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

April 21, 2004

IN REPLY REFER TO FILE NO.: 933-0055
USPS Priority Mail

FINAL REPORT

Mr. George Halvorson, Chairman and CEO
KAISER FOUNDATION HEALTH PLAN, INC.
One Kaiser Plaza
Oakland, CA 94612

RE: ROUTINE EXAMINATION OF KAISER FOUNDATION HEALTH PLAN, INC.

Dear Mr. Halvorson:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs 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 Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on January 29, 2004. The Department received the Plan's response on March 17, 2004

This Final Report includes a description of the compliance efforts included in the Plan's March 17, 2004 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 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."

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 provide 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 March 17, 2004 response, please provide the documentation no later than ten (10) days from the date of the Plan's receipt of this letter.

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

As noted in the attached Final Report, the Plan's March 17, 2004 response did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on January 29, 2004. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the report. If the Plan fails to fully respond and/or resolve the deficiencies presented in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

Please email an electronic copy of your response directly to the undersigned at jlarsen@dmhc.ca.gov, in order to expedite the reporting process. In addition, please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal <http://wp.dmhc.ca.gov/efile> under Report/Other, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is for the response to this report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov or Ed Cheever at (916) 324-8738 or email at echeever@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

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 call.

Sincerely,

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

Cc: Maria Borje-Bonkowski, Director Health Plan Licensing, Kaiser Foundation Health Plan, Inc.
Richard Cordova, Southern California Region President, Kaiser Foundation Health Plan, Inc.
Mary Ann Thode, Northern California Region President, Kaiser Foundation Health Plan, Inc.
Deborah Stokes, Vice President and Controller, Kaiser Foundation Health Plan, Inc.
Karen Keenan, Senior Counsel, Legal Department, Kaiser Foundation Health Plan, Inc.
Laura Weisshar, Controller Accounting Services-South, Kaiser Foundation Health Plan, Inc.
Lewis Chartrand, DMHC Deputy Director
Debra L. Denton, Assistant Chief Counsel, DMHC Office of Enforcement
Melissa Moon, Counsel, DMHC Division of Licensing
Mark Wright, Chief, DMHC Division of Financial Oversight
Agnes Dougherty, Senior Examiner, DMHC Division of Financial Oversight
Patricia Mazzeo, Examiner, DMHC Division of Financial Oversight

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

KAISER FOUNDATION HEALTH PLAN, INC.

FILE NO.: 933-0055

DATE OF FINAL REPORT: APRIL 21, 2004

SUPERVISING EXAMINER: JOAN LARSEN
EXAMINER-IN-CHARGE: AGNES DOUGHERTY
EXAMINER STAFF: KIM MALME, NED GENNAOUI, GALAL GADO, PATRICIA MAZZEO, MABEL WU, and MARTHA VILLEGAS

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 three organizations that comprise the Kaiser Permanente Program. The other two organizations are Kaiser Foundation Hospitals, a nonprofit public benefit corporation; and, the Permanente Medical Groups, for-profit professional organizations.
Type of Plan:	Full-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:	As of June 30, 2003, the Plan reported 6,534,391 members with 6,218,714 members in California and remainder in Hawaii. The Plan has approximately 8.2 million members nationwide, which includes its licensed health plan subsidiaries outside of California.
Service Area:	Major counties within California: Capital, Central California, East Bay, Golden Gate, North Bay, South Bay, Coachella Valley, Inland Empire, Metropolitan Los Angeles/West Los Angeles, Orange County, San Diego County, the Valleys (Woodland Hills, Kern County and Panorama City), Tri-Central (Baldwin Park, Harbor City, Bellflower), Western Ventura County.
Date of Last Public Routine Financial Examination Report:	October 3, 2000

FINAL REPORT OF A ROUTINE EXAMINATION OF KAISER FOUNDATION HEALTH PLAN, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs 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 Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on January 29, 2004. The Department received the Plan's response on March 17, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's March 17, 2004 response to the Preliminary Report, in accordance with Section 1382(c).

We performed a limited scope examination of the financial report filed with the Department for the quarter ended June 30, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our examination also included a limited review of certain fiscal and administrative transactions of the Plan' affiliate, Kaiser Foundation Hospitals ("Hospitals"). Our findings are presented in this report as follows:

Section I.	Calculation of Tangible Net Equity
Section II.	Compliance Issues
Section III.	Internal Control Issues
Section IV.	Other Issues

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained within 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 Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. CALCULATION OF TANGIBLE NET EQUITY (TNE)
(In Thousands)

Net Worth of Plan and Hospitals combined as of June 30, 2003[1]	$7,146,218
Less: Intangible Assets	(134,879)
Receivables from Affiliates	(365)
Tangible Net Equity	$7,010,974
REQUIRED TNE as of June 30, 2003	(677,898)
Excess TNE at June 30, 2003	$6,333,076

Rule 1300.76 requires each plan to maintain TNE at least equal to the specified minimum amounts at all times.

As of June 30, 2003, the Plan, on a combined basis with Hospitals, was in compliance with the TNE requirements of Rule 1300.76.

Therefore, no response to this section is required.

Although the Plan, on a combined basis with Hospitals, was in compliance with the TNE requirements of Rule 1300.76, the Department found deficiencies in the Plan's calculation of TNE that are addressed under Section II. A., below.

SECTION II. COMPLIANCE ISSUES

A. TANGIBLE NET EQUITY (TNE)

Section 1376 states that each plan shall have and maintain TNE equal to an amount that is calculated based upon requirements set forth in Rule 1300.76. Rule 1300.76(a) sets forth the method for determining the required amount of TNE that shall be maintained at all times.

The TNE reported by the Plan on its DMHC filing forms was not calculated correctly due to the following:

[1] Net worth reflects the net worth of the Plan on a consolidated basis with its wholly owned subsidiaries and combined with Hospitals on a consolidated basis with its wholly owned subsidiaries.

1. The Net worth position of the Plan was not reported on a consolidated basis with its wholly owned subsidiaries. [See Section II. B. for related comments.]

2. The full amount of the past due affiliate receivable was not deducted.

3. Intangible assets were not deducted.

4. In calculating the required amount of TNE, the Plan incorrectly included fee-for-service reimbursements (or "dollar-for-dollar" medical reimbursements, as referred to by the Plan) as capitated expenses. As a result, the Plan understated its required amount of TNE. Our examination resulted in a higher required TNE for the period ended June 30, 2003, as presented above in Section I.

The Preliminary Report noted that the Plan took corrective action to eliminate dollar-for-dollar medical reimbursements from its capitated expenses for purposes of calculating required TNE. It also deducted affiliate receivables that were past due. These actions were reflected in the Plan's financial filing with the DMHC as of September 30, 2003. However, the Plan did not report its net worth on the consolidated basis with its wholly owned subsidiaries and did not deduct intangible assets as required.

The Preliminary Report required that the Plan state the actions taken to correct all of the noted deficiencies and report its TNE in accordance with Rule 1300.76. The Plan was also required to state the management position(s) responsible for overseeing the corrective action and continue monitoring to ensure ongoing compliance.

The Plan responded by stating that it believed that its established reporting practice of including Plan financial information on the Orange Blank [now referred to as the DMHC Report Form] *itself, and providing combined affiliate and subsidiary information as supplemental information, was acceptable to the Department and in accordance with applicable Knox-Keene requirements. The Plan confirmed its corrective action as filed with the Department for the 3rd QTR 2003 with respect to correctly reporting the affiliate receivables and exclusion of dollar-for-dollar reimbursements as capitated expenses for purposes of the TNE calculation. The Plan also confirmed that it agreed to provide certain information for the Plan and its subsidiaries and Kaiser Foundation Hospitals ("Hospitals") and its subsidiaries on a combined basis on the Orange Blank, beginning with 4th Qtr. 2003. The Plan's 4th Qtr. 2003 Orange Blank was prepared including such combined information as well as deducting intangible assets as required. A copy of this filing was submitted with the Plan's Response.*

The Plan also noted in its response that a large portion of the affiliate receivables in question represented Plan funds that were invested by the Plan's affiliate, Kaiser Foundation Hospitals, as part of a centralized treasury investment function. The Plan did not view these amounts as affiliate receivables required to be deducted in the calculation of TNE, because they were available to the Plan upon short notice. The Plan confirmed that, in the combined filings with Hospitals, these affiliate receivables are eliminated in the course of the consolidation process.

The Plan stated that its Assistant Controller is the management position responsible for implementing the changes and the Plan's Controller will perform monitoring to ensure ongoing compliance quarterly.

The Plan's compliance efforts, as described above, are responsive to the corrective action required.

The Department noted that the Plan's calculation of TNE, as presented in the supplemental information that accompanies the DMHC Report Form for quarter ended December 31, 2003, deducts affiliate receivables and intangible assets. However, the affiliate receivables and intangible assets were not reported on the correct lines of Report #1-Part A: Assets of the DMHC Report Form. The affiliate receivables represent relocation loans to officers and are considered secured by the Plan for Generally Accepted Accounting Principles purposes, but these receivables are not considered secured by the Department for TNE calculation purposes. Therefore, these receivables are to be presented on line 9:Unsecured Affiliate Receivables of Report #1-Part A: Assets of the DMHC Report Form; and Intangible Assets are to be presented on line 14: Intangible Assets and Goodwill. The Plan is required to make these corrections in its DMHC Report Form filing for the quarter ended March 31, 2004, due May 15, 2004.

B. FINANCIAL REPORTING

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 1300.84 (f) states that a Plan with subsidiaries that are required to be consolidated under GAAP must present consolidating financial statements or consolidating schedules for balance sheet and statement of operations.

Rule 1300.84 (c) provides that financial statements of a plan are to be on a combining basis with an affiliate, if the plan or such affiliate is substantially dependent upon the other for the provision of health care, management or other services. An affiliate is required to be combined regardless of its form of organization, if the following conditions exist:

- Affiliate controls, is controlled by, or is under common control with, the plan, either directly or indirectly; and,

- Plan or the affiliate is substantially dependent, directly or indirectly, upon the other for services or revenue.

Our examination disclosed that the Plan was not filing the DMHC financial report form on a consolidated basis with its wholly owned subsidiaries, as required by Rule 1300.84(f). The financial statement information filed was based upon the Plan's operations in California and Hawaii only. Although the Plan filed consolidating schedules

with it subsidiaries as a separate attachment to its financial filings with the Department, it was not preparing the DMHC Report Form on a consolidated basis, in accordance with GAAP.

Our examination also disclosed that the Plan was not filing the DMHC Report Form on a combined basis with Hospitals and its wholly owned subsidiaries, as required by Rule 1300.84(c). Therefore, the Plan was required to file combined financial statements with Hospitals because both entities meet the requirements for combined filings pursuant to subsection (1) and (2) of this regulation. Both entities are under common control since they share the same Board of Directors and executive management. Also, Hospitals is dependent upon Plan for revenues and Plan is dependent upon Hospitals for inpatient services.

The Preliminary Report acknowledged that the Plan had initiated corrective action by confirming in writing that it would file the DMHC Report Form on a consolidated basis with the Plan's wholly owned subsidiaries, and combined with Hospitals and its wholly owned subsidiaries. The Preliminary Report required the Plan to begin filing the DMHC Report Form and supplemental reporting of TNE on a combined basis, beginning with the quarter ending December 31, 2003. A copy of the financial filing was to be submitted with the Plan's response. The Plan was also required to state the management position(s) responsible for overseeing the corrective action and continue monitoring to ensure ongoing compliance.

The Plan referred to its response to Section II.A of this report, and stated it made the required filing for the quarter ended December 31, 2003. A copy of the filing was submitted with its response. The Plan stated that monitoring to ensure ongoing compliance will be performed quarterly by the Plan's Controller.

The Plan's compliance effort, as described above, is responsive to the corrective action required.

C. CLAIMS REIMBURSEMENT

Section 1371 requires a 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. This Section requires 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 45 working days after receipt of the claim by the health 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.

Our examination for compliance with Section 1371 was limited to the review of claims for covered services provided by Hospitals that were paid by the Plan. The Department contracted with Macias Consulting Group to review the Plan's compliance with emergency claims subject to Section 1371.35 and other claim reimbursements (e.g., ambulance, durable

medical equipment) subject to Section 1371. The results of the review performed by Macias Consulting Group were addressed in a separate Preliminary Report issued on January 21, 2004. The Plan responded on March 16, 2004. A separate Final Report will be issued by the Department.

Northern and Southern California regions of Hospitals administer their claims processing operations separately. The deficiencies noted by the Department are reported by region, as follows:

Northern California

Our examination disclosed the following concerns as a result of our detailed claims review:

1. Interest was not paid for the period of time that late claims were internally pended for certain types of processing. (6 claims out of a paid claim sample of 100 claims, representing 6%). Interest was not paid and/or calculated correctly as a result of entering the following "pend" codes that stop the accrual of interest.

REASON CODE	DESCRIPTION
AH	Audit Hold
AO	APC Error
CB	COB Auto Edit
IC	Invalid CPT-UB82 Code
RV	Invoice Returned to Vendor
TR	Waiting for Transplant Reconciliation
WE	Waiting for EOMB

In some cases, the Plan explained to the Department that additional information was needed in order to continue processing the claim. However, a letter contesting the claim was not sent and/or a copy was not retained to support that the claim was contested in accordance with Section 1371. Examples are as follows:

SAMPLE NO.	PEND CODE	RECEIPT DATE	PAID DATE
23	AH	4/24/2002	7/2/2002
24	RV	10/02/2001	7/10/2002
26	AH	1/28/2002	7/18/2002
46	AH	11/4/2002	2/14/2003

2. Interest was not paid on additional payments for claims initially paid at lower amounts than indicated by the billed services and by the authorization. Upon appeal by the claimant, additional amounts were paid late without interest (14 claims out of a paid claim sample of 100 claims, representing 14%). In some cases it was explained that lower amounts were initially paid due to insufficient information to process the claim at the higher amount. The Explanation of Benefits accompanying the initial payment did not

state specific reasons for contesting the claim and/or paying the claim at the lesser amount, in accordance with Section 1371. Examples are as follows:

SAMPLE NO.	RECEIPT DATE	PAID DATE	INITIAL PAID AMOUNT	ADDITIONAL PAID AMOUNT
64	8/2/1999	9/5/2001	$ 32,132	$41,792
65	6/1/2001	9/14/2002	$202,921	$17,418
67	1/7/2000	2/14/2002	$ 17,862	$42,653
85	2/1/2002	4/17/2002	$ 8,024	$42,897
86	2/1/2002	4/17/2002	$ 8,266	$30,236

3. Interest was not paid on amounts withheld from claim payments for purposes of claims audit. The amount withheld (5%) was paid late without interest (20 claims out of a paid claim sample of 295, representing 6.7%). Examples are as follows:

SAMPLE NO.	RECEIPT DATE	5% PAID DATE
381(Strata5-22)	3/4/2003	6/5/2003
295(Strata5-50)	8/14/2001	11/23/2001
343 (Strata6-16)	8/17/2001	Appealed on 7/21/2003 no payment
350 (Strata6-29)	12/05/2001	6/9/2002
338 (Strata6-32)	5/29/2001	10/5/2001
383 (Strata7-11)	5/22/2002	12/6/2002
382(Strata7-13)	4/25/2002	10/16/2002

The Preliminary Report required that the Plan submit a Corrective Action Plan ("CAP") to substantiate the corrective action implemented to comply with Section 1371. The CAP was to include the following:

a. Identification of all non-emergency claims for which interest and fees were not correctly paid, since date of service on or after October 1, 1998. These claims shall include those claims paid late in which the payment of interest did not accrue during the time that the claim was internally pended, as described above. It shall also include those claims that were resubmitted after the original claim was incorrectly paid or denied and those claims where a portion was withheld for claims audit and the withheld amount was paid late.

b. Evidence that interest and fees, as appropriate, were paid for the claims identified in the paragraph above. This evidence is to include a schedule that identifies the following: the claim number, date of service, date of receipt, date of claim payment, provider name, paid amount, check number, interest paid, penalties paid, payment date of interest, interest payment check number.

c. Policies and procedures implemented to illustrate that the Plan provides adequate oversight to ensure that Hospitals claim processing system automatically accrues and

pays the correct interest on all late claims, pursuant to Sections 1371. The revised procedures shall include processes that ensure that the correct amount of interest is calculated, whenever a claim is resubmitted after the original claim was incorrectly paid or denied.

d. Policies and procedures implemented to substantiate that the remittance advice now cites the specific reasons to the claimant for a denial of all or a portion of each claim.

In addition, the Plan was required to state the date of implementation for each of the items in the above CAP, the management position(s) responsible for overseeing the CAP and to continue monitoring to ensure ongoing compliance.

The Plan's response to the Preliminary Report summarized three categories of claims for which remediation was requested:

1) claims internally pended for certain types of processing (as evidenced by particular "pend" codes),

2) claims where adjustment payments were made after the claims were initially paid at a lower amount in error; and,

3) claims suspended for a Medical Audit Department site audit.

The Plan acknowledged that interest is owed and remediation will be implemented for the second and third categories stated above. The Plan stated that a listing would be prepared, interest calculated, and checks with appropriate attachments sent to the provider. The Plan stated that the required evidence would be submitted to the Department in the form requested and that remediation will be completed by June 30, 2004.

Regarding the first category above (pended claims), the Plan acknowledged that interest is owed and remediation will be implemented for pend codes AO, CB, IC, TR and WE unless the Plan is able to locate a letter indicating that the claim was properly contested and subsequently paid timely. The Plan stated remediation will be completed by June 30, 2004 and the required evidence will be submitted to the Department in the form requested.

The Plan requested that it be permitted to utilize alternative evidence to support the non-applicability of interest to claims pended under codes AH and RV in certain instances where a copy of the letter contesting the claim is no longer available. The Plan stated that there are approximately 400 claims for which the Plan believes alternative supporting evidence may be available. This number comprises less than 6% of the total number of pended claims to which remediation may apply. The Plan submitted two examples of the type of proposed alternative evidence referenced above with its Response.

The Plan proposes that after it completes its research of the approximately 400 AH and RV claims referenced above, it will remediate claims for which neither a letter properly contesting the claim nor alternative evidence similar to the above examples was found. The Plan states such remediation will be completed by June 30, 2004. The required documentation for the remediated claims will be submitted to the Department in the form requested. In addition, the Plan states it will submit a listing of any claims not remediated and retain copies of the supporting letters and alternative evidence described above.

The Plan provided copies of the Plan's and TPMG's policies and procedures for the correct payment of interest as attachments to its response. The Plan stated that specific reasons for claim denials were included in letters, rather than in remittance advices. The Plan referred to Section II.F. of its response for a discussion of the Plan's Aurora DS letter generating system.

The Plan stated that its Director of Survey Readiness was the management position responsible for overseeing the corrective action for the appropriate application of interest. The Plan represented that its Health Plan Regulatory Services staff perform the annual oversight audits.

The Plan's compliance efforts as described above are not responsive to the corrective action required, because the compliance efforts are not completed. The Plan is required to submit a timeline with dates for completing specific actions towards full compliance for each of the corrective actions required in the preliminary report and repeated in this report. The timeline is due with your response to this report.

In addition, the Plan is required to submit status reports that demonstrate the Plan's progress towards completing the actions in the timeline and full compliance by June 30, 2004. The status reports are due bi-weekly with the first one due within approximately two weeks from the Plan's response to this report or May 28, 2004, the second update due June 11, 2004, the third update due June 25, 2004 and last update due June 30, 2004. The status reports shall be submitted to the attention of Joan Larsen, Supervising Examiner, and may be submitted via email.

The Plan's proposal for alternative evidence to support the non-applicability of interest to claims pended under the pend codes, AH and RV, in instances where a copy of the letter contesting the claim is no longer available is acceptable only in cases where the Plan can determine that a letter was sent to the claimant, notifying them in writing that the claim was contested or denied and the reasons for it. Therefore, the Plan may not conclude that interest is not applicable on late claims or late portions of claims in which there is no evidence to substantiate this.

The sample claim submitted as Example 1, Exhibit II.C.1.a. with the Plan's response does not indicate whether the interest paid was calculated to include the time that it was internally pended using the AH or "Audit Hold" pend code. Our examination

disclosed that these types of late claims did not include interest during the period of time that they were internally pended for codes, such as AH and other codes listed under paragraph 1. above. The policy and procedures submitted as Exhibit II.C.1.d emphasize capturing the proper timeframe for calculating interest, when a claim is contested and new information is received to continue processing the claim. It does not describe procedures for capturing the correct timeframe for calculating interest on a claim or portion of a claim that is reprocessed because the original claim was incorrectly paid. It also does not reflect revised procedures for capturing the timeframe while a claim is internally pended for reason codes, such as AH, during which time the accrual of interest has stopped, although the late claim has not been contested.

Therefore, the Plan is required to submit revised policies and procedures to address these issues and to describe any system enhancements made to capture the appropriate timeframes for calculating interest on all late claims, including late adjustments on claims.

In response to the Department's request for revised procedures that require remittance advices to cite the specific reasons for the denial of all or a portion of each claim, the Plan stated that specific reasons for claim denials were included in letters, rather than in remittance advices. The Plan is required to submit policies and procedures to demonstrate that letters sent to claimants cite the specific reasons for the denial. The Plan is also required to submit a sample of these letters with its response to this report.

Southern California

Our examination disclosed the following concerns as a result of our detailed claims review:

1. Interest was not paid on claims that were paid late (23 claims out of a paid claim sample of 60, representing 38.3%) for the following reasons:

- Claims were initially denied or paid incorrectly. Upon appeal by the claimant, additional payments were paid late without including interest.

- Claim payments were held for audit. Upon release, the claim was paid late without including interest.

2. Interest was not paid on late claims during the period May 2001 to November 2001. The Department identified approximately 3,000 claims (or less than 2% of paid claims) during this period of time in which interest was not paid.

Examples are as follows:

SAMPLE NO.	RECEIPT DATE	PAID DATE	BILLED AMOUNT
1	4/5/2001	11/9/2001	$27,335
33	3/26/2001	10/8/2001	$38,652
34	4/10/2001	7/9/2001	$73,075

The Preliminary Report required the Plan to submit a CAP to substantiate the corrective action implemented to comply with Section 1371. The CAP was to include the following:

a. Identification of all non-emergency claims for which interest and fees were not paid, since date of service on or after October 1, 1998. These claims shall include those claims that were resubmitted after the original claim was incorrectly paid or denied and those claims where payment was withheld pending a claims audit and then payment was made late.

b. Evidence that interest and fees, if appropriate, were paid for the claims identified in the paragraph above. This evidence is to include a schedule that identifies the following: the claim number, date of service, date of receipt, date of claim payment, provider name, paid amount, check number, interest paid, penalties paid, payment date of interest, interest payment check number.

c. Policies and procedures implemented to illustrate that the Plan provides adequate oversight to ensure that Hospitals claim processing system automatically accrues and pays the correct interest on all late claims, pursuant to Sections 1371. The revised procedures shall include processes that ensure that the correct amount of interest is calculated, whenever a claim is resubmitted after the original claim was incorrectly paid or denied.

In addition, the Plan was required to state the date of implementation for each of the items in the above CAP, the management position(s) responsible for overseeing the corrective action and to ensure ongoing compliance.

The Plan's response stated that as of March 1, 2004, the Plan completed implementation of a process to ensure that interest is paid correctly on late claims. The Plan stated that the process enhancements included a change in the claims payment system logic, and the use of an exception report for ensuring that interest is calculated and paid correctly.

The Plan also indicated that the Southern California Claims Administration (SCCA) had established a corrective action plan to remediate non-emergency claims for the period from October 1, 1998 through February 2004. The Plan represents that as of March 2, 2004 it identified the universe of claims to be audited and remediated for incorrect interest payment. The Plan stated these claims include claims involving payment adjustments after the original payment or late payment where payment was withheld pending a claim audit. The Plan represents that remediation will be done for those claims in which interest was not paid or was paid incorrectly.

The Plan's response stated that the remediation was delayed until April 2004 and will be completed by October 31, 2004 due to various reasons, such as a relocation of the SCCA from Pasadena to Downey and the need to restore claims older than 24 months from tape history to active status. The Plan represents that upon completion of the corrective action, the required evidence will be submitted to the Department in the form requested.

The Plan submitted the SCCA policy and procedures addressing interest for emergency and non-emergency claims for its hospital claims as an attachment to its response.

The Plan confirmed that the SCCA Operations Leader was the management position responsible for overseeing the corrective action for the appropriate application of interest; the monitoring is to be done through monthly claim audits performed by SCCA's Quality Assurance function; and, the Plan's Health Plan Regulatory Services staff performs the annual oversight audit.

The Plan's compliance efforts as described above are not responsive to the corrective action required because the compliance efforts are not completed. The Plan is required to submit a timeline with dates for completing specific actions towards full compliance with the corrective action required in the preliminary report and repeated in this report. The timeline is due with your response to this report.

In addition, the Plan is required to submit status reports that demonstrate the Plan's progress towards completing the actions in the timeline and full compliance by October 31, 2004. The status reports are due bi-weekly with the first one due within approximately two weeks from the Plan's response to this report or May 28, 2004, the second update due June 11, 2004, and so on, with the last update due no later than October 31, 2004. The status reports shall be submitted to the attention of Joan Larsen, Supervising Examiner, and may be submitted via email.

D. ADMINISTRATIVE AGREEMENT

Section 1367 (h) requires that contracts with subscribers and enrollees, providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair reasonable, and consistent with the objectives of this chapter.

Rule 1300.51 (d) (N) requires every applicant for licensure to file copies of its administrative services agreement.

Section 1352(a) and Rule 1300.52 require all plans to file an amendment with the director within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information. Section 1352(b) and Rule 1300.52.1 requires all plans to file material changes to the plan's operations as a Notice of Material Modification prior to any changes being implemented. 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 the above Section and Rules, as the following administrative agreements were not filed to support current arrangements:

1. The Plan did not have an administrative services agreement with its affiliate, Hospitals, that described the following cash investment arrangements and transactions:

    - "Sweeping" of excess cash from the Plan and its subsidiaries to Hospitals
    - Investment of funds on behalf of Plan and its subsidiaries by Hospitals
    - Retention of title to the invested funds in the name of Hospitals
    - "Daily Loan Balance" procedures for recording amounts owed and payable as a result of the cash sweep and allocation of expenditures between the parties.

2. The Cash Management Services Exhibit to the administrative services agreement between the Plan and various Plan subsidiaries outside of California (e.g. Kaiser Foundation Health Plan of Colorado ("Colorado")) provides that the Plan shall invest excess cash on behalf of Colorado. However, Hospitals invests the excess cash for Plan and its subsidiaries.

3. The Plan did not have an administrative services agreement with its affiliate, Hospitals, or with the Southern California Permanente Medical Group ("SCPMG"), authorizing the Plan to offset receivables and payables between Hospitals and SCPMG. Specifically, the Plan provides administrative accounting services to both Hospitals and SCPMG that includes offsetting receivables and payables on their behalf as part of its accounting functions.

The Preliminary Report required the Plan to review its administrative arrangements with Hospitals, and each of its affiliates, and file with the Department any revised or new administrative services agreements necessary to adequately support the services currently being performed on behalf of the Plan and its subsidiaries or for any services being provided by the Plan to an affiliate or other entity. A separate agreement was to be filed for each entity.

The arrangements described in the agreements was to address the elements noted below:

- A detailed description of each function performed by Hospitals on behalf of the Plan and its subsidiaries outside of California or by the Plan on behalf of each affiliate including Hospitals.

- A detailed description of the Plan's oversight procedures for continuous monitoring for the proper performance of each of the delegated services, to include the type of report and related timeframe for the report to be provided to the Plan for each delegated function; and, the identification of the management position(s) that will be responsible for oversight of each of these delegated functions.

- A written right of offset agreement authorizing the offsetting of receivable and payable transactions between KFH and any other entity including SCPMG [Reference to Section 1384, 1345 (s), and Rule 1300.45 (q)].

The required agreements were to be electronically filed with the Department's Filing Clerk in Sacramento as an amendment, in accordance with the Section and Rules stated above.

The Plan was required to provide evidence (i.e., a copy) in its response to this report that the required filings were submitted to the Department within forty-five (45) days after receipt of the Preliminary Report.

The Plan was also required to explain why it had not previously filed these amendments. Furthermore, the Plan was required to state the policies and procedures implemented to ensure that changes in contracts and agreements were properly filed with the Department, the date of implementation, and the management position(s) responsible for ensuring that all administrative arrangements are supported by written administrative agreements and properly filed with the Department in compliance with the Section and Rules stated above.

The Plan responded that it is currently developing an Administrative Services Agreement between the Plan and Hospitals to document the administrative services currently being performed by the entities for one another (other than those services already addressed in the Hospital Service Agreement). The Plan stated that the agreement would specifically address the cash sweep, daily loan balance procedures and investment arrangements, including the fact that title to the invested funds is held in the name of Hospitals. Offset arrangements between the entities will also be addressed. In addition, the Plan stated that the Agreement would include a description of the Plan's oversight procedures for monitoring the administrative services provided by Hospitals.

The Plan stated that existing Administrative Services Agreements between the Plan and its various health plan subsidiaries in the regions outside of California (the "ROCs") will be amended to delegate investment responsibility to its affiliate, Hospitals. The Plan also stated that any additional amendments would be made to reflect any other services that Hospitals provides to the ROCs on the Plan's behalf.

The Plan responded that a Right of Offset agreement between the Plan, SCPMG and Hospitals is being prepared to document that the parties have agreed to the offsetting of receivables and payables between SCPMG and Hospitals. The Plan stated that although SCPMG will be a party to this Right of Offset agreement, SCPMG is not an affiliate of either the Plan or Hospitals. (Similarly, TPMG is not an affiliate of either the Plan or Hospitals.)

The Plan confirmed that when the agreements and amendments are completed and executed by the parties, they would be electronically filed with the Department's Filing Clerk in Sacramento as an amendment to the Plan's license, in accordance with the requirements of the Knox-Keene Act and regulations. The Plan represented that it will submit such filing no later than June 30, 2004.

The Plan stated that agreements and amendments described were not previously prepared and filed because the Plan believed its current administrative services agreements, along with the administrative services aspects of the Medical Service Agreements with TPMG and SCPMG and the Hospital Service Agreements with Hospitals, were sufficient to address the provision of services among the entities.

The Plan represented that its Controller is responsible for ensuring that all administrative arrangements are supported by written administrative agreements and properly filed with the Department. The Plan further stated that the monitoring of this compliance would occur through the quarterly financial review process conducted by the Plan Controller's department.

The Plan's compliance efforts as described above are not responsive to the corrective action required because the compliance efforts are not completed. The Plan is required to submit a timeline with dates for completing specific actions towards full compliance with the corrective action required in the preliminary report and repeated in this report. The timeline is due with the Plan's response to this report.

In addition, the Plan is required to submit status reports that demonstrate the Plan's progress towards completing the actions in the timeline and full compliance by June 30, 2004. The status reports are due bi-weekly with the first one due within approximately two weeks from the Plan's response to this report or May 28, 2004, the second update due June 11, 2004, the third update due June 25, 2004 and last update due June 30, 2004. The status reports shall be submitted to the attention of Joan Larsen, Supervising Examiner, and may be submitted via email.

E. MONITORING FINANCIAL VIABILITY OF CAPITATED PROVIDERS

Rule 1300.67.8(c) requires a health plan to monitor the financial capacity of providers when they are compensated on a capitated basis. Section 1375.1(a)(3) and (b) requires a health plan to demonstrate a procedure for prompt payment or denial of provider claims and the financial soundness of the Plan's arrangements for health care services. Health plans that capitated provider groups and delegate claims payment functions to these provider groups must have procedures in place to ensure that these groups comply with Sections 1371, 1371.35 and 1375.1(a)(3) and (b).

Northern California and Southern California

Our examination disclosed that the Plan does not monitor the financial capacity of its capitated providers. Although the Plan monitors claims payment processing practices of its capitated providers, the Plan does not have written procedures in place to review their financial statements or other financial documents for compliance with the financial viability requirements of these Sections and Rule.

The Plan's compliance division, Health Plan Regulatory Compliance, provided policies and procedures for the oversight of delegated providers claims processing, but not for the oversight of their financial viability. Examples of capitated providers in which oversight procedures were not provided to support this aspect of compliance with Rule 1300.67.8(c) were provided to the Plan and included TPMG and SCPMG.

The Preliminary Report required the Plan to state the procedures implemented to ensure that the Plan monitors the financial capacity of its capitated providers in compliance with Rule 1300.67.8 (c). These procedures were to state the type of financial documentation the Plan obtains from the capitated providers, and the type of review performed as part of its monitoring process.

The Plan was required to provide a copy of these updated policies and procedures, state the date implemented, the management position responsible for ensuring the implementation of these procedures, and the controls implemented for monitoring continued compliance in this area.

The Plan responded that during the time period that was the subject of this financial audit, the Plan engaged in a number of activities on a regular basis to monitor the financial performance and capacity of TPMG and SCPMG. These activities included, among others:

- *annual development and negotiation of the Basic Contractual Payment*
- *annual budget development and monthly budget oversight meetings*
- *monthly income statement review*
- *periodic balance sheet reviews*
- *joint Plan and PMG review of external provider contracts for financial impact.*

The Plan noted that it is the only health care service plan with which TPMG and SCPMG contracts. The Plan also stated that due to the compensation arrangements under the Medical Service Agreements with the Plan, TPMG and SCPMG are not "risk-bearing organizations" for purposes of Section 1375.4 of the California Health and Safety Code.

The Plan stated that it has now formalized its processes for monitoring the financial viability of capitated providers, including TPMG and SCPMG. Beginning 1st Qtr. 2004, the Plan's Northern and Southern California Directors of Financial Planning & Analysis will obtain and review quarterly unaudited financial statements and annual audited financial statements for its capitated providers that are delegated for claims payment. After analyzing such information, they will prepare annual "Summary of Financial Condition" reports for review by the Plan's Northern and Southern California CFOs, respectively.

A copy of the Plan's policies and procedures for monitoring the financial viability of capitated providers was submitted as an attachment to its response.

The Plan represented that the management positions responsible for implementing these policies and procedures are the Northern California and Southern California Directors of Financial Planning & Analysis. The Plan stated the monitoring is performed by the Plan's Financial Governance area.

The Plan's compliance efforts as described above are responsive to the corrective action required.

F. BOOKS AND RECORDS

Section 1381 (a) requires all records, books, and papers of a plan, management company, solicitor, solicitor firm, and any other provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm shall be open to inspection during normal business hours by the director.

Rule 1300.85.1 states the retention requirements for the books of account and other records for each plan. It also requires that Plans store their books of account and other records in an easily accessible place at the offices of the Plan. After such books and records have been preserved for two years, the Rule states that they may be stored, subject to their availability to the Director within not more than 5 days after request.

Northern California

Our examination disclosed that copies of letters sent to providers contesting a claim were not retained. Claims were contested because more information was needed in order to process the claim and/or because a portion of the entire claim was denied.

The following are examples:

Sample No.	Receipt Date	Paid or Denied Date	Paid Amount
7	8/22/2001	1/17/2002	$2,673.
400	3/21/2001	6/29/2001	$0
405	5/31/2001	9/28/2001	$0
407	8/16/2001	6/28/2002	$0
409	6/14/2001	11/29/2002	$0

The Preliminary Report required that the Plan state the procedures implemented to ensure that the Plan is retaining copies of all letters sent to providers for contesting a claim in compliance with Section 1381 (a) and Rule 1300.85.1.

The Plan was required to provide a copy of these updated policies and procedures, state the date implemented, the management position responsible for ensuring the implementation of these procedures, and monitoring for continued compliance in this area.

The Plan responded that it acknowledged that it was unable to provide copies of the letters for contested claims for the audit sample. The Plan stated that during the period that was the subject of the audit, claim letters were not consistently produced from a single system, which created difficulty in retrieving them. The Plan also stated that it provided documentation indicating entries into the system and related dates supporting the timeliness of the claim adjudication.

The Plan stated that it independently identified this deficiency prior to receiving the Department's findings and corrected it as of January 1, 2004. As a result of this correction, the Plan's AOMS claims payment system now interfaces with the Aurora DS letter generating system to produce all claim letters from a single system. This new system also archives the letters and allows for their retrieval.

The Plan represented that the management position responsible for implementing this correction is the Plan's Director of Survey Readiness. The Plan stated that the monitoring will be done through the annual claims audit performed by Health Plan Regulatory Services staff, which will include the review of contested claim correspondence as an element of their audit.

The Plan's compliance efforts as described above are responsive to the corrective action required.

G. FIDELITY BOND

Rule 1300.76.3 requires that each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner, and employee of the plan, whether or not they are compensated. It shall provide for thirty- (30) days' notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan provided by schedule.

The Plan's fidelity bond did not include the thirty (30) days written notification to the Director prior to cancellation.

The Preliminary Report required that the Plan file a complete copy of the fidelity bond, including all endorsements, which complies with the requirements of Rule 1300.76.3, as an amendment filing with the Filing Clerk in Sacramento.

The Plan was required to provide evidence (i.e., a copy) in its response to the Preliminary Report that the requested filing was submitted to the Department within forty-five (45) days after receipt of the report.

The Plan was also required to provide a copy of its policies and procedures implemented to ensure compliance with the above Rule, state the date implemented, the management position responsible for ensuring the implementation of these procedures, and the monitoring for continued compliance in this area.

The Plan responded that its fidelity bond was amended by adding Endorsement #11, which states that the insurer must provide at least thirty (30) days written notice to the Director of the Department prior to cancellation. The Plan stated that as amended, the fidelity bond complies with all of the requirements of Rule 1300.76.3. A copy of the Plan's fidelity bond, including the new Endorsement #11 and all other endorsements, was submitted as an amendment filing with the DMHC Filing Clerk in Sacramento on March 12, 2004 and included as an attachment to the Plan's response.

The Plan represented that the Corporate Insurance Manager was responsible for arranging for annual renewals of the fidelity bond. The Plan also stated that at the time of renewal, the Corporate Insurance Manager would complete a checklist confirming that the renewal policy meets the requirements of Rule 1300.76.3 and retain a file of the completed checklist. A copy of this policy and procedure was submitted as an attachment to the Plan's response.

The Plan also stated that the Director of Corporate Risk Management is responsible for monitoring continued compliance in this area.

The Plan's compliance efforts as described above are responsive to the corrective action required.

SECTION III. INTERNAL CONTROL

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.

Statement on Auditing Standards (SAS) No. 78 states "Internal control is a process---effected by an entity's board of directors, management, and other personnel---designed to provide reasonable assurance regarding the achievement of objectives in the following categories: (a) reliability of financial reporting, (b) effectiveness and efficiency of operations, and (c) compliance with applicable laws and regulations."

SAS 60 requires an auditor to communicate reportable conditions noted during the examination to appropriate personnel. Reportable conditions involve matters coming to the auditor's attention relating to significant deficiencies in the design or operation of the internal control structure, which could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

CLAIM RESERVES

Our examination included a review of the claim reserves for the California operations of Hospitals. The Plan is financially responsible for the claim expenses of Hospitals. The following internal control weakness was identified:

Northern California

Our examination disclosed that the reserves for referral claims in the Northern California region of Hospitals was consistently understated by approximately $3.5 to $8.9 million for the period of January 2001 through March 2003, when compared to actual paid claim information for dates of service during this period. Although, the amount of understatement was not material and the total reserves for all regions was adequate, the length of time that this occurred for the Northern California region indicates that the methodology used to determine the claims reserve in this region should be reviewed.

The Preliminary Report required that the Plan state the policies and procedures implemented to strengthen the above weakness, the date of implementation, and the management position responsible for compliance and for monitoring continued compliance.

The Plan responded that in November 2003, the process for calculating IBNR reserves for referral claims in the Northern California region of Kaiser Foundation Hospitals was changed in order to address this weakness. The Plan stated that as modified, the process is now consistent with the process used to calculate all other categories of claim reserve estimation (i.e., Northern California and Southern California emergency claims, and Southern California referrals).

The Plan also stated that under the new process, a claim payment triangle is produced on a monthly basis detailing the claims paid to date by month of service. This data is then used as part of an actuarial model to calculate an IBNR balance. The Plan further stated that checking claims run-outs and making revisions as payments emerge is an integral part of the process. The Plan stated that general ledger reserves are reconciled to the actuarial estimates on a monthly basis.

The Plan confirmed that its certifying actuary is responsible for the monthly production and review of the reserves currently and going forward. The Plan stated that the monitoring is performed through review of the reserves at a monthly meeting with the Northern California financial staff, including the Northern California Controller, prior to the financial close.

The Plan provided an example of the results generated under the revised approach, and the reconciliation of general ledger reserves to the actuarial estimates for January 2004 was submitted as an attachment to its response.

The Plan's compliance efforts as described above are responsive to the corrective action required.

SECTION IV. OTHER ISSUES

BOARD MINUTES

Board minutes for the Plan and Hospitals do not reflect approval of the specific combination of Plan/Hospitals long term subordinated debt issued by Plan and by Hospitals to satisfy statutory net worth or other regulatory requirements of guaranteed subsidiaries, such as the Kaiser Foundation Health Plan in New York and Kansas. During the examination, the Plan's staff indicated that these decisions were not reflected in the Board minutes since they are management, rather than Board decisions. The issuance of debt by Plan and Hospitals results in part from the Guaranty Agreement entered into by these two parties in April 1989, in which they agreed to act as guarantors for the liabilities of one another and certain Plan Subsidiaries. Therefore it is recommended that these financial transactions be discussed and approved by the Plan's Board of Directors and reflected in the minutes.

The Preliminary Report required the Plan to provide assurances that all material transactions including issuance of debt related to its guaranty agreements shall be approved by the Plan's Board of Directors and reflected in the Board minutes.

The Plan responded that the Finance Committee of the Plan's Board of Directors is charged with reviewing major transactions, investments and expenditures which represent a significant financial commitment or which have significant strategic or operational implications for the Plan. The Plan represented that under the Finance Committee's charter, certain categories of major transactions must be reviewed by the Finance Committee and recommended for approval by the Board.

The Plan stated that an amendment to the Finance Committee charter was approved by the Plan's Board of Directors on March 10, 2004. **.** *Pursuant to that amendment, guarantees and long-term extensions of credit that are either (1) over $25 million, or (2) restricted as to repayment (such as subordinated debt), have been added to the categories of major transactions requiring review and recommendation by the Finance Committee. The Plan also stated that once such transactions are submitted to and approved by the Board, those approvals would be documented in the Board's meeting minutes or in Board resolutions adopted by unanimous written consent.*

The Plan confirmed that on an annual basis, the Plan's Controller will verify that all guarantees and long-term extensions of credit issued during the year and requiring Board approval are properly documented in Board minutes or resolutions.

The Plan's compliance efforts as described above are responsive to the corrective action required.