as a result of remediation.

In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance. If the Plan was not able to complete the CAP or portions of the CAP within 45 days of receipt of this report, the Plan was required to submit a timeline with its response and monthly status reports until the CAP is completed.

The Plan responded that ESRD S-21 and 37 were remediated with interest at the time of the audit. SCCA performed a sweep of CalPERS ESRD claims from May 31, 2008 through August 25, 2009 to determine if any other CalPERS ESRD claims required remediation for co-payment deductions. Ten (10) such claims were identified and remediated with additional payments of \$1,785 and interest of \$91.50. Claims staff who originally adjudicated the remediated claims received one-on-one, informal refresher training.

In addition, a control report will be run semi-annually to ensure that co-payments for ESRD services are not deducted for CalPERS members. The first such report was run for CalPERS ESRD claims adjudicated from August 25, 2009 through February 1, 2010. Out of 369 claims, no claims were identified where co-payments were deducted for CalPERS members.

The Plan identified the Director, Southern California Claims, and the Compliance Director, California Claims, as the individuals responsible for the CAP.

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

H. COLLECTION PRACTICES

The Plan's Policy for Bad Debt and Collections Section 1.1 states, "Guarantor portions and out-of-pocket liabilities are due and payable within 30 days of receipt of initial bill."

The Department's examination disclosed the following collection deficiencies:

1. Inconsistent Collection Practice

The examination found that the balance's due date on the member/guarantor's billing statement is based on 15 calendar days from the statement date. The current 15-day remittance of the balance due is inconsistent with the Plan's Policy for Bad Debt and Collections, and does not allow member/guarantor adequate time to review the accuracy of charges on billing statement and pay the total amount owed. Several members have complained that this practice is unfair.

The Plan was required to state the Corrective Action Plan ("CAP) that it implemented to correct the above deficiency with its response to this report. In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

The Plan responded that a change in the due date, which will provide 30 days from the statement date, except for subsequent statements with past due amounts, will be embodied in a revised finalized Collections Policy on March 31, 2010. This Policy was submitted to the Department with the Plan's April 13, 2010 response. The due date field for subsequent statements with only a past due amount will show "PAST DUE". The Plan believes this change will provide ample opportunity for members to review and, if indicated, make pertinent inquiries regarding their statements.

When changes to the statements are made resulting from input from the focus groups (referenced in the response to C1), the revised statements will conform to the Collections Policy.

The Plan identified the Senior Vice President, Finance Operations California, the VP, Revenue Cycle, SCAL, and the VP, Revenue Cycle, NCAL, as the individuals responsible for the CAP.

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

2. Conflicting Information about Account Write-offs

Based on member's complaints filed with the Department, callers to the Plan's Deductible Product Service Center ("DPSC") were told, "Your account has been written off." Callers perceived that statement to mean that the Kaiser internal provider has accepted the member's payment in full for billed charges and has written off the remaining amount owed. Consequently, they are upset when they received subsequent communication from a collection agency. The DPSC staff should not inform members that their accounts have been "written off" unless these accounts are administratively written off, and the Kaiser internal provider has no intent to collect on the remaining amount owed.

The Plan was required to state the Corrective Action Plan ("CAP") that it implemented to correct the above deficiency with its response to this report. In addition, the Plan was required to state the management position(s) responsible for overseeing the CAP and a description of the monitoring system implemented to ensure continued compliance.

The Plan responded that prior to the DMHC Deductible Billing Survey, member calls were handled by the Deductible Product Service Team. Beginning in April 2009, member calls were incrementally transitioned to the Member Services Call Center (MSCC) which handles such calls for all lines of business, with 100% of the DHMO member calls to be transitioned to the MSCC by March 1, 2010.

To enhance member understanding and to ensure consistency and accuracy of information provided to members regarding their account status, including information regarding any amounts which have been referred for collections, the MSCC has created a new process for Customer Service Representatives (CSR) to adhere to when responding to member inquiries regarding their accounts. The new process was documented in Member Service Call Center's Process for Disclosing and Collecting Monies Owed to Kaiser Permanente, and was submitted to the Department with the Plan's April 13, 2010 response.

This process requires CSRs to investigate a member's account and use accurate, clear terminology to inform members of the status of their account balance and any amount in collections at the time of inquiry. CSRs will not use phrases such as the account has been "written off" when discussing the member's account.

Training of MSCC to implement the new process has begun. The following training plan will be provided to the Deductible Queue CSRs and our Team Managers, QA Analyst and Health Care Service Specialist who support these CSRs and Queue.

- 1) Present "Member Service Call Center's Process for Disclosing and Collecting Monies Owed to Kaiser Permanente" to all CSRs and supporting managers, through 3/12/10*

- 2) Review "Member Service Call Center's Process for Disclosing and Collecting Monies Owed to Kaiser Permanente" with CSRs and supporting managers in a Deductible Team Meeting in March -- meeting to be scheduled.
- 3) Present a training "Learning Break" on Escalated Calls and Diffusion Skills, to all of the above staff concluding no later than March 31, 2010.
- 4) Refresher Plan on P and P and Escalation skills will be reviewed via Learning Break with this Deductible team, every 4 months this year (March, by July, by November) and will revisit need in 2011.

Upon completion of training, monitoring of compliance with policy will occur with monthly monitoring of deductible product calls.

The MSCC QA Department monitors and evaluates customer service representatives' calls monthly.

The Plan identified the VP, Member Service Call Centers, as the individual responsible for the CAP.

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

SECTION II. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required for this Section.

KAISER FOUNDATION HEALTH PLAN, INC.
Northern California and Southern California Regions

**Final Report of the
Non-Routine Examination of Kaiser Foundation Health Plan, Inc.**

Exhibit FE-5

PLAN'S ADDENDUM RESPONSE TO FINAL REPORT

This Exhibit FE-5 and accompanying Attachment 1 represent the Plan's Addendum Response to the Department's Final Report dated April 30, 2010. The deficiencies delineated in the Department's Preliminary Report of the Non Routine Examination of Kaiser Foundation Health Plan, Inc., dated January 14, 2009, were responded to in detail in the Plan's March 10, 2010 submission (see eFile no. 20091297-5, Exhibit FE-13 Attachments 1-5).

On April 13, 2010, the Plan filed an Amendment to the Plan's Response to the Preliminary Report (see eFile no. 20091297-6) which included specified Policies and Procedures, the Service Level Agreement, and SCAL Confidential Provider Designation as specified in the Plan's submission of March 10, 2010 (see eFile no. 20091297-5, Exhibit FE-13 Attachment 1).

On April 28, 2010, the Plan filed an Amendment to the Plan's Response to the Preliminary Report (see eFile no. 20091297-7) which included a brief statement under Exhibit FE-13 Attachment 1 explaining the Deductible Health Maintenance Organization ("DHMO") Potential Liability Credits Report and the DHMO Potential Liability Credits Report under Exhibit FE-13 Attachment 1a. The report provided information regarding member accounts which show credit balances and includes the resolution for each member account.

In this submission, the Plan is providing under Exhibit FE 5 Attachment 1, a brief statement regarding the Department's findings in Deficiency A1 of the Department's Final Report.

Other Exhibits Included in This Filing:

Exhibit FE-5 Attachment 1: Plan Statement Regarding Deficiency A1

KAISER FOUNDATION HEALTH PLAN, INC.
Northern California and Southern California Regions

**Final Report of the
Non-Routine Examination of Kaiser Foundation Health Plan, Inc.**

Exhibit FE-5

PLAN ADDENDUM RESPONSE TO FINAL REPORT

In the Plan's April 13, 2010 response to Deficiency A1 as listed in the Department's Preliminary Report, the Plan noted that a Service Level Agreement would be implemented between the Plan and its internal providers that specifies "that 90 per cent of all billing statements, if balance due, will be sent out to the deductible member within 125 days of the date of service." In this statement, the Plan did not intend to imply that it expects that 10 percent of billings will not be processed in a timely manner. It is a minimum standard, with the expectation that timely claims submissions and subsequently timely guarantor statements will be generated more than 90 percent of the time. The Plan's Health Plan Oversight Committee and Health Plan Revenue Cycle Executive Committee continue to provide oversight to ensure timeliness of claims submission.

In the Department's finding for Deficiency A1 in the Final Report, the Department states that, "we find that contracted providers generally bill within 90 days and non-contracted providers generally bill within 180 days to insure adequate cash flow to fund their operations." The Department then finds that "Kaiser internal providers have difficulties generating claims within the norms experienced by other health plans..." The Department's assertion is not supported by the Department's findings as cited in the Final Report, which demonstrates that Kaiser internal providers also generally bill within 90 days of the date of service. For example, as depicted in the Report, during the first quarter of 2009, 95 percent of all professional claims in Northern California and 97 percent of all professional claims in Southern California were submitted within 90 days of the date of service.